Anticipating ‘secure’ developments

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Anticipating ‘secure’ developments

*How pre- and postnatal healthcare professionals work with risk and trust and (re) shape mothers’ and fathers’ roles in the Netherlands, Germany and Poland*

Inaugural dissertation

For obtaining the degree of doctor of philosophy in the faculty Sociology at the Johann Wolfgang Goethe University in Frankfurt am Main

submitted by

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from: Den Helder, the Netherlands

2017
(Year of submission)

2018
(Year of publication)

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Date of the verbal examination:

April 18 2018
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This dissertation originates from a larger project named: *Apparent: international and national studies of norms and gender division of work at the life course transition to parenthood*. The Apparent project was directed by Prof. dr. Daniela Grunow, located in the faculties of Social Sciences at the University of Amsterdam and at the Goethe University Frankfurt, and lasted from 2011-2016. The research leading to these results has received funding from the European Research Council under the European Union’s Seventh Framework Programme (FP/2007–2013) / ERC Grant Agreement no. 263651.

A part of this dissertation has been published online before, as the result of the joint efforts of two authors.

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1 Introduction
1.1 Interrogating perspectives on mothers’ and fathers’ roles in family life and work at the transition to parenthood

Over the past century, there has been an increasing interest in and uncertainty about what is happening and what might happen in the future when women and men become mothers and fathers and new children are born into the world; how will these men and women perform in their new roles as parents and in their existing roles in the labour market? How will parents divide tasks and how will families affect the lives of their young children? And accordingly: how will young children prosper and develop in the early stages of their life course? Hence, everyday parenting activities, once considered as “relatively unimportant private routines” (Lee et al. 2010, p.294), have been problematized and destabilized and as such they have become increasingly subject to public debates and governmental investments, since the range of activities that constitute ‘parenting’ are to concern the next generation and the entire society (Donzelot 1979; Lee et al. 2010; Ramaekers and Suissa 2011). This dissertation provides an in-depth examination of how distinct perspectives on mothers’ and fathers’ roles are presented, integrated and shaped on different levels in varying countries.

Within the concerns about family life and work, three parallel but separate conversations have been detected. All these conversations recognize a problem, but the problem definitions and solutions differ (Gornick and Meyers 2003, p.2):

1. Public health, education and child development studies are concerned with how children prosper on various dimensions and the role of the family in ‘child outcomes’ in terms of their physical, mental and cognitive health and well-being, including concerns about how children are ‘programmed’ through their early brain development (see Macvarish et al. 2014), which is to be promoted by parents’ – in particular mothers’ – availability and their opportunities to invest in parenting and to be out of the labour market.

2. Welfare state scholars and policy analysts are concerned with the work-family conflict and with how working parents, in particular mothers, are overburdened by competing demands on the labour market and at home. The focus here is on policies that enable parents, especially mothers, to
combine working and caring tasks and achieve a work-life balance, by access to leave and flexibility of work.

3 Feminists and women’s movements on the other hand are concerned with gender inequality in the labour market and at home and how parenthood norms structure women’s and men’s roles in fixed directions, implying limitations for mothers to participate in employment. The focus in this conversation is on the lack of access that mothers have to the social, political and economic advantages tied to the labour market when they opt out of employment, and on suggesting alternatives, such as outsourcing childcare and fathers’ involvement in caring and household work.

So far, there has been limited dialogue between the participants of these conversations (Gornick and Meyers 2003), although some scholars have argued for a research agenda that integrates the different concerns and solutions:

“Restricting the focus only to equal opportunities between men and women is not sufficient, and even less so the argument that it is necessary to increase women’s labour force participation rate for economic reasons. Both arguments underplay the children’s perspective. More promising, both from the point of view of social justice and from that of responding to parents’ concern for their children, is the argument which integrates the gender equal-opportunity discourse with that of children’s rights and equal opportunities among children. [...] A research agenda must be developed that integrates the distinct dimensions involved when discussing who should care for very small children, how much and under what conditions” (Saraceno 2011, p.92, 94).

On the one hand, we can find scholars who argue that family policies play a crucial role in such an integration of perspectives, by providing mothers and fathers with equal opportunities to work and to contribute at home; by focussing on the role of the state and of the family, and by facilitating high quality parental and non-parental care (Gornick and Meyers 2003; Saraceno 2011; Coltrane and Behnke 2013). On the other hand, we can find scholars who have paid attention to child development discourses and healthcare experts’ roles who conclude that professional fields and experts involved with childbirth and child development play a crucial role in reproducing
mothers’ and fathers’ gendered work and care divisions, legitimated by ‘children’s needs’. These scholars propose that an integration of perspectives that includes sensitivity to gender (in)equality should therefore be introduced to these professional and expert fields (Vuori 2009; Knaak 2010; Murphy 2003; Müller and Zillien 2016; Tiitinen and Ruusuvuori 2014).

In this dissertation I argue that not only the separate perspectives described above should be studied in relation to one another, but also the contexts in which these perspectives are framed and applied (Veltkamp and Grunow 2012). Indeed, one could ask whether it is sufficient to look at family policies alone to fully understand how the separate solutions provided to (anticipated) problems of a) children’s development, b) work-family conflicts and c) gender inequality are institutionalized in a given country, because the concerns for children, family life and parents’ roles and investments are also institutionalized in public healthcare policies. This is in particular the case in pre- and postnatal healthcare, a service that is potentially as informative for new parents in performing and balancing their new roles as family policies are, not least because these services include direct contacts between healthcare professionals, parents and children.

The first contribution of this thesis is therefore that I establish a framework in which work-family and parenting institutions are analysed in relation to pre- and postnatal healthcare policies, family policies and cultural values about gender roles, parenting and child development. The second contribution is that this is done in a cross-national comparison between the Netherlands, Germany and Poland, because such policies are predominantly country-specific and a comparison is especially suitable to shed light on the particular nature of healthcare and family policy institutions, cultural values and the relationships between them in a particular context, as well as on the differences and similarities between diverse contexts. The third contribution is that I examine how the presented macro level institutions in these countries are on the individual level related to pre- and postnatal healthcare professionals’ perceptions and their interactions with diverse mothers, fathers and children within these countries.

The focus in this study is on gender, as a social structure, rooted in institutional, interactional and individual levels of societies (Risman 2004; Grunow and
Veltkamp 2016) in which distinctive ‘maternities’ and paternities’ are produced and reproduced in everyday life (McNay 1999; West and Zimmerman 1987). When looking at gender, I take into account how mothering and fathering roles intersect with other categories that can be related to forms of disadvantage and privilege, such as parents’ socio-economic class positions and ethnic backgrounds (see Crenshaw 1989; Lutz et al. 2011). Moreover, this study focuses on perceptions of ‘risk’ within perspectives on mothers’ and fathers’ roles and child development, as a means to deconstruct how and to what end mothers’ and fathers’ roles are problematized and framed, who are targeted and made responsible for particular roles in family life and work and how this is dealt with in the professional practice.

1.2 Institutions and risk perceptions

As visualized in figure 1.1 (page 16), problem definitions and solutions about mothers’ and fathers’ roles are investigated in relation to a) pre- and postnatal healthcare policies, b) family policies and c) cultural values about gender roles within the family (here defined as ‘gender culture’), and cultural values about parenting, childhood and child development (here defined as ‘parenting culture’), in order to study the nature of these problematizations and whether they are in line or in conflict in a given context. The inner rings of figure 1.1 that concern ‘professionals’ and ‘interactions’ are explained on page 23, after discussing the institutional and (cross-)national components of this research in the following sections.

Starting on the macro level, policies, cultural values and social structures are approached as ‘institutions’. With institutions, I mean webs of interrelated formal and informal norms and rules (Nee and Ingram 1998, p.19), as “more enduring features of social life” (Giddens 1984, p.31), that structure social, economic and political relationships (North 1990; Douglas 1986; Nee and Ingram 1998), including forms of discourse as well as political, economic and legal institutions (Giddens 1984). A distinction needs to be made between institutions and organizations, in which “institutions are the rules of the game and organizations are the players” (North 1993, p.4). Moreover, “the rules may arise spontaneously in response to a variety of problems, and perform many functions without any single overall objective” and
organizations “refer to a purposive arrangement for achieving a specific goal” (Douglas 1993 in Fardon (ed.) 2013, p.36). In our case, the focus will be on family policies and pre- and postnatal healthcare policies and how they relate to particular cultural values on the one hand, and on pre- and postnatal healthcare organizations and professionals on the other hand.

Figure 1.1 Conceptual model institutions and risk perceptions about mothers’ and fathers’ roles

Source: Own depiction derived from Grunow and Veltkamp’s (2016, p.13) figure that relates ‘institutions’ to individual parents-to-be, inspired by Bornstein and Cheah’s (2006, p.4) “Contextual ecological view of development” and Schutz’ (1972) “Phenomenology of the Social World”

‘Culture’ is in this dissertation understood as “structured, practice-based systems of situated collective knowledge and understanding used to organize and manage life” (Ingold 2000, summarized by Boholm and Corvellec 2011, p.178). Cultural values are not approached as a coherent system, but as “divergent or even contradictory values and ideals [that] may exist” (Pfau-Effinger 2005, p.6) within specific contexts (Douglas 1986; McNay 1999).
In this study, I look at ‘gender culture’ as it is reflected in “dominant cultural family models”, which are based on “cultural values in relation to the family-employment relationship of the adult family members, the gender division of labour within the family, and the most suitable form of care for the children” (Pfau-Effinger 2005, p.533). It should be noted that ‘care for children’ is in this definition understood in relation to parents’ employment patterns. Therefore, I will in addition also take ‘parenting culture’ (Lee 2014) into account, to detect the dominant cultural models that concern cultural values of how children and childhood should be approached, how children should be raised and cared for, and what they supposedly need and from whom to develop ‘properly’. I include this to also explicitly capture cultural values that relate to the conversation about family life and work focused on ‘child development’ (see page 12). As said earlier, this research takes into account how policies and cultural values regarding mothers’ and fathers’ roles intersect with broader social structures of gender and social class, thereby acknowledging and examining diversity among ‘parents’ and constructions of ‘parenthood’ (Lutz et al. 2011).

It is salient to note that the problem definitions within the distinct conversations about mothers’ and fathers’ roles after childbirth, in particular those related to children’s development and gender equality, are not so much referring to immediate problems, but they rather point to unfavourable or harmful outcomes on individual and societal levels anticipated in the future, as predicted by correlations found in scientific research, on the one hand regarding children’s health and development (Ramaekers and Suissa 2011) and on the other hand regarding mothers’ and fathers’ career patterns and social and economic positions over their life course (Esping-Andersen 1999). In that sense, these family life and work conversations present perceptions of ‘risk’, when using the definition:

“The probability that a particular adverse event occurs during a stated period of time or results from a particular challenge.” (Royal Society 1992, p.2)

This definition is useful in shedding light on assumptions that are central to such risk perceptions, namely in how they represent ‘adverse events’; in how they apply a ‘time frame’, and in how they assume ‘categorizations’ (Brown et al. 2013). A selecting of
particular ‘adverse events’ shows that outcomes which are considered unfavourable are not merely ‘rational’ calculations of what could happen in mothers’, fathers’ and children’s lives, but what is defined as ‘adverse’ is moral, political and loaded with cultural values (Douglas 1992; Møller and Harrits 2013; Brown et al. 2013). Hence, it is particularly relevant to examine risk perceptions integrated in diverse institutions more closely, because “which risks, at which level, are acceptable to groups of people is always a social question” (Boyne 2003, cited by Desmond 2015, p.201).

Using a ‘time frame’ (Royal Society 1992; Brown et al. 2013) appears to be central within risk perceptions in child development studies. The renewed interest in parenting has been framed as a mechanical approach to childhood and to being a parent, that promotes scientifically informed parenting behaviour to avoid negative outcomes and obtain good outcomes for children over time (Ramaekers and Suissa 2011; Lee et al. 2010; Knaak 2010; Faircloth 2014a). During the twentieth century, the dominant Western framing of childhood shifted from one in which children ought to be disciplined and protected from themselves to a belief that children should be happy, able to play and require protecting from the world (Ansell 2005), as vulnerable and dependant beings (Christensen 2000, Bluebond-Langner and Korbin 2007). In tandem with an increased emotional valuing of childhood as a ‘sacred’ phase (Zelizer 1994), shifts in social welfare governance (Donzelot 1979) and paediatric medicine (Halpern 1988) have been detected that has shaped an intensifying concern with the development and well-being of families and children (Reich, 2005:9; Elizabeth and Larner 2009). Within such social and policy contexts, child rearing is increasingly conceptualized and medicalised in terms of harm prevention and risk. Scholars in public health and child development sciences have thus advocated the importance of problem detection and early intervention in children’s lives to safeguard their unknown futures (Lee et al. 2010) and avoid suffering (Hermanns et al. 2005).

A time frame in anticipating adverse events also appears to be central to feminist and gender equality studies in the analysis of mothers’ and fathers’ roles and task divisions over the life course. An on-going ‘traditionalization’ of working and caring roles within couples has been found during and after the phase of family formation (Grunow et al. 2007; Grunow et al. 2012; Evertsson and Nermo 2007; Fox 2009), despite of increased gender egalitarian values (Davis and Greenstein 2009; Lück
and gender equal divisions of work and care prior to childbirth (Blossfeld et al. 2006). Apart from unfavourable outcomes framed in terms of gender (in)equality; feminists and welfare state scholars have also outlined social risks such as future poverty for mothers and their children when mothers opt out of the labour market (Esping-Andersen 2009), in a time in which nuclear families are declining and alternative family forms have become much more common (Beck and Beck-Gernsheim 2002; Zinn 2008).

“[Not participating in paid work by] women with very young children is considered problematic because it can lead to particularly serious social risks for women in relation to income, career changes and social security in old age, and thus contribute to the persistence of traditional structures of gender inequality” (Pfau-Effinger 2012, p.530).

As expressed in the above mentioned definition of risk (Royal Society 1992); it is of interest to this dissertation that conversations about parenting roles relate ‘particular challenges’ in the past and present to ‘adverse events’ in the future, thereby implying a ‘categorization’ of groups (Brown et al. 2013; Heyman et al. 2013; Harrits and Møller 2011) of parents (e.g. mothers versus fathers; parents with higher and/or ‘native’ social class backgrounds versus parents with lower and/or ‘non-native’ social class backgrounds) and groups of children (e.g. those expected to do well versus those expected to do poorly). While such categorizations provide important information on the population level, it is much harder to use them for risks assessments and interventions at the individual level (Heyman et al. 2013). It is therefore salient to study discrepancies between how categorizations of gender and class are addressed in institutions, and how healthcare professionals work with such risks in practice in interaction with individual mothers, fathers and children.

Investigating distinctive perceptions within institutions thus enables an investigation of how healthcare and family policies do more than offering parents technical solutions to technical problems, in focussing on particular concerns, groups and outcomes over time. We can question how risk perceptions are situated in broader tendencies detected in ‘reflexive modernity’ (Beck 1992; Beck et al. 2003; Giddens 1991; Zinn 2008) as intensifying attempts within modern societies to ‘colonize the
future’ (Giddens 1991) in order to avoid risk, suffering and uncertainty (Alaszewski and Burgess 2007; Zinn 2008; Wilkinson 2013) now that traditional family forms and boundaries between social spheres (such as ‘public/ private’; ‘nature/ nurture’ and ‘scientific/ unscientific’) are more and more blurring (Beck et al. 2003, p.22; see also Zinn 2008; p.45).

At the same time, the comparative research design of this study provides an opportunity to examine how risk perceptions are specific and situated in sociocultural contexts, rather than universal intensifying concerns that generally follow from a “new individualized culture”, as suggested by the work of Beck (Zinn 2008, p.47-48). Beck’s conceptualization of risk can in that sense be understood within a particular historical context strongly focused on the challenges posed by advanced capitalist, rational and secular developments in Northern Europe and, at times, particularly in Germany (Brown 2015a). It is therefore important to deconstruct risk perceptions as institutionalized in diverse policies and reflected in cultural values to see how risk perceptions on mothers’, fathers’ and children’s futures are constructed within varying national contexts.

1.3 Cross-national comparison of the Netherlands, Germany and Poland

In this study, pre-and postnatal healthcare and family policy institutions and cultural values about gender roles and parenting are investigated in a comparative perspective in order to deconstruct the nature of these institutions and to detect and understand cross-national similarities and differences, developed within specific historical processes. The countries selected for this study are the Netherlands, Germany and Poland.

These neighbouring countries reflect important differences in their political, cultural and socio-economic histories and current situations as well as in the ways they relate to transnational developments of increasing gender equality ideals (Beck and Beck-Gernsheim 2002) and increasing attention for parenting and children’s development (Lee et al. 2010). The Netherlands and Germany are and have been relatively ‘rich’ countries; with cultural values focused on ‘well-being’ rather than ‘survival’
In the Netherlands, strong domestic cultural values are combined with those of female autonomy (Kloek 2010; Van Daalen 2005; 2007; 2010; Van Den Berg en Duyvendak 2012; Bosch 2010) and a relatively weak divide between public and private spheres (Duyvendak and Wekker 2016). In Germany, in particular the former FRG, childhood and childcare, predominantly performed by mothers, have on the other hand been much more clearly valued and experienced as the realm of the private sphere (Thelen 2012) and as parents’ responsibility – not that of the state (Gottschall 2004; see also Thelen 2012). Cultural values in Poland have been focused on ‘survival’, rather than ‘well-being’ (Inglehart and Carballo 1997), due to socioeconomic circumstances in which a large part of the population lived in poverty after the collapse of communism (Titkow and Duch 2004; Ryndyk and Johannessen 2015, p.8). A culture of dual working, developed under communist rule, is combined with an emphasis on the family, strongly related to the Catholic Church, as being the central and main institution to transmit values and skills of ‘Polish identity’ (Titkow and Duch 2004; Ryndyk and Johannessen 2015, p.6).

Cross-national differences can also be found in pre- and postnatal healthcare policies and structures: the Netherlands stands out as a country where pregnancy and giving birth is approached as a physiological process, which is primarily guided by midwives rather than obstetricians (De Vries et al. 2013); Germany is known for its extensive healthcare system (Ehrich et al. 2016) and pregnancy and giving birth mainly takes place in hospitals under medical supervision (Hemmingki and Blondel 2001); Poland developed its healthcare system partly under communist rule and pregnancy and giving birth is predominantly located in hospitals under medical supervision (Pendleton 2015; Bayley 2007; Bray et al. 2010), although a strong social movement after the communist collapse has achieved a change in obstetric care standards that favour women’s rights, family relationships and baby-friendly medical environments (Gajewska and Pawliszak 2013). The countries also developed different public child healthcare services; with preventive low-threshold centres of collaborating paediatricians and nurses in all municipalities in the Netherlands (NJC 2016) and self-employed paediatricians, who parents typically select themselves and who perform preventive examinations alongside treatment in Germany (Ehrich et al. 2016) and Poland (Mokrzycka et al. 2016). In Poland, child healthcare services developed much
more recently, as part of ‘family medicine’ established since the 1990’s (Windak and Palka 2015)

Further differences exist in family policies; the Netherlands has moved from a familialist conservative welfare state focused on a breadwinner model to a more liberal welfare state in which dual-working is promoted and the work-family balance is approached as parents’ individual responsibility, facilitated by part-time work and private childcare regulated by the government (Lewis et al. 2008; Christiaens 2008; Veltkamp and Grunow 2012; Evertsson 2016). Germany on the other hand moved from a familialist conservative welfare state focused on a breadwinner model in a socio-democratic direction, facilitating long paid parental leave with a use-or-loose policy for fathers and an extension of public childcare facilities starting at age one (Evertsson 2016; Dechant and Rinklage 2016). However, facilities usually have limited opening hours and the realization of an extension of facilities has often been a difficult and slow process, because the government is restricted in her influence on local authorities and voluntary parties (Evers et al. 2005). Poland, as a post-socialist dual-earner state, moved towards a familialist welfare state with conservative as well as socio-democratic elements, in which paid parental leave has strongly increased over the past years, including access for fathers to parental leave. The minimal provision of childcare facilities on the other hand resembles the expectation that informal childcare is arranged within families (Keryk 2010; Mishtal 2012; Szelewa and Polakowsli 2008; Evertsson 2016).

Hence, this cross-national variance in socioeconomic and political histories, healthcare policies and structures, family policies and cultural values enables:

1. A cross-national comparison of institutions and constructions of risk, and how they relate to each other within the Netherlands, Germany and Poland
2. An analysis of how these institutions and risk constructions play out in the everyday work of healthcare professionals operating in these three countries, and
3. An explanation of which institutions and risk constructions matter (most) to which of healthcare professionals’ perceptions and interactions with (expecting), mothers, fathers and children
1.4 Macro level and micro level analysis: policies and interactions

Alongside an analysis of macro level policies and cultural values, the main contribution of this thesis lies in a qualitative cross-national comparison of the perceptions and practices of pre- and postnatal healthcare professionals working with (expecting) parents and young children in the Netherlands, Germany and Poland. Such a study of healthcare professionals is salient because conflicts and deviances within policies can be researched well by examining how problems are managed and how is dealt with conflicts *in practice* (Woolgar and Pawluch 1985; Boholm and Corvellec 2011). It is in face-to face social interactions that institutions, as webs of interrelated formal and informal norms, mainly play out and can be studied (Nee and Ingram 1998, p.19), while professional-family interactions are particularly relevant in this respect, because professionals mediate between policies and individual people on the ‘street-level’ (Lipsky 1980). Moreover, phenomenological studies have shown that the ‘concreteness’ of knowledge in face-to-face interactions is often more informative to individuals within healthcare settings when they anticipate uncertain futures, than more ‘abstract’ and ‘remote’ forms of information (Brown 2009). Healthcare professionals are thus deemed important in shaping mothers and fathers’ roles and in how they get to ‘know’ and anticipate specific elements of parents’ and their children’s futures.

This research is designed in a way that the linkages between macro-level institutions and structures on the one hand and micro-level practices and interactions on the other hand come to the fore and can be studied in the different countries. It is through *experiences* situated in a specific context, translated into generalized and *abstract ways of knowing*, that people interpret their own and other people’s actions and motivations (Schutz 1972, p.187). Such generalized and abstract ways of knowing can more easily be confirmed, checked and/ or adapted in closer direct face-to-face relationships (1972, p.163), while stereotypical knowledge on the other hand provides professionals with tools to cope with and make sense of parents who are more distant to them (Brown 2015b; see also Lipsky 1980).

Hence, while applying population based ‘risk knowledge’ on the individual level is not an easy task for professionals (Heyman et al. 2013); ‘intensities of knowing’
(Schutz 1972, p.163) differ in relation to various individual mothers, fathers and children. Deeper ‘we-relationships’ can be formed in some direct interactions, producing mutual understanding, familiarity and a high level of concrete knowledge, or more distant ‘they-relationships’ can be formed, in which knowledge is more abstract and remains more stereotypical because there is little opportunity to develop a direct understanding of the other person (Schutz 1972, p.163-187; Veltkamp and Brown 2017). I argue in this dissertation that the likelihood that ‘we-relationships’ and ‘they-relationships’ are formed with some parents and children rather than others can be related to institutional structures, such as who is targeted and made responsible in healthcare, who is available to attend consultations, and who can and cannot connect easily to stocks-of-knowledge implying how risks in parenting roles and child development are defined (Lareau 2003; Romagnoli and Wall 2012). This means that what constitutes professional knowledge, as well as how this knowledge is developed and conveyed, is informed by the specific institutional context and should therefore be studied as such.

Yet, professionals that work with parents have a relative autonomy, or ‘discretionary space’ (Lipsky 1980; Freidson 2001) in how to understand, advice and interact with particular families, in which inter-subjectivities are affected by their varying past experiences (Brown 2015b) with “divergent or even contradictory values and ideals” (Pfau-Effinger 2005, p.6) and institutions within the given contexts in which they live and work. This research investigates therefore the risk perceptions and ways of knowing that specifically positioned pre- and postnatal healthcare professionals apply, form and reproduce, the ways in which they relate to (diverse) mothers, fathers and children, and the range of options they see as feasible when doing this.

1.5 Research questions and chapters

The analysis of how macro level institutions relate to micro level perceptions and interactions is facilitated by a structure throughout this dissertation and within the separate chapters that starts from a more abstract and general level of presenting theory and findings and then moves to (and goes back and forth from) the more concrete and individual levels. The theoretical approach underlying this thesis is
The overarching research question underlying this thesis is:

*How do healthcare and family policy institutions and professional-family interactions in the Netherlands, Germany and Poland culturally construct risk and responsibility in anticipating and valuing particular consequences for children and parents, and how does this contribute to the reproduction and shaping of mothers’ and fathers’ gendered parenting roles?*

I briefly outline the five empirical chapters that address different layers and aspects of the research question

1. Chapter 4: Culture and risk representations in pre- and postnatal healthcare and family policy institutions in the Netherlands, Germany and Poland. A cross-national policy comparison

The focus in this chapter is on the culturally constructed representations of risk in macro-level policy institutions and the historical trajectories in which they have developed. It examines within each country, and compares between the countries, which risk objects and objects at risk about pregnancy, childbirth and early childcare are framed in policies, how they relate to one another and how this is intertwined with categories of normality and pathology, and of gender and social class. Moreover, this chapter investigates cultural coherences and contradictions between these risk representations within countries.

2. Chapter 5: Dutch, German and Polish professionals negotiating medical and cultural institutions and parenting categories in ideal-typical risk knowledge. Professionals’ ideal-typical knowledge about ‘risk’ in the Netherlands, Germany and Poland: A qualitative cross-national comparison

This chapter moves to the level of pre- and postnatal healthcare professionals’ generalized and situated ‘ideal-typical risk knowledge’ and investigates within – and compares between – countries and professions, how institutional risk constructions
within medical and wider cultural contexts are reflected and negotiated pragmatically in professionals’ accounts, and how this reflects and results in categories of normality and pathology, and of gender and social class.

3. Chapter 6: Risk and responsibilities for mothers and fathers in ideal-typical knowledge of Dutch, German and Polish professionals. A qualitative cross-national comparison.

Chapter 6 examines – and compares between countries – professionals’ ideal-typical knowledge about parenting risks and responsibilities and how they are gendered, in suggesting particular caregiving roles for parents, mothers and/or fathers. Moreover, this chapter looks at how professionals frame and approach mothers’ and fathers’ roles in the reconciliation of work and care, as situated within the institutional context, and at how the tensions that can be detected in relation to these institutions are approached.

4. Chapter 7: The everyday ‘risk work’ of Dutch healthcare professionals: Inferring ‘safe’ and ‘good’ parenting through trust, as mediated by a lens of gender and class. A phenomenological study

This chapter, a published article co-authored with Patrick Brown, builds on Schutz (1972) and takes a phenomenological approach while zooming in on Dutch child-healthcare professionals. This study examines how these professionals work with risk in practice and construct knowledge of mothers, fathers and children in their everyday ‘risk work’, how and to what extent they build trust relationships with diverse parents, and how this relates to broader social structures of gender and social class.

5. Chapter 8: Pre- and postnatal healthcare professionals knowing, trusting and responsibilizing fathers in the Netherlands, Germany and Poland. A phenomenological cross-national comparison

Chapter 8 builds on the previous chapters and combines the comparative design and phenomenological approach to interrogate professional-father relationships and how varying healthcare and family policy institutions shape diverse professionals’
knowledge frameworks and opportunities – as well as how individual professionals use and stretch these opportunities – to interact with fathers, get to know fathers as caregivers and establish trust relationships with fathers from diverse social-class and ethnic backgrounds.

Chapter 9 discusses the main conclusions, and reflects on the theoretical, methodological and policy implications of this thesis, on the limitations and on future research directions.
2 Theoretical approach
2.1 The interplay between institutions and individuals

Central to this research is the interplay between institutional contexts and the sense-making processes of social actors to give meaning to the world around them, particularly regarding gender roles, risk perceptions and understandings of family life and work. As outlined in the introduction, this dissertation draws on the work of Schutz (1972) who offers a framework to examine how motivational and interactive processes contribute to, and are shaped by, wider social structures (Schutz 1972; Berger and Luckmann 1967; see also Brown 2015b):

“... the meaning of particular social phenomena can be interpreted layer by layer as the subjectively intended meaning of human acts. In this way the structure of the social world can be disclosed as the structure of intelligible intentional meanings” (Schutz 1972, p.7).

In a similar fashion Douglas (1986) argues, inspired by Durkheim, that individuals establish a model of the social order in their minds, and we can thus think of “the individual mind as society writ small” (1986, p.45). Therefore, studying experiences with and perceptions of gender and parenting roles in family life on the micro levels enables us to reveal broader societal institutions, and a social organization of interactions and experiences. Accordingly, Risman (1987, p.9) relates this social order to structures of gender when she claims that particular parenting or work-related interactions and experiences are available to particular types of actors, which thus shapes context-specific differences in mothers’ and fathers’ roles – rather than these roles being determined by biological conditions or early socialization.

What Douglas and Risman add to Schutz’ approach is an encouragement to examine the interplay between institutions and individuals’ sense-making processes from two sides, starting with how institutions define “sameness” (Douglas 1986, p.56) and how they are founded on “reason and nature” to achieve legitimacy. Hence according to Douglas, “half of our task is to demonstrate this cognitive process at the foundation of the social order. The other half of our task is to demonstrate that the individual’s most elementary cognitive process depends on social institutions” (Douglas 1986, p.45; see also Logue et al. 2016). In this sense, Douglas’ approach resonates with the more
recent work of institutional theorists who are interested in collective and cultural dimensions of institutional fields (Logue et al. 2016, p.1588). Salient to my study, Risman proposes that studying gender, as a social structure, requires “full attention to the web of interconnection between gendered selves, the cultural expectations that help explain interactional patterns, and institutional regulations” (Risman 2004, p.433). This framework thus helps us to investigate and compare varying institutions that impact on family life and work, and how they in turn affect and are used by individuals as ‘reference points’ to understand, plan and activate caregiving roles and opportunities (Grunow and Veltkamp 2016; Douglas 2013 [2008], p.49, 50; Hobson and Fahlén 2009).

### 2.2 Culture and risk perceptions in institutions

According to Douglas, institutions are interrelated with ‘culture’ in how people order and make sense of their world (Douglas 1986; 6 Perri 2014; Logue et al. 2016). Hence, formal and informal institutions, in our case healthcare and family policies and values about parenting and gender, develop out of cultural ‘thought styles’. As such, cultural types and institutions can thus be studied and compared to obtain “a more precise and theoretical view of society […]” (Douglas 2013 [1995], p.17,18)

“Culture is not a separate element, out there, above and beyond the town meeting and the family breakfast table. […] Unless culture is brought into the analysis of every point there is no way that sociologists can make sense of behaviour. Each way of organizing social life is also at the same time a way of organizing thought and values. […] We have to think of culture as the outcome of standard ways of negotiating responsibility and therefore as inhering centrally in society at every level” (Douglas 2013 [1995], p.17, 18).

In Douglas’ view, culture is never coherent, but it is filled with conflict since particular thought styles and ‘types of bias’ are based on – often competing and parallel – forms of social organization (Douglas 1986; 6 Perri 2014), which can be found on all societal levels. Likewise, Pfau-Effinger (2005) has reflected on complex and at times conflicting interrelations between culture and welfare state policies,
while establishing a comparative model that takes divergent and contradictory values as well as other institutions, social structures, social practices and political actors into account. The focus in this model is on ‘welfare culture’: “the relevant ideas in a given society surrounding the welfare state and the way it is embedded in society”, arguing that “the cultural values and ideals which predominate in the welfare culture restrict the spectrum of possible policies of a welfare state” (2005, p.4). Such a delineation of culture, as solely applied to the welfare state, enables a comparative focus on the selected dimension. However, it also narrows down the types of potentially conflicting values and thought styles within the social organization of family life and work that impact on and relate to mothers’ and fathers’ roles.

In the theoretical approach to my study, I take a step back to grasp how culture constructs and reveals the social order within diverse societies. In her earlier work, Douglas (1966) has argued that ideas of purity and what is considered profane and reprehensible within a society are expressions of symbolic systems. What is perceived as dangerous is intertwined with disorder, transitional stages and the margins of these symbolic systems (1966, p.115). In her later work, Douglas’ focus has shifted to the cultural construction of ‘risk’ as conceptualizations about the consequences of actions, and in that sense responsibility (Douglas 1992; Brown 2013). Cultures and policies that shape family life and work can therefore be compared and deconstructed more extensively when taking risk perceptions underlying a broader range of relevant institutions into account. As has been argued in the introduction, examining risk perceptions which underlie pre- and postnatal healthcare institutions alongside those underlying family policy institutions can thus shed further light on the social organization – and inherent tensions – of family life and work and the construction of particular responsibilities and dangers for children, mothers and fathers in varying contexts.

Indeed, like any other thought and knowledge framework, perceptions of risks are not technocratic calculations of probability, but they are filled with cultural values, moral principles and political arguments (Douglas 2013 [2000], p.206, 207; Douglas and Wildavsky 1982; Brown 2014; Zinn 2008). In order to understand and compare particular ‘risks’ within and between different contexts, Boholm and Corvellec (2011) propose a framework that conceptualizes risk as the simultaneous situated...
construction of a ‘risk object’ which is posing a threat, an ‘object at risk’ that is supposed to be in danger from this threat, and the causal relationship between them (Boholm and Corvellec 2011). Risk can thus be understood through the cultural characteristics that define risk, and the value ascribed to what is seen as ‘at risk’ (2011, p.178). In Douglas’ words: “[the] view, of a people caught in a web of arguments about risks and values, allows the anthropologist to develop a different, more comprehensive way of looking at risk. It finds an institution, say local government, or a factory, or a transport system, and treats it as a risk-producing and controlling framework. How the people behave in this frame depends on the state of their knowledge” (Douglas 2000 in Fardon 2013 (ed.), p.206, 207).

2.3 Categories and social classifications

A more precise understanding of the interrelations between culture and constructions of risk within situated institutions and interactions can be developed by introducing concepts of ‘categories’ and ‘categorizations’ to this theoretical framework. That is, institutions are able to impact on interactions and individuals because they are based on analogy and are used for social grouping, while the stabilizing principle of an institution is the naturalization – and acceptance – of social classifications (Douglas 1986, p.46-48). It is through categories that individuals understand, act and interact with each other in the world, and categories are embedded in people’s minds, in discourses and in social practices (Harrits and Møller 2011, p 229).

Since the past decades, scholars in linguistics, sociology and psychology have engaged extensively with the study of categories and categorization (see for instance Bourdieu 1984 and Jenkins 2000), while policy studies (see for instance Schneider and Ingram 2005 and Yanow 2003) have shown a more recent interest in how governments and policies regulate individuals’ lives through state-defined categories (Harrits and Møller 2011). Harrits and Møller (2011) argue in this respect for a clearer theoretical distinction between ‘categorizations’ – as “the grouping of objects that share a particular characteristic” (Stone 2002, p.164, cited by Harrits and Møller 2011, p.230) – on the political level through institutions on the one hand, and on the social level through interactions between ‘street-level’ professionals and citizens on
the other hand. They further advocate for a clearer understanding of the complex interplay between these two levels, since we should not treat them as interchangeable (2011, p.235).

The investigation of sameness and difference in institutional categories on political and interactional levels is illuminating for this research, because it allows us to understand how categories of gender and social class in parenting are constructed, reproduced and/ or changed in different contexts (McNay 1999) and on how they intersect (Crenshaw 1989; Lutz et al. 2011). When we look at the case of biological differences between men and women in their bodily engagement in pregnancy, giving birth and breastfeeding, it can on the one hand be argued that it does not seem fully accurate to say that “nature doesn’t have categories; people do” (Stone 1988, p.307, cited by Harrits and Møller 2011, p.235). Yet, the categories to frame these biological differences still need to be made, institutionalized and enacted by people. What is more, it becomes highly salient to see how this categorization is done, and how gender differences between mothers and fathers arise over the course of giving birth as rooted in, and extending beyond, ‘nature’, through the ‘naturalization’ of social classifications in parenting.

Drawing boundaries around and between categories considered as ‘safe’ and categories considered as ‘dangerous’ requires to ascribe ‘risk objects’ with an identity, and also a downplaying of other characteristics. At the same time, ‘objects at risk’ are constructed around concepts such as “value, loss, vulnerability and need for protection” (Boholm and Corvellec 2011, p.179, 180). Scholars have argued that although parents are increasingly addressed in seemingly gender-neutral terms in parenting policies, it is predominantly mothers who are framed and approached (Daly 2013) as ‘risk managers’ responsible for (breast) feeding (Knaak 2010) and intensive ways (Hays 1996; Faircloth 2014a) of ‘attachment parenting’ (Faircloth 2014b), while fathers’ roles in children’s development and their (positive) impact on children’s (cognitive and linguistic) outcomes have only been within the scope of child development and public health research since relatively recently and to very limited degrees (Phares 1992; Phares et al. 2005; Leidy et al. 2013; Tamis-Le Monda 2013; Keizer 2016). When we look at categories of social class, parenting and preventive public health policies have claimed a relation between ‘poor parenting’ and having a
‘lower socioeconomic background’, which was found to be misplaced in many occasions, while it could easily lead to stigma (Dermott and Pomati 2016; Møller and Harrits 2013).

The investigation of categories therefore also sheds light on the systematic interpretation of normality and pathology and how is dealt with defiance (Canguilhem 1989, p.246, cited by Harrits and Møller 2011) and risk (Møller and Harrits 2013; Brown et al. 2013), which is especially relevant for the field of pregnancy, giving birth and parenting in which governance is predominantly, but to cross-nationally varying degrees, informed by medical definitions (Van Teijlingen 2005; Veltkamp and Grunow 2012). While pregnancy is in some contexts approached as ‘pathology’ similar to ‘illness’, it is in other contexts framed as ‘physiology’ and a ‘normal’ feature of everyday life (van Teijlingen 2005; Brubaker and Dillaway 2009; Amelink-Verburg and Buitendijk 2010). Increasingly however, pregnancy has been related to risk aversion and fear for negative outcomes (Lowe and Lee 2010) in which ‘normality’, characterized by the absence of ‘pathology’, is “an ever-narrowing window” (Scamell and Alaszewski 2012; see also Amelink-Verburg and Buitendijk 2010).

Feminists and social movements have claimed that as a result ‘women’ are not involved in decision-making about their own bodies, pregnancies, deliveries and children (Kateman & Herschderfer 2005; Brubaker and Dillaway 2009). Such a claim shows at the same time how categories of ‘normality’ and ‘pathology’ are – in different streams of knowledge – frequently intersecting with categories of gender and, as mentioned earlier, social class. Specific types of classifications can thus reveal the social organizations of societies, because “in the face of danger, accusations fly right and left, but not randomly” (Douglas 2013 [2008], p.58). Yet, attention for contextual understandings of (risk) categories in parenting, or even for cross-national variations in child-development knowledge frameworks, is rare (Keizer 2016; de Jong and Colijn 2010). The main hierarchical distinction in public health and child development studies that is often made is between children growing up in ‘developed’ or ‘high-income’ versus in ‘developing’ or ‘middle-income’/ ‘low income’ countries, a categorization in which concerns are structures by categories of normality and
wealth, and pathology and poverty in a globalizing world (see for instance Villar and Belizán; Unicef 2014).

2.4 Governance: categorization through institutions

As an attempt to disentangle how categorizations are constructed at different levels, let us now move to the political and administrative societal levels, where categorizations of ‘normality’ and ‘abnormality’ are made and reproduced through institutions within for instance medical, educational, scientific and welfare state arrangements that serve as a means for governments to control and nurture their populations (Foucault 1977; 1997; 2000). Drawing on Weber (1994), the political is in this sense understood as “the legitimate use of state power” that employs a ‘bureaucratic field’ with the “power to construct categories as well as a mechanism of ‘disciplining the minds of people’ (Bourdieu 1998, p.11)” (Harrits and Møller 2011, p.234). Rose and Miller (1992, p.175) define governance as:

“the historically constituted matrix within which are articulated all those dreams, schemes, strategies and manoeuvres of authorities that seek to shape the beliefs and conduct of others in desired directions by acting upon their will, their circumstances or their environment."

Many centres of knowledge and government have been detected within contemporary societies (O’Malley 2008, p.56), and it is therefore of interest to unpack complex forms of governance in an examination of how knowledge and power get entangled in institutional structures, as shaped over time in particular contexts (Foucault 2000; Rose et al. 2006). Rose and Miller (1992; see also Veltkamp and Grunow 2012) have deconstructed government influence into more noticeable mechanisms and networks. According to them, the most important characteristic of modern governments is the ability ‘to govern at a distance’, whereby a government recognizes independent actors and tries to manage them without destroying the autonomy of their activity. This enables governments to guide families and individuals, while the ideal of citizenship is not disrupted. In order to do so, governments need contacts with non-political authorities, who in turn have contacts with citizens. On the first level of contacts
between governments and administrative and/or non-political authorities, it is policies – and within them the use of language, discourse and representations (Foucault 1992; Fairclough 1992; 2003) – which are central in framing objectives and thereby in defining categories that imply inclusions and exclusions.

“Categories highlight elements that are deemed to be similar within the boundaries they draw and different from elements beyond those boundaries. These perceptions of sameness of things in different categories become the organizing principles or logic around which categories are built: something belongs in category A because it shares ‘A-ness’ and is not ‘not-A’. (Yanow 2003, p.9) According to this definition, a political category relies on a kind of membership that draws a boundary between who to include and who to exclude from the category” (Harrits and Møller 2011, p.230).

Political categories have for instance been found to contain social and cultural stereotypes, popular images and cultural characterizations (Schneider and Ingram 1993; see also Harrits and Møller 2011, p.235). When aiming to understand policies – in our case pre- and postnatal healthcare and family (leave) policies – and their potential impact on family life, this translates into an investigation of which particular problems and risks are represented in policies, what kinds of underlying assumptions and cultural values can be detected, how they have come about, what is ignored, and how on the one hand categories of ‘normality’ are demarcated and how on the other hand types of parents are (not) included within the scopes and definitions of these particular policies (Bacchi 2009, p.2-18). This approach appears to be suitable to support the ‘first half of our task’ (Douglas 1986, p.45), that is: understanding and comparing the social organizations of family life and work, as well as the tensions within them, through macro-level institutions in order to reveal how mothers’ and fathers’ gender roles are shaped and reproduced in nationally and cross-nationally varying contexts.
2.5 Street-level professionals: categorization in and through interactions

The ‘second half of our task’ (Douglas 1986, p.45), and the most central one in this research, is about what Rose and Miller (1992) refer to as: the contact of ‘non-political authorities with individuals’, and according to Harrits and Møller (2011, p.230): the enactment of social categories in interactions between street-level bureaucrats and citizens, which “may prove a particularly fruitful laboratory for studies of current forms of categorization” (2011, p.242). Indeed, a “focus on ‘the social actor in action’ (Lave 1988, p.13) can explain how risk definitions are cognitive operations that emerge not in the intangible world of concepts, but in the lived-in world of livelihood, dwelling, skill and engagement (Ingold 2000)” (Boholm and Corvellec 2011, p.186).

In the context of Western governments generally having implemented increasing levels of risk management in their policies, mainly informed by medical and epidemiological research (Kemshall 2002), it is likely that professionals working in healthcare practices adopt and understand risks, and the categories they represent, as ‘real’ (O’Malley 2008, p.57, 61). However, rather than simply replicating and integrating technical dimensions of risk into their work, professionals have negotiated a compromise through which to ‘govern’ health within the “autonomy or status of their profession” (O’Malley 2008, p.62). This means that within their ‘discretionary space’, professionals have to make judgements of how the individual cases they encounter do or do not fit into prescribed categories and subsequently how they will treat individual cases in respect to existing institutions (Lipsky 1980); an assessment that requires practical experiences and ‘tacit knowledge’ (Freidson 2001; Duyvendak et al. 2006) According to Lipsky (1980, p.4) it is thus only in interactions between ‘street-level bureaucrats’ and individuals that policies are ‘made real’.

This brings us to the next consideration relevant to the enactment of social categories in interactions: street-level bureaucrats, in our case healthcare professionals, are themselves part of the system of categorization, and they thus bring with them to the interactions their positions in these categories as well as their cognitive and embodied experiences with social categories. This therefore also informs professionals’ assessments of individual cases and supports and explains the reproduction of social
categories within street-level interactions (Harrits and Møller 2011, p.242). Accordingly, Lipsky (1980) has argued that professionals often cope with their complex task of mediating between general categories and particular individuals by using stereotypes. It is exactly through comparisons and analogies that people make sense of the world and of others (Douglas 1986; Schutz 1972). Drawing on Stone (2002), Harrits and Møller (2011) provide the following example:

“A child suffering from ADHD can be classified as disabled or as a product of bad parenting, resulting in two very different sets of rights with regard to welfare support. According to Stone, such a categorization depends on the way the process of categorization is organized, but also on the particular group comparison (Stone 2002, 53). Is the child compared to other disabled children, for example children with learning disabilities or to misbehaving children in general? The comparison rather than the specific case decides” (Harrits and Møller 2011, p.232).

The question then becomes whether social categories are always necessarily reproduced in interactions, and whether it is mostly a matter of which categories are reproduced and why. According to Douglas, thought styles can change and paradigms may shift due to competition and instability inherent to cultures (1986; 1999). While Douglas emphasizes that it is institutions who define and confer sameness (Douglas 1986, p.53, 56), she also ascribes a relative autonomy to individuals to make choices in this respect: “individuals, as they pick and choose among analogies from nature those they will give credence to, are also picking and choosing at the same time their allies and opponents and the pattern of their future relations.” (p.63) This does not explain however how shifts in thought styles and social categories come about and can be shaped within micro-level interactions.

An example can be provided from Douglas’ later work (Douglas 2013 [2000], p.215), in which she discusses the position and opportunities of the ‘risk officer’ who needs to assess and apply risks on the lowest level in larger organizations. In this discussion, Douglas does not move beyond considering problems of control and how difficult it is to incorporate risk concerns into different institutions, and thus focuses on ‘the risk of the risk officer’ and the degree to which institutions are, or fail to be, deterministic. Douglas argues that certainty is an institution, or an outcome of institutions, while
uncertainty is (or is not) blocked institutionally. How individuals relate to this is a matter of knowledge, and particularly an agreement in knowledge (Douglas 2001; Logue et al. 2016, p.1594).

As seen from the perspective of the professional, applying population based ‘risk knowledge’ on the individual level is not an easy task (Heyman et al. 2013). The question is therefore how professionals get to know risk in individual cases and how they develop knowledge in interactions. Zinn (2008) has argued that professionals use tools of emotion, intuition and trust to cope with the uncertainty inherent to anticipating the as-yet-unknown future, including gut feelings, tacit knowledge and relying on others (Möllering 2001; Barbalet 2009; see also Anspach 1993; Polanyi 1967). This means that professionals combine more rational-calculative ways of reasoning with these less formal ways of knowing in order to make the ‘leap of trust’, that has been considered vital when acting between the rational and the non-rational (Zinn 2008) in the face of the unknown future (Möllering 2001). Accordingly, scholars in phenomenology have found that the greater ‘concreteness’ of knowledge in face-to-face interactions is more informative to individuals within healthcare settings who need to make inferences about what might happen in the future, than more ‘abstract’ and ‘remote’ information (Brown 2009). When ‘risk assessment’ is shaped by who professionals feel they can or cannot trust, the everyday construction of knowledge about parents through interactions becomes highly salient.

To accomplish our theoretical understanding of how social categories of gender, social class, normality and abnormality are shaped and reshaped within micro-level professional-family interactions; we will turn back to the work of Schutz on intersubjectivities. As discussed in the introduction of this dissertation (see page 23), Schutz (1972, p.163-187) relates different intensities of knowing others to levels of immediacy, mutuality and concreteness of knowledge (Brown 2015b) (strongest in case of more intimate ‘we-relationships’), as opposed to abstract, ideal-typical and anonimized knowledge (strongest in case of more remote ‘they-relationships’). This means that social actors generalize, and in a way anonimize, their subjective experiences into “interpretative schemes” as “ideal types” of “persons” and of “patterns of action” (Schutz 1972, p.186-187). At the same time, since “the typical and only the typical is homogeneous” (1972, p.186), actors (aim to) continuously
construct knowledge of the persons they meet by interpreting those persons’ concrete expressions, acts and intentions (1972, p.101). Introducing these distinctive modes of knowing to the cross-national study of ‘street-level’ professional-family interactions, then, enables an understanding of the interactional dynamics involved in the enactment and development of risk perceptions and social categories, as well as how they in turn reveal, relate to and are placed in broader political and cultural institutions and policies.
3 Methodological approach
3.1 Introduction

This research is designed as a comparative qualitative study. More specifically, I address my research question about situated constructions of risk and trust in relation to categories and categorizations of gender, social class and ‘normality’ over the course of pregnancy, childbirth and early childcare by employing a ‘multi-level’ (Creswell and Plano Clark 2007) and ‘multi-sited’ (Marcus 1995; Falzon 2016) ethnographic design. In doing so, different sources of data are collected and analysed within three countries, and subsequently ‘triangulated’ when integrating them in the analysis (Creswell and Plano Clark 2007, p.64; Collins et al. 2006; Matthews 2005; Carter et al. 2014). To make sense of constructions of risk and trust in pre-and postnatal healthcare and family policy institutions, and in professional-family interactions, I combine data sources of in-depth semi-structured interviews, participant observations (Hammersley and Atkinson 2007) and policy documents (Fairclough 2004; Hajer 2005; Yanow 1999; 2014).

3.2 Epistemology and approach

In my study, I adopt a constructionist epistemology (Bryant and Charmaz 2007; Charmaz 2008). Theorists employing this research paradigm see both the actions and accounts of research participants, and the researchers’ recordings and reports as constructed (Bryant and Charmaz 2007, p.21) in the sense that “one’s lenses condition what can be seen” (Lamont and Swindler 2014, p.155; Schutz 1972; Latour and Woolgar 1979). This also means that I do not treat what has been seen or recorded in this study as ‘objective’, assuming an external ‘truth’ which can be discovered by the researcher when appropriate methods are used, as would be the case in a ‘positivist’ research paradigm (Bryant and Charmaz 2007, p.21).

These epistemologically competing perspectives do not underlie only micro-level qualitative versus macro-level quantitative methods (Lamont and Swindler 2014), but also the main forms of sociological ethnography: grounded theory (using a constructivist approach) and the extended case method (using a positivist approach) (Tavory and Timmermans 2009, p.243). In grounded theory, the sociological case is
evoked from the narratives of actors in the field and “the institutionally and
interactionally delimited ways members in the field ‘case’ their action”, whereas in
the extended case method the sociological case depends on the predefined theoretical
narratives, of which the boundaries are tested in the empirical field (2009, p.243). In
this study, I apply the grounded theory method in employing a “systematic, inductive,
and comparative approach for conducting inquiry for the purpose of constructing
theory” (Bryant and Charmaz 2007, p.1).

As a sub-project of the larger Apparent project1, which involves ‘national and
international studies of norms and gender division of work at the life course transition
to parenthood’, my study is embedded in a broader research framework. When
preparing for data gathering, theoretical concepts of ‘gender’, to which I added ‘risk’,
had already been formulated prior to data collection, which highlights the
combination of an inductive and a deductive approach (Hennink et al. 2011). This
approach fits however within the grounded theory method rather than the extended
case method, because:

a) I have been going back and forth between the data, analysis and theory in an
ongoing iterative process in which theoretical concepts have developed and
changed (Bryant and Charmaz 2007, p.1);
b) remaining ‘open’ to the data and theory should not be understood as having
“an empty head” (2007, p.20) assuming that sociologists do work with the
theoretical knowledge they have developed over time (Tavory and
Timmermans 2014) in which ‘sensitizing concepts’ (Blumer 1954) are
informative to the research question and data collection, and:
c) having chosen a theoretical framework that largely builds on the
phenomenological theory of Schutz (1972), the theory employed rather
presents the ‘grammar’ of sense-making in the social world – compatible with
how theory is used in the grounded theory method – than theories proposing
“What kind of observations should be seen in the world” – compatible with
how theory is used in the extended case study method (Tavory and

1 The Apparent project is directed by Prof. Daniela Grunow and financed by the European Research
Council/ ERC Starting Grant. See www.apparent-project.com.
The studies in chapter 7 and 8 of this dissertation most clearly resemble a phenomenological approach, in their aim to study professionals’ “make meaning of their lived experience” (Starks and Brown Trinidad 2007, p.1372).

The constructionist epistemological approach I employ in this study has therefore informed the overall research design, data collection and data analysis, as well as the criteria used to establish ‘rigour’. Different perspectives on achieving methodological rigour in qualitative studies have been advocated and debated (Tobin and Begley 2004). Some scholars have argued that adapted forms of ‘validity’ and ‘reliability’, as developed and used within quantitative research, are appropriate concepts for the evaluation of qualitative research (Guba and Lincoln 1981; LeCompte and Goetz 1982; Morse et al. 2002). Others have, from a more constructionist position, claimed that qualitative research “needs to be evaluated on its own terms” (Finley 2006, p.325; see also Katz 2015 [1981]), and researchers should select the criteria that fit best with their study, out of a range of criteria currently offered within qualitative research.

In my study, I have used Katz’ (2015 [1981], p.127, 128) interpretation of the concepts: ‘representativeness’ (“can generalizations be justified?”), ‘reactivity’ (“how do you know it looks the way you describe it when you are not looking?”), ‘reliability’ (“how do you know your descriptions are the right ones? […] How do we know you did not overlook disconfirming data, or even make it all up?”), and ‘replicability’ (“if we wanted to test your analysis by repeating your research, how would we know what to do?”) to question my research design, data and ‘evidence’. Particularly important in relation to the grounded theory method has been internal variety of the data, and within this variety the search for ‘negative cases’ that do not fit the initial conceptual and analytical structure. In order to make sense of these disconfirming cases, the analysis and theory has been developed further until variety could be understood from an overarching theoretical understanding (Katz 2015 [1981]; Tavory and Timmermans 2009).
3.3 Research design

3.3.1 Multi-level approach: interactions and institutions

The discussion about distinctive approaches within sociological ethnography presented in the previous section reflects a more general increase in the number of debates within the qualitative research field over the past decennia (Lamont and Swindler 2014, p.154). Methodological disputes in the Sociological discipline in the sixties and seventies were largely focused on the differences between micro qualitative approaches versus macro quantitative approaches, where the period thereafter has been characterized by an increasing “pluralistic coexistence” of methodologies, mixed method approaches and the advancement of, as well as an increase of debates within, qualitative research in general (2014, p.153). This also encompasses a growing interest in the interrelatedness of macro-level and micro-level social phenomena (see Elias 2000 [1979]; Baur and Ernst 2011; Cetina and Cicourel 2014).

Inspired by the Apparent project, which amongst others studies cross-nationally the interplay between macro-level family policy institutions and micro-level planned work- and care divisions of parents-to-be (Grunow and Evertsson 2016; Grunow and Veltkamp 2016), my study positions itself within this development, with an interest in the interrelatedness of macro and micro level phenomena. I am doing this first with a focus on interactions in my study. As Knorr-Cetina (1981) has argued, we can hardly develop knowledge of the meaning of social phenomena when we are looking at either the societal level or at the level of individual acts alone, but the meaning of social phenomena “must be traced to the definitions, working perspectives, negotiations and translations which arise during interaction and which characterize bureaucratic procedure” (1981, p.14). A focus on interactions and actors’ sense-making of others (Schutz 1972) are therefore central to my research design.

However, Buroway (1998, p.15; see also Tavory and Timmermans 2009, p.156) claims – when advocating for an extended case approach – that social forces often stem from processes outside of the scope of the empirical study and they should therefore be brought in and tested through theory. Tavory and Timmermans (2009, p.256) argue in turn that when such forces are outside of respondents’ and
fieldworkers’ awareness, they only exist in the researchers’ theory and may thus easily be conceptualized as external and self-evident. In my study, I bridge this opposition by bringing ‘social forces’ – in our case healthcare and family policy institutions, that may not always be explicitly present in interviews and interactions – under the scope of the study, rather than identifying them through theory. This allows me on the one hand to look for implicit clues within interviews and interactions that relate to and draw upon particular policy institutions, and thus to examine whether policy discourses “resonate” with professionals and inform how they define situations (Bröer 2008, p.95). On the other hand, this allows me to study institutions cross-nationally, as being constructed within particular settings themselves (Douglas 1986; Bacchi 2009).

3.3.2 Multi-sited focused ethnography in healthcare settings

This research concerns a “multi-sited” (Marcus 1995; Falzon 2016), “cross-national comparative ethnography” (Jørgensen 2015), designed as a focused ethnography (Hammersley and Atkinson 2007) which is performed at multiple sites within healthcare contexts spread over different countries (Clerke and Hopwood 2014). Such a design is strong: “Because context often varies for different subgroups, comparing subgroups is a technique that has the potential of helping researchers to maximize their understanding of phenomena” (Onwuegbuzie and Leech 2007; p.249). Hence, the type of ethnography I employ in this dissertation deals with distinct problems in specific contexts, while the research is conducted in highly specialized fields (Knoblauch 2005; Wall 2015) of pre- and postnatal healthcare. The focus is on participants’ “common behaviours and shared experiences, based on the assumption that the participants share a cultural perspective” with other participants in the same context (Wall 2014, p.3; see also Cruz and Higginbottom 2013).

The study is designed to get an understanding of healthcare professionals’ views, practices and knowledge construction (Bogner et al. 2009), while they interact with (expecting) mothers and fathers at different time points over the course of pregnancy, childbirth and early childcare within cross-nationally and cross-professionally different contexts. Taking an ethnographic and interpretative phenomenological approach to knowledge construction means that knowledge is derived from healthcare
professionals’ sense-making processes and interpretations of their everyday life and interactions (Hammersley and Atkinson 2007; Edwards and Holland 2013; Maggs-Rapport 2000), with an interest in how professionals, as social actors, are influenced by the (sub) cultures in which they live (Draper 2015; Harrits 2016). This ethnographic approach can bring out “histories, relationships and cultural experiences that influence healthcare professionals’ experiences of health and illness” as well as their perceptions of risk (Draper 2015, p.36; cited by Harrits 2016).

Important for this study, as for ethnography more generally, is that policy documents and written texts should not be overlooked as ethnographic data, since “many of the social settings we study are self-documenting, in the sense that their members are engaged in the production and circulation of various kinds of written material” (Hammersley and Atkinson 2007, p.121). This is not least the case for professional healthcare settings, where forms of accountability have become increasingly important, due to governmental, market and insurance companies’ influence on the healthcare sector (Van Hassel et al. 2012), as well as for family policies conveyed within governmental documents and websites. The forms of discourse produced in these documents can be studied as “the medium through which versions of the world are constructed and produced as pressing or ignorable” (Potter 2003, p.14).

3.4 The study area

The sites which are chosen for this research concern three urban areas in the Netherlands, Germany and Poland, as depicted in figure 3.1. The selection of these neighbouring countries is informed by cross-national differences in historical, socioeconomic and political developments, in healthcare policies and in family policies (see page 20 for a more detailed description). One urban area is chosen in each country to limit within-country variance, in relation to the sample size and the in-depth nature of the data, and based on the assumption that healthcare professionals working in the same area have more similarities than professionals working in different regions. The healthcare professionals’ accounts are thus considered in relation to characteristics of their specific working area and in relation to national institutions (see Górny & Torunczyk-Ruiz 2013), as an “embedded case study.
approach that takes cross-national characteristics into account” (Nilsen et al. 2013, p.29; see also Grunow 2016).

Figure 3.1 Selected areas in the Netherlands, Germany and Poland

![Map of the Netherlands, Germany, and Poland with marked areas]

Source: Own depiction based on Google maps

The selected pre- and postnatal healthcare professionals are chosen because of their frequent contacts with families over the course of pregnancy, childbirth and early childcare (see page 59 for my sampling and recruitment strategy). What is more, they are typically involved at different points in time, and with varying durations, along this process, which enables a comparison of professionals’ knowledge about and experiences with parents and children and of professional-family interactions across different professions.
Figure 3.2 Time line professionals’ involvement

Source: own depiction

For all countries, *midwives* are involved with expecting parents from the earlier to the final stages of pregnancy; at the time of the delivery and in postpartum care, up to six weeks after birth, while German midwives can extend this period for up to one year after birth in case of breastfeeding, or specific problems and questions (Thomas 2011). German midwives do not always start in the first term of pregnancy, because different than in Poland and the Netherlands, there is more variance in when parents approach a midwife and whether a midwife is (immediately) available. *Postpartum care assistants* – as a typically Dutch profession – are in the Netherlands involved from birth up until eight days after birth (Wiegers 2006). *Paediatricians and nurses in child healthcare* (from now on CHC) are involved in the ‘early’ (first four) years, starting four weeks after birth with a consultation with the paediatrician. In the Netherlands, a CHC nurse – in team collaboration with CHC paediatricians – pays the family a visit at home two weeks after birth. The German and Polish paediatricians continue their care until adulthood, while the Dutch paediatricians and nurses end their care at the age of four, which is then continued by other paediatricians, specialized in school age children. A part of the paediatricians in the Polish sample are working in neonatology and with preterm born babies. They are involved around birth and in the first weeks to months after birth. Such wards are also part of the Dutch and German healthcare system, but none of the Dutch and German respondents included in this study worked on neonatology wards.
3.5 Methods and data

The data of my study (see table 3.1, page 53) consists of in-depth interviews with pre- and postnatal healthcare professionals (n=53; 23 in the Netherlands, 12 in Germany and 18 in Poland); participant observations (61 in the Netherlands, 55 in Germany and an ethnographic visit next to hospital observations during the interviews in Poland), and policy documents of midwifery, postpartum care, CHC and family policies.

The fieldwork was started in the Netherlands in 2011 and lasted until 2015 due to additional theoretic sampling. The Dutch fieldwork has been the first study that was performed within this project, and later on served as a blueprint for the fieldwork conducted in Germany in 2014 and in Poland in 2015. Affiliated researchers, Alexandra Ils (from the Goethe University in Frankfurt, who also works within the Apparent team) and dr. Katarzyna Adamszczyk (who works at the Adam Mickiewicz University in Poznań and is an associate member of the Apparent team), have been recruited to gather the German and the Polish data, and another Polish researcher has been recruited to perform three additional interviews within the same Polish area.

3.5.1 In-depth interviews

In-depth interviews are especially suitable to gain insight into people’s experiences and meaning-making processes (Seidman 2006; Legard et al. 2003). Some scholars (Savage and Burrows 2007; Jerolmack and Khan 2014) have highlighted the limitations of interviewing as a research technique that collects meanings which are constructed in retrospect and influenced by the interview setting, while what people say often does not predict what they do. These scholars have advocated that it is much more important to focus on behaviour, and study what people do in practice rather than what they say in interviews (Lamont and Swindler 2014). The focus on behaviour is indeed valuable, and therefore part of the investigation in this study. However, from a constructionist epistemology, we can argue that participant observations of behaviour are also constructed in and influenced by research settings (2014, p.159).
### Table 3.1 Data sample for each country

<table>
<thead>
<tr>
<th>Country</th>
<th>Year of interview</th>
<th>Professionals Interviewed</th>
<th>Interviews n = 53</th>
<th>Professinals observed n = 23</th>
<th>Observations n = 116</th>
<th>Policy documents and literature²</th>
</tr>
</thead>
<tbody>
<tr>
<td>NL</td>
<td>2011-2015</td>
<td>Midwives</td>
<td>23</td>
<td>10</td>
<td>61</td>
<td>Ministry of Health Literature on policies, history and culture</td>
</tr>
<tr>
<td></td>
<td>2011-2015</td>
<td>Postpartum care assistants</td>
<td>5</td>
<td></td>
<td></td>
<td>Policy and protocols Dutch Midwifery Association: KNOV Consultation schedule Birth plan</td>
</tr>
<tr>
<td></td>
<td>2012</td>
<td>CHC Paediatricians</td>
<td>5 (+1)³</td>
<td>5</td>
<td>28</td>
<td>Policy and protocols postpartum care Assistance: Kraamzorg Nederland Policy and protocols Dutch CHC: JGZ Consultation/ Vaccination schedule</td>
</tr>
<tr>
<td></td>
<td>2011-2012</td>
<td>CHC Nurses</td>
<td>8 (+2)</td>
<td>7</td>
<td>33</td>
<td>Policy and protocols German CHC: Consultation/ Vaccination schedule</td>
</tr>
<tr>
<td>DE</td>
<td>2014</td>
<td>Midwives</td>
<td>12</td>
<td>8</td>
<td>55</td>
<td>Ministry of Health Literature on policies, history and culture</td>
</tr>
<tr>
<td></td>
<td>2014</td>
<td>CHC Paediatricians</td>
<td>5</td>
<td>5</td>
<td>46</td>
<td>Policies and protocols German CHC: Consultation/ Vaccination schedule</td>
</tr>
<tr>
<td>PL</td>
<td>2015</td>
<td>Midwives</td>
<td>18</td>
<td>2</td>
<td>0</td>
<td>Ministry of Health Literature on policies, history and culture</td>
</tr>
<tr>
<td></td>
<td>2015</td>
<td>CHC Paediatricians</td>
<td>2</td>
<td></td>
<td></td>
<td>Policy and protocols Polish CHC: Paediatricia Consultation/ Vaccination schedule</td>
</tr>
<tr>
<td></td>
<td>2015</td>
<td>Paediatricians neonatology</td>
<td>7</td>
<td>2, and two wards</td>
<td></td>
<td>Policy and protocols Polish CHC: Consultation/ Vaccination schedule</td>
</tr>
</tbody>
</table>

² See Appendix D, page 311, for a more detailed list of the policy documents that have been used
³ For chapter 7, one paediatrician and two nurses working with children aged 4-18 were added to the sample, while an interview with one nurse from the original sample was not used for the study (n=15).
In-depth interviews are in my study chosen as an important data source because of several strengths: interviews have a good fit with systematic research designs, while cross-context comparisons can be organized and interpreted relatively easily; interviews can combine depth of understanding with theoretically motivated questions; interviews can disclose emotional aspects of experiences, and interviewers can probe about institutions, interactions, social contexts, meanings and imaginary scenarios (2014; p.145, 159; see also Seidman 2006).

In this study, I therefore used semi-structured in-depth qualitative interviews with healthcare professionals in The Netherlands, Germany and Poland, organized as theory-generating expert interviews and focussed on forms of knowledge and interaction (Bogner and Wolfgang Menz 2009). Interviews explored the informants’ views about the general aims of the profession, the nature of the informants’ relationships with parents, their views and examples of good and bad parenting as well as their role as advisers in relation to parents’ behaviour.

More explicit questions that invited the professionals to reflect on roles of mothers and fathers and on risks came later in the interview, to first allow for a more open exploration of how professionals related to such categories and categorizations (Weiss 1996). After the first five Dutch interviews the item list has been adapted and improved; questions were clarified and questions that turned out to be theoretically less relevant were taken out. The final item list (see appendix A, page 297) served as the basis for the rest of the interviews in all three countries. The interviews were performed in the healthcare professional informants’ and researchers’ ‘native’ languages, meaning respectively in Dutch, German and Polish.

Interview items about ‘good’ and ‘bad’ parenting; behaviour in parenting that professionals would encourage and discourage; what professionals themselves found important for young children, and about mothers’ and fathers’ roles in caregiving have generated informative data in detecting risk knowledge ideal types, as well as off-the-record comments on parenting and participant observations. In the Dutch and Polish interviews, professionals were also asked about what they considered as ‘threats’ for unborn and new-born babies. This question was not part of the item list for the German interviews, because it was not clear at that point that risk would be a
part of the overall framework. I was able to detect ideal types of risk in the German interviews as well, especially by triangulating interviews with observations, but this dissimilarity in interview items has and should be taken into account in the cross-national comparison of risk ideal types. At the same time, not including risk in the item list in one of the countries provided a chance to take into account how ‘risk framing’ can affect data; Green (2009) suggests that “risk framing can prioritize ‘risk’ in ways that misrepresent the most salient and determining logics of how phenomena are understood” (2009, p.506). This is discussed further in the methods sections for chapter 5 and 6, where it appeared to be most relevant.

Interviews prioritized depth and openness, resulting in a limited amount of cases per country. Since the Dutch system involves regular professional-parent-child interactions with a wider range of professionals compared to the German and Polish systems, more interviews were conducted in the Netherlands than in Germany and Poland (The Netherlands: n=23; 5 midwives; 5 postpartum care assistants; 5 paediatricians and 8 nurses; mean duration=75 minutes; Germany: n=12; 7 midwives and 5 paediatricians; mean duration=75 minutes; Poland: n=18; 9 midwives and 9 paediatricians; mean duration 30 minutes). Interviews with midwives and maternity care assistants were generally longer than interviews with paediatricians (mean duration paediatricians: 73 minutes in The Netherlands; 56 minutes in Germany and 24 minutes in Poland; mean duration midwives, nurses and postpartum care assistants 80 minutes in the Netherlands; 88 minutes in Germany, 32 minutes in Poland).

The shorter interviews with Polish paediatricians and midwives and to a lesser degree the German paediatricians reflected the relatively limited time of these professionals to participate in the interview and their more formal approach to the research, compared to especially the German midwives and the Dutch midwives, postpartum assistants and paediatricians. In the shorter Polish interviews, all the interview items were covered and they were found to contain enough depth to compare their accounts to those of the Dutch and German professionals. The main difference was that the initial answers of the Polish respondents were often not followed up by further exploring questions, as was the case in the Dutch and German interviews. The Dutch and German interviews thus had a higher level of depth and detail, although this also included more excerpts that in the end turned out to be less relevant for the analysis.
3.5.2 Participant observations

The direct observation of a variety of situated face-to-face interactions, which include important and immediate features of situations not visible in interviews, is a major advantage of ethnographic methods, particularly suitable for the study of interactional dynamics within social contexts (Lamont and Swindler 2014, p.159; Jerolmack and Kahn 2014, p.181; Hammersley and Atkinson 2007). Hence, participant observations are included in this study to provide insights into professional risk assessment and categorizations, and to enable the possibility of triangulating professionals’ narratives (what people say they do) with observations of this ‘risk work’ (what people actually do) (Bryman 2008, p.379; Jerolmack and Kahn 2014; Lamont and Swindler 2014).

Knowledge derived from observations is helpful in interpreting interviews and institutional contexts and also vice versa (Matthews 2005), since knowledge of healthcare professionals’ previous experiences and background factors are often not observable in interactions (Lamont and Swindler 2014, p.160). The tensions that emerge when triangulating sources of data are useful to understand the more taken-for-granted aspects of professional lifeworlds, which are essential to phenomenological analyses (Schutz 1972).

In order to thicken the data and facilitate interpretation, the interview data was therefore triangulated with non-participant observations of professional-family consultations (Collins et al. 2006): 61 consultations of (10) CHC paediatricians and nurses were observed in the Netherlands, and 52 consultations of (8) midwives and CHC paediatricians were observed in Germany (see page 53). These observations were followed by a brief conversation between the interviewer and the professional whereby the professional was asked about the specific assessment to explore how professionals interpreted the interactions they were part of (see also Van Duursen et al. 2004).

The Polish professionals did not agree to being observed in consultations; the approached midwives claimed it would be impossible to do observations in the privacy of families’ homes and the approached paediatricians claimed obstacles in terms of being short in time and working with vulnerable patients: preterm babies and their parents (Polish field notes - section 4). What was accomplished was half a day of
fieldwork observation, performed by the Polish researcher and me, at the academic ward specialised in pre- and postnatal healthcare were 10 out of the 18 Polish respondents worked. We have observed two doctors at work at the neonatology and premature ward and two of the interviewed paediatricians were invited to reflect further (in English) on their profession, the healthcare context, the interview and on how they experienced risk and trust in relation to specific parents. Meanwhile, these paediatricians have walked us around the wards in practice. This provided and improved an understanding of the context in which these healthcare professionals worked (Hennink et al. 2011), what they did in their everyday work and how they interacted with mothers, fathers and children. Moreover, the Polish researcher, having a young child herself, provided insights into the Polish healthcare and family policy context by providing her reflections and everyday knowledge of the Polish healthcare practice, during the fieldwork as well as in extensive talks (Polish field notes - section 5).

3.5.3 Policy documents

Macro-level institutions are in this study interrogated within a “country-specific case study design” (Lewin-Epstein and Stier 2006, p.1; Brymann 2008, p. 55), to provide insights in their complexity and to examine the relations and contradictions between context-specific institutions, and how they might influence interactions and every day life situations (Brymann 2008; Bröer 2008). Relevant sources of institutional characteristics can only to a limited extent be derived from and measured within interviews (Lamont and Swindler 2014, p.161) and the study of relevant characteristics, in our case in the form of policy documents, therefore serves as a mean to triangulate interview and observation data (Creswell and Plano Clark 2007; Collins et al. 2006). Policy is believed to be effective through discourse and language, containing and producing categorizations and classifications (Foucault 2000; Hajer 1995; Møller and Harrits 2013; Hacking 2004; Yanow 2000; 2014; Bacchi 2009). In encouraging the investigation of forms of power in multiple forms of governance and institutions, Foucault was among the first who “gave us ways in which to understand what is said, can be said, what is possible, what is meaningful – as well as how it lies apart from the unthinkable and indecipherable” (Hacking 2004, p.299).
The institutions selected as of interest to this study concern pre-and postnatal healthcare policy documents and family policy documents, constructed through and understood from historical and cultural values (Douglas 1986) in the Netherlands, Germany and Poland. The policy documents which I analyse in this study concern policies and protocols in midwifery and CHC and postpartum care in the Netherlands, including contact moments and vaccination schedules, and national family policies, including parental leave policies, childcare policies, part-time and flexible work policies and tax policies for couples. These documents are complemented first with (scientific) documents and articles produced within healthcare professions, and second with scientific literature that discusses (historical developments of) cultural values and perceptions of family roles, parenting and child development in the Netherlands, Germany and Poland.

In order to illuminate macro-micro connections, the different sources of data have been gathered simultaneously (Singer and Willet 2003, p.10, 11; Baur 2009). Healthcare and family policy developments potentially informative to individual practices are on the one hand approached as ‘snapshots’, in which I mainly focus on institutions at play up until the moment in time when the interview and observation data have been gathered (Grunow 2016). However, trends that are effectuated in policy changes a few years after the interviews and observations could already have been informative to the professionals at the time of the interviews and observations. Therefore, when relevant, I allowed on the other hand for a small margin in time to also take policy markers into account that took place a few years after the data collection, as outcomes of longer-lasting trends and developments. In these cases, I was reflexive about the fact that interview and observation data had been gathered earlier. My approach is therefore moving towards a more ‘process-oriented methodology’ paying attention to how macro-level figurations and micro-level practices are interrelated changing processes (Baur and Ernst 2011; Elias 2000), while individuals’ sense-making processes include references to past, present and anticipated times (Schutz 1972; Emirbayer and Missche 1991).
3.6 Recruitment and sampling

In qualitative research, qualitative inferences are based on a subset of all the observations that might have been observed. This makes the sampling design a particularly important element in the research process (Onwuegbuzie and Leech 2007; p.241). In my research, multiple cases have been selected in order to study how context interrelates with the ways in which pre- and postnatal healthcare professionals work with risk and trust in relation to diverse mothers and fathers. The selection of cases is thus an even more pertinent issue, since one of the main aims of this study is to compare and conflict the cases, without sacrificing “the uniqueness and complexity of the case” (2007, p.249, see also Stake 2000; Miles et al. 2013). As my sampling design, I have employed ‘stratified purposive sampling’, with the aim to “select groups that display variation on a particular phenomenon but each of which is fairly homogeneous, so that subgroups can be compared” (Richie et al. 2013, p.11; see also Creswell 2013). More specifically, I used a “nested sampling design” (Onwuegbuzie and Leech 2007, p.239, 246), which means that criteria are ‘interlocked’ or ‘nested’ ”that is: controlling the representation of one criterion with another […] for reasons of interdependence between the characteristics” (Richie et al. 2013, p.118).

This sampling strategy is suitable to distinguish between country-level and healthcare profession-level institutions and thus enables a comparison of three sub-groups of pre- and postnatal healthcare professionals: one sub-group working in the Netherlands, one sub-group working in Germany and one sub-group working in Poland. Each of these subgroups represents two sub-samples of pre- and postnatal healthcare professionals: one working in ‘obstetric care’ (OC), and one working in ‘child healthcare’ (CHC). In the Dutch sub-sample, obstetric care professionals are divided in midwives and postpartum care assistants, and in the Polish sub-sample, obstetric care professionals are divided in midwives and paediatricians working in neonatology.

The ‘nested sampling design’ is often used in grounded theory approaches to derive more data from sub-samples and key informants and to recruit additional participants as a form of theoretical sampling, focused on development and refinement of emerging themes and ideas (Onwuegbuzie and Leech 2007; p.246). In my research, the samples were generally selected prior to the study, whereas the sub-sample of
Dutch postpartum care assistants was added later, and the Polish sub-group was selected in a later stage than the Dutch and German sub-groups. The nested design has been chosen because it is suitable to a cross-national sampling design in the sense that it allows for different layers of selected cases, whereas a ‘parallel sampling design’ is more suitable for subgroups drawn from the same level of study (2007, p.239).

The strategic non-random selection of cases within pre- and postnatal healthcare as depicted in figure 3.3 has been driven by theory (Hammersley and Atkinson 2007, p.33; see also Glaser and Strauss 1967). Pre- and postnatal healthcare professionals who had repeated institutionalized contact with parents over the course of pregnancy, childbirth and early childcare were considered for this study.

**Figure 3.3 Nested sampling design: sub-groups and sub-samples drawn from pre- and postnatal healthcare professionals in Europe**

![Diagram of nested sampling design](image)

Source: own depiction based on Onwuegbuzie and Leech 2007

Interviews and observations were located within purposively sampled obstetric care and CHC services, in order to study constructions and perceptions of risk within healthcare practices which were in different ways related to childbirth, health and vulnerability. Relevant professionals were therefore selected in relation to ‘time’ (the
moment and frequency of their involvement with parents and very young children); ‘people’ (as representing different roles in pre-and postnatal healthcare), and ‘context’ (to examine how different contexts demand different behaviours and responsibilities) (Hammersley and Atkinson 2007, p.35-39).

The selection of midwives (and postpartum care assistants in The Netherlands) and paediatricians (and nurses in The Netherlands) was furthermore supported by an analysis of policy documents in these countries and by a Dutch pilot study I performed in which I interviewed a midwife, CHC nurse and an obstetrician and three couples of expecting/ new parents to establish which professionals had in these cases been central, and which professionals had frequent contacts with (expecting) parents. Obstetricians were not included in the Dutch sample, because they interacted with a smaller selection of pregnant women due to the Dutch ‘obstetric care system’. For reasons of comparability, obstetricians were also not included in the German and Polish sample. The Dutch healthcare professionals are divided over four professions, because Dutch midwives delegate a part of their tasks to postpartum care assistants and Dutch CHC paediatricians share their professional tasks with CHC nurses in low-threshold centres organized by the municipality, where preventive examinations are spread equally between these types of professionals, who typically collaborate in larger non-hierarchical teams. CHC nurses in Germany and Poland on the other hand have a more limited role of assisting in the paediatric practice.

In the recruitment process, potential informants were provided with a two-page information brochure about the research, which emphasized the comparative aspect of the study (see appendix B, page 301). For the Dutch sample, four paediatricians and six nurses in CHC were recruited via the network of the ‘Academische Werkplaats’, affiliated with several Dutch universities and healthcare policy institutions, who provided access to the CHC management level and two CHC teams in the selected region; all but one of these team members participated in being interviewed and all but one of these respondents agreed to participant observations. One pilot interview with a CHC nurse was added to the sample and in addition, a CHC paediatrician and CHC nurse working on a third location were approached to increase the number of respondents. The latter nurse was also asked for and agreed to participant observations. Two of the Dutch midwives were approached via birth preparation
classes and three midwives as well as the five postpartum care assistants were approached via purposive, and snowball, sampling. Participant observations focused on CHC paediatricians and nurses, and the Dutch midwives and postpartum care assistants were not asked for participant observations.

For the German sample, access to midwives was granted via the ‘Hessische Ministerium für Soziales und Integration’ who forwarded the flyer with project description to the ‘Landesverband der Hessischen Hebammen’, through which five midwives could be recruited. Three of these midwives were asked for and agreed to participant observations. An additional two midwives who were especially active in midwifery education were added to the sample to increase the number of respondents. The recruitment of paediatricians was more complicated and was eventually established via one of the interviewed midwives, who introduced the researcher to the ‘Deutschen Kinderschutzbundes’ and to a paediatrician in specific. This paediatrician had a prominent position in the local paediatrician network and through this network, four additional paediatricians could be recruited. All five paediatricians agreed to participant observations. Although the participant observations of midwife consultations proved to be very insightful for the understanding of German midwives’ practices and interactions, the majority of observations in the German sample concerned consultations of paediatricians.

For the Polish sample, a large academic hospital specialised in pre- and postnatal healthcare was approached and the main nurse of the neonatology ward referred the researcher to the professor and head of the neonatology wards. Seven paediatricians working at this ward agreed to being interviewed, although within a limited time frame. They did not agree to participant observations, because of time constraints and the vulnerability of in particular preterm babies and their parents. In order to increase the number of respondents and to include paediatricians who performed preventive examinations, two additional CHC paediatricians were added to the sample; one working in a private practice and one working in a hospital. As for the midwives, one midwife working at the ward for preterm infants and one midwife working at the infertility ward (with pregnant mothers and their spouses) were recruited in the same maternity hospital as the seven paediatricians. Via a birth preparation course, four midwives visiting families in their homes were added to the sample and a second
Polish researcher in addition recruited three midwives working in a hospital in another city in this area, to increase the number of respondents.

Most of the Polish participating paediatricians (7 out of 9) worked mainly at a neonatology ward for premature babies. On the one hand, this limits the cross-national comparability of the paediatricians’ accounts, because these paediatricians form a special group within the sample of paediatricians. On the other hand, it also provides an interesting – and ‘extreme’ (Richie et al. 2013, p.114) case, because these paediatricians worked with the most vulnerable of babies, facing the strongest uncertainty and biggest threats (Anspach 1997). Moreover, although these paediatricians could not straightforwardly be compared to the other paediatricians, their accounts of and interactions with parents could nevertheless be analysed and situated within the specific institutional context in order to see how threats and concerns for children’s developments and gender roles played out in these specific practices, and how this impacted on levels of proximity and concreteness of knowing within interactions. Similarities with other paediatricians concerned: education, working in the field of ‘family medicine’, and being in contacts with new-born children and their parents in a health context. Within the data set, I could distinguish between the Polish CHC paediatricians performing preventive examinations and the paediatricians working in the ward(s).

Some of the selected midwives worked in a hospital or clinic and other midwives guided women and men in birth preparation courses and ‘at home’, whereas regular consultations which were not hospital-based mainly took place at the midwife office in The Netherlands and at the family home in Germany and Poland. Other midwives had in-clinic as well as home-based experience. All participants in the Dutch sample were women, reflecting the high level of gender segregation in Dutch CHC, midwifery and nursery (Van Lieburg 2001). In the German and Polish samples, all midwives were women, while paediatricians were either women or men, reflecting the gender divisions in these sectors in Germany and Poland. Further variation was achieved in years of experience (mean experience Dutch professionals: 10 years; German professionals: 19 years; Polish professionals: 14 years) and in working area: while some of the respondents worked in the larger city of the selected area, others worked in the less urban sites of the same area. Participants’ background
characteristics were taken into account in the analysis of the data (see Appendix C on page 305 for an overview).

The minimal sample size was set at five respondents for each sub-sample, whereas Onwuegbuzie and Leech (2007, p.245) advise to select at least three respondents for each case, and slightly more in case of a nested sampling strategy. The eventual sample size for each sub-sample was based on ‘theoretical saturation’, meaning that enough depth was reached for each particular case and additional respondents were not expected to add much to the theoretical understanding of that case (2007; Strauss and Corbin 1994; Richie et al. 2014). However, the total number of Polish CHC paediatricians (n=2) appeared to be limited for that particular sub-sample. Tentative conclusions could still be drawn, because the two respondents were found to be relatively homogeneous in their accounts and representative for the Polish CHC sub-sample, rather than being “atypical” (Onwuegbuzie and Leech’s (2007; p.244).

3.7 Analysis

3.7.1 Abductive approach

The interviews were recorded, transcribed and anonymized (Weiss 1994; Hammersley and Atkinson 2007). One Polish respondent did not give permission for recording and the Polish researcher made notes during this interview, which were typed out immediately afterwards. Another one of the Polish interviews was transcribed while immediately being translated into English. Although these two interviews were included in the data set, they were treated with more caution. All the participant observations were afterwards typed out into detail as field notes (Clifford 1990; Charmaz 2008; Emerson et al. 1995). These notes have been numbered and categorized chronologically, which enabled me to analyse and present them as such. A ‘within-case’ and ‘cross-case’ (Miles et al. 2013, p.100) ‘thematic analysis’ has been employed by means of encoding qualitative information in order to detect ‘themes’ within the data set, as underlying patterns that organize the various observations (Boyatzis 1998). The interview transcripts, extensive field notes from observations and policy documents were analysed for all countries and cases
separately through open, constant comparison, using an ‘iterative-inductive’ (O’Reilly 2012) and ‘abductive approach’ rooted in grounded theory (Tavory and Timmermans 2014).

In this sense I combined inductive and deductive approaches in which theoretical concepts served as ‘sensitizing concepts’ (Blumer 1954; Bowen 2006; Tavory and Timmermans 2014; Kelle 2007) that have been informative to the interview guide, observation topics and the selection and analysis of policy documents. The sensitizing concepts used for the interview guide were relatively broad and included ‘parenting’, ‘professionalism’, ‘gendered parenting’, ‘family policy institutions’, ‘risk’ and ‘uncertainty’. During the data collection and analysis, I remained close to the individual participants and their meaning-making processes (Schutz 1972; see also Fereday and Muir-Cochrane 2006) thereby “moving up from the particular to the more general” (Bryant and Charmaz 2007, p.15; see also Charmaz 2008), while I remained open to surprises, unexpected findings and ‘negative cases’ (Katz 2015 [1981]). Along this process, theoretical insights have been adapted, and new insights have been constructed (Meyer and Lunnay 2013) in order to (re)build theory (Bryant and Charmaz 2007). The thematic analysis and reflection on the data (Granbom et al. 2014) was therefore characterized by a going back and forth between the data, theory and sensitizing concepts (Katz 2015 [1981]).

Commonly recurring and salient themes emerging within interviews and observations were identified through coding (Boyatzis 1998; Charmaz 2007). Codes and findings were discussed in-depth with the native speaking researchers to obtain ‘intercoder agreement’, in which obscurities and discrepancies could be reconciled, with the native-speaking interviewers being more knowledgeable about the particular interviews (Campbell et al. 2013). The main themes were interrogated further through triangulation of the interview and observational data, the study of historical institutions, and the policy document analysis to see how they did or did not relate to one another. Moreover, specific interview excerpts and observational data were interpreted in relation to the wider narrative of the professionals (Weiss 1994; Smith and Osborn 2004). This was facilitated by case summaries for each respondent (Miles et al. 2013, p.124, 148), which contained background information of the respondents, descriptive codes alongside the main themes within the particular interview and
observations, including excerpts of the data, and page numbers directly relating to the original data. Taking professionals’ wider narratives into account provided insights in coherency and inconsistencies within interviews and between interviews and observations.

In the initial stages of the analysis, I used Atlas.ti software package for coding the data, whereas in the later stages using a “case-ordered descriptive meta-matrix” – which orders descriptive data from all cases by the main variables of interest – and a “content-analytic summary table” – as a conceptually ordered display of the thematic content for all cases – appeared to be especially suitable ‘cross-case analytical techniques’ (Onwuegbuzie and Dickinson 2008, p.208, 209). Within these qualitative data ‘matrices’ (see Cassel 2004; Miles et al. 2013), that is: “spreadsheets [that] contain numerous cells into which summarized data are entered by codes (columns) and cases (rows)” (Gale et al. 2013), data for all the individual participants has been ordered in relation to the sub-samples and the sub-groups (see figure 3.3. page 60), which facilitated a thematic understanding of cross-case and within-case comparisons (Onwuegbuzie and Leech 2007; Miles et al. 2013), as well as a going back and forth between individual-level and group-level data, and between the original data and the thematic interpretations. This method has been found to be increasingly useful for the analysis of qualitative data in multi-disciplinary health research, because it helps to “compare and contrast data by themes across many cases, while also situating each perspective in context by retaining the connection to other aspects of each individual’s account” (Gale et al. 2013, p.6).

3.7.2 Primary and secondary data analysis

Within this cross-national study, I have worked with ‘primary’ Dutch data which I gathered myself and ‘secondary’ German and Polish data which has been gathered by associated researchers. Working with secondary data has been perceived as problematic and challenging in qualitative research, a) because of the contextually embedded nature of data; b) because researchers need to relate closely to their data, and c) because secondary data is often derived from a different research question and design (Thorne 1994; Hinds 1997; Irwin 2013; Gillies et al. 2005). I was able to deal with these challenges, first because the complete data set was based on the same
research design, research questions and interview questions, second because I collaborated closely with the other researchers, as colleagues, over the entire process of fieldwork preparation, data collection, data translation and data analysis, and third because I was able to invest in a close relationship with the total data set, thereby also becoming an ‘integral part’ of the secondary data (Temple et al. 2006).

An important challenge that needed to be addressed concerned the multiple languages involved in this research (Temple et al. 2006), since language differences in qualitative research can easily lead to a loss of meaning (Van Nes et al. 2010). While this challenge could not be completely overcome – I am a native Dutch speaker with high proficiency in the English language, moderate proficiency in (reading) the German language, and no proficiency in the Polish language –, with the help of the associated German and Polish researchers I have attempted to get as close as possible to the meanings interpreted from the original interviews.

High quality academic translators, familiar with qualitative interviews, translated the Polish interviews word by word (including pauses) into English and the Polish researcher checked these translations (see Regmi et al. 2010; Van Nes et al. 2010). The Polish transcripts, English translated transcripts and recordings were all provided and accessible to me for the analysis. I have thus also listened to the recordings and went back to the original Polish words used in order to capture their meaning as precise as possible, while I checked and discussed these into detail with the Polish researcher. The German interviews were delivered as German transcripts and as recordings. I was able to read, translate and listen to these interviews myself, while precise meanings were in these interviews also investigated and discussed into detail in on-going and frequent meetings with the German researcher. Furthermore, the detailed fieldwork notes and own sense-making processes of the researchers were taken into account in the data analysis and discussed in comparison to the overall findings in order to capture on the one hand their particular knowledge about their own countries and on the other hand the things that initially seemed too trivial or routine to mention from a within-country perspective (see Temple et al. 2006). The translated quotes used in the empirical chapters are accompanied by the original language quotes in the appendix (Appendix H, see page 329).
3.8 Data and methods in the individual chapters

The methodological approach presented in this chapter applies to all chapters in this dissertation, however the particular methods, data and analysis are specific for individual chapter and are outlined in this section. The individual chapters therefore do not contain a method section.

3.8.1 Chapter 4: a cross-national policy comparison

This study contains a “country-specific case study design” (Lewis-Epstein and Stier 2006, p.1; Brymann 2001, p.55), which on the one hand enables an exploration of how different institutions are interrelated, coherent and/or conflicting within specific contexts, and on the other hand provides a detailed picture of the complexity and ‘nature’ (Brymann 2001, p.53; Stake 1995) of context-specific institutions, which are to structure “typical” and common “everyday situations” (Yin 2003, p.41, cited by Brymann 2001, p.56; Lewis-Epstein and Stier 2006), in our case professional knowledge and professional-family interactions. The institutions selected for this study follow a strategy similar to the selection of cases of healthcare professionals. A policy comparison within and between countries is facilitated by a cross-case design (Onwuegbuzie and Leech 2007; Richie et al. 2013) in which the countries serve as overarching categories and the selected policies within these countries – that is: policies within ‘obstetric care’ (OC), ‘child healthcare’ (CHC) and ‘family policies’ (FP) – serve as sub-categories.

For this analysis, policy documents of midwifery, postpartum care and CHC have been collected (Appendix D, page 311) through national healthcare portals within the Netherlands, Germany and Poland. The policy documents and publicly accessible information provided to families include descriptions of the main aims and tasks of the job, contact moments, vaccination schedules and (medical) procedures. Policy documents have been analysed by using ‘content analysis’ (Hsieh and Shannon 2005; Neuendorf 2002) and ‘discourse analysis’ (Hajer 1995). I have used content analysis to “interpret meaning from the content of text data” through a ‘directed approach’ in which the analysis has started from theory (Hsieh and Shannon 2005, p.1277).
Furthermore, policy documents and information publicly provided to families about parental leave policies, childcare policies and flexibility of work have been collected for each country through governmental websites and Ministries of Family and Health. Documents considered for selection included national policy documents and information for parents, disseminated in the past 15 years (from 2002 onwards) for each of the selected policy domains.

The theory that guided the analysis (see also chapter 2) included a) Bacchi’s (2009) questions focused on how problems are constituted, against what background and in relation to whom; 2) more concretely: Boholm and Corvellec (2011)’s framework about the construction of ‘risk objects’ and ‘objects at risk’ and 3) Harrits and Møller’s (2011; 2013) conceptualization of ‘categories’ and ‘at risk groups’. Furthermore, I used discourse and interpretive policy analysis (Yanow 2000; 2014) in the sense of looking more closely into the definitions and words used within the policies to address (particular) parents, mothers and fathers and the extent to which these discourses were gendered (Daly 2013). The quotations derived from policy documents presented in chapter 4 were selected because they reflect the wider collection of the policy document(s) for that country.
The analysis of policy documents is performed against the background of historical developments and cultural values potentially intertwined with institutions (Douglas 1986). Therefore, I have selected scientific literature on healthcare, family policies, parenting, childhood and family roles within each of the countries in order to provide a better understanding of the complexity of institutional contexts (Brymann 2001; Stake 1995), and the cultural coherencies and contradictions of risk representations (Douglas 1992; Boholm and Corvellec 2011) in various policies and policy domains.

3.8.2 Chapter 5 and 6: a qualitative cross-national comparison

Chapter 5 and 6 are designed as a qualitative cross-national comparison. A qualitative approach is especially suitable for an in-depth understanding of professionals’ implicit and explicit generalized forms of risk knowledge, as motives and beliefs behind their actions (Weber 1968; Hennink et al. 2001). The cross-national comparison helps to investigate whether such interpretive frameworks are more commonly found among professionals working in specific institutional settings and how risk knowledges and professionals’ understandings of parents reflect the extent to which they use institutions as ‘reference points’ (Grunow and Veltkamp 2016; Bröer 2008).

For these studies, I have drawn on the complete data set of interviews (n=53) with midwives, postpartum care assistants, paediatricians and nurses in the Netherlands (n=23: 5 midwives; 5 postpartum care assistants; 5 paediatricians; 8 nurses), Germany (n=12: 7 midwives; 5 paediatricians) and Poland (n=18: 9 midwives; 9 paediatricians), on participant observations (61 in the Netherlands, 55 in Germany and an ethnographic visit in Poland), brief follow-up interviews and in-between remarks during the observations. The interview items most relevant for this analysis concerned ‘good’ and ‘bad’ parenting, behaviour in parenting that professionals would encourage and discourage, what professionals themselves found important for young children, and about mothers’ and fathers’ roles in caregiving. In the Dutch and Polish interviews, professionals were also asked about what they considered as ‘threats’ for unborn and new-born babies. This question was not part of the item list for the German interviews, because it was not clear at that point that risk would be a part of the overall framework of this thesis. I was able to detect ideal types of risk in the
German interviews as well, especially by triangulating interviews with observations, but this dissimilarity in interview items should be, and has been, taken into account in the cross-national comparison of risk ideal types.

In particular, for these chapters I have employed a thematic ‘within-case’ and cross-case’ analysis (Miles et al. 2013) in which themes interpreted as ‘organizing the observations’ have been detected and coded in the data set (Boyatzis 1998). Based on Schutz (1972 and Boholm and Corvellec (2011), professionals’ ‘ideal types of risk’ have been operationalized as: \textit{generalizing expressions} about professional and parenting roles that go beyond the individual experience when displaying sense-making thoughts that depict a threat, as a ‘risk object’, a ‘vulnerability’ in need of protection, as an ‘object at risk’, or causal assumptions assuming the relationship between these risk objects and objects at risk. ‘Ideal types of safe parenting’ have been operationalized as: the responsibilities that professionals ascribe to parents and what in their view constitutes important, necessary, ‘good enough’ and/ or potentially fruitful practices of parenting, hence what children need from their parents and what parents do well and/ or ideally should (learn to) do or come close to doing. ‘Ideal types of ‘safe sharing’ have been operationalized as: thoughts about performing and sharing of care in relation to paid work and about what a mother, a father and/ or a family should or could do in (combining) work and care. Ideal types were firstly inductively derived from the data in a more open comparative approach (Boyatzis 1998; O’Reilly 2009), while they were secondly triangulated (Creswell and Plano Clark 2007; Collins et al. 2006) with and analysed in the light of the cultural risk representations and categories found in institutions, as discussed in chapter 4.

As cross-case analytical techniques, I have mainly used two strategies: \textit{qualitative data matrices} (Cassel 2004; Miles et al. 2013; see chapter 3, page 66) and \textit{case summaries} (Miles et al. 2013). For the matrices, a “case-ordered descriptive meta-matrix” served as a means to display descriptive data from all cases by the main variables of interest (see Appendix E, page 315), while “content-analytic summery tables” displayed the thematic content for all cases (see Appendix F, page 317) (Onwueguzie and Dickinson 2008, p.208, 209). Through the case summaries for each respondent, I have facilitated the interpretation of data excerpts in relation to the
wider narrative of particular respondents reflected in the full interview and observations (Miles et al. 2013; Weiss 1994).

Furthermore, I have used ‘ideal type clouds’ in chapter 5, thereby proposing a different use of ‘word clouds’ than is common for large text data sets (McNaught and Lam 2010), based on the identification of the ‘ideal types’ I coded in the analysis, as a supplementary tool to convey meaning through the creation of visual elements that summarize and highlight important data characteristics and research implications (Onwuegbuzie and Dickinson 2008, p.209). With these visualizations, I employed a “summative approach to qualitative content analysis” with a focus on visualizing the “underlying meanings of the words or the content” (Hsiu and Shannon 2005, p.1283, 1284). The main ideal types for each sub-samples of professionals (see page 60) have been manually translated into scores in which the scores correspond with the size of the ideal types presented in the cloud. The parameters underlying these scores can be found in Appendix G, page 323: total scores (varying between 1 and 9) are based on 1) the portion of professionals within a profession that expressed this ideal type (score between 1 and 3); 2) the frequency in which it was expressed within at least one of these professionals’ interviews and/ or observations (score between 1 and 3), and 3) the weight and meaning this ideal type had within the wider context of the interview and/ or observations (score between 1 and 3).

Wordart (formerly Tagul) online software was used to turn ideal types and scores into ideal type clouds for the professions within each of the countries.

The ideal type clouds should be treated as an initial visible overview of relevant ideal types per ‘case’ (the ‘group’ of professionals working within the same profession within the same country). Limitations of comparing the ideal type sizes within and between cases are first that the data was not exactly similar for each case. Participant observations have for example not been performed for all the professionals (e.g. not in

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4 In which I have demarcated the cases based on separate occupation and training for the job: Dutch midwives and Dutch postpartum care assistants, as well as Dutch paediatricians and Dutch nurses are thus treated as separate cases, although they overlap within the sub-sample, and Polish paediatricians working in OC and in CHC are treated as one combined case, although they are distinguished within the sub-sample (see page 60)

5 Score 1 proportion of professionals: 1=0-33%; 2=34-66%; 3=67-100%; score 2 frequency mentioned: 1=1x; 2=2x, 3≥3x; score 3 value attached: 1=casually mentioned; 2=emphasized; 3=moral indignation or strong emphasis; see Appendix G, page 323)
Poland) and interviews have not been as lengthy for all the professionals (with the Polish interviews generally being shorter), which makes it more likely to have less frequent repetitions within the Polish data. Second, the size of the ideal types in the cloud are skewed to the amount of ideal types presented, while these amounts were not similar for all cases. Third, the score includes one component that relates to the relative number of professionals for whom the ‘ideal type’ has been found, and two components that relate to the strength of the ideal type within the account of at least one respondent.

The ideal type clouds are used despite of their limitations, because they work well in providing a summative visualization of the overall themes and provide a tool for the reader to grasp the varying ideal types in comparison. Moreover, I could partly control for individual accounts giving a large weight to the appearance of certain ideal types, because I could assess the ideal types qualitatively in the light of the other interviews, triangulate them with the findings in the previous chapter on relevant institutions, and leave out ideal types with a high score for one professional, while deemed less relevant for the broader case. However, it should be made clear that the nuanced and thorough analysis is presented and discussed more thoroughly and in-depth in the chapter itself.

3.8.3 Chapter 7: a phenomenological study

The analysis of this study, written together with Patrick Brown, was informed by interpretative phenomenological approaches. This framework led us to focus upon ongoing, embodied and negotiated processes of sense-making and expectation-construction amidst uncertainty (Schutz 1972; Smith and Osborn 2003). Interpretative phenomenological analysis is chiefly concerned with depth of analysis rather than common themes across larger numbers of participants. In this sense we explored the ways in which understandings of self, others and social contexts are constructed and the various formats through which sense-making in the present is shaped and structured by lifeworlds emerging out of the past (Berger and Luckmann 1967).

In-depth interviews with Dutch CHC professionals (n=15; 9 nurses and 6 paediatricians; mean duration = 75 minutes) were conducted alongside 61
observations of consultations with ten of these fifteen professionals. Observations were performed in a more non-participant manner. Each observation was followed by a brief informal interview whereby professionals were asked about their understandings and logics of reasoning (White 2002; Van Duursen et al 2004). This design aimed to develop insights into how the professionals interpreted and understood interactions with families. Observations granted insights into professional risk assessment and enabled the possibility of triangulating professionals’ narratives (what people say they do) with observations of this risk work (what people actually do), with knowledge gleamed from observations helpful in interpreting interviews and vice versa (Matthews 2005). The tensions that emerged when triangulating these two sources of data were useful in providing a window into some of the more taken-for-granted aspects of professional lifeworlds which are fundamental to phenomenological analyses (Schutz 1972).

The interviews and observations were located within four local services, purposefully sampled (in terms of urban-rural locations and related levels of socio-economic and ethnic diversity) within the national CHC (JGZ) system. The services were located across ‘de Randstad’ area spanning several major Dutch cities. After meeting the professionals in a team meeting, ten of the eleven professionals agreed to be interviewed, with nine of the ten agreeing to being observed during consultations. Snowball sampling was used to access professionals within two other locations, thus increasing the total number of interviews (n=5) and observations (n=1). All participants were women, reflecting Dutch CHC more broadly as there appear to be almost no male CHC professionals (Lieburg 2001). Twelve interviewees focused on the age group 0-4 and three interviewees on the age group 4-19 years old. These latter three interviews were only used for this chapter, and not for the other chapters.

Interview transcripts, alongside extensive field notes from observations (and the brief interviews after each consultation), were initially analyzed through a more ‘open’, constant comparison approach by which commonly recurring and salient themes emerging within professional narratives were identified; alongside patterns within observations. This initial coding was sensitized by social theoretical literature on risk and uncertainty, alongside the interpretative phenomenological
orientation of the research. Following an abductive logic, these theoretical insights were in turn critically reworked in light of emerging themes from the data (Meyer and Lunnay 2013). Core themes were then subjected to more specific investigation, through the triangulation of interview and observational data, assessing patterns of corroboration and inconsistencies within these. A hermeneutic circle was invoked by which specific interview excerpts, or observed interactions, were interpreted in light of wider narratives of the professional involved and vice versa (Smith and Osborn 2003). Double-coding and critical discussions of analytical frameworks were used to enhance the validity and consistency of our analysis.

3.8.4 Chapter 8: a phenomenological and cross-national comparative approach

In this chapter, I combined a phenomenological approach with a cross-national comparative design when studying relational trust within professional-father relationships in different contexts. It has been argued that phenomenology is not often used in (anthropological) health and medicine studies, because ambivalence is shown towards using the (patient’s) personal narrative as an important source of data, since such narratives are perceived as sometimes irrelevant and hard to compare, sample sizes are usually small and this is deemed difficult to combine with cross-national designs (McElroy and Jezewski 2000). It has meanwhile been shown that phenomenological approaches offer salient insights in professional-patient trust relationships (Brown 2009), also when focused on professionals making sense of families (see chapter 7; Brown and Veltkamp 2017). In this chapter, I approach the narratives of professionals as situated within particular institutional context, thereby linking healthcare and family policies to professionals’ ways and degrees of knowing fathers, in order to study these linkages in-depth. While moving between theory, analysis and data, the focus in this chapter has been on professionals ascribing caregiving responsibilities to fathers, as ‘negative cases’ (Katz 2105 [1981]; Tavory and Timmermans 2009) in the sense that these cases are studied more in-depth because they diverged from the overall patterns.

For this study, I have again drawn on the complete data set of interviews (n=53) with midwives, postpartum care assistants, paediatricians and nurses in the Netherlands (n=23: 5 midwives; 5 postpartum care assistants; 5 paediatricians; 8 nurses), Germany
(n=12: 7 midwives; 5 paediatricians) and Poland (n=18: 9 midwives; 9 paediatricians), on participant observations (61 in the Netherlands, 55 in Germany and an ethnographic visit in Poland), brief follow-up interviews and in-between remarks during the observations. The analysis combined the within-case and cross-case analysis described for chapter 5 and 6 with the more in-depth phenomenological analysis described for chapter 7. Accordingly, the discussion and presentation of verbatim quotations is (in parts of the chapter) more in-depth than the multiple quotes presented in chapter 5 and 6, but (in parts of the chapter) not as detailed as in chapter 7 (see Cordon and Sainsbury 2006 for the different purposes of verbatim quotations among qualitative research).

3.9 Ethical considerations

3.9.1 Informed consent

The professional respondents were asked for informed consent before participation in this research (Weiss 1994; Miles et al. 2013). They were informed through a meeting and/or a two-page information leaflet about the general aims of the (comparative) study, including the Apparent website and contact details, to give the respondents an idea of the research they participated in (see appendix B, page 301). Based on this information, they could consent to being interviewed and observed. The respondents were not informed beforehand about the specific interest in how they interacted with mothers versus fathers, neither about how they performed ‘risk work’, because this might have affected their behaviour in ways that would have made any conclusions from the research invalid (Hammersley and Atkinson 2007, p.211). The head of the wards in the Polish academic hospital where most of the paediatricians were interviewed gave informed consent to the research, as well as to approaching the paediatricians working in his staff, and the overarching organization of CHC in the Netherlands, ‘de Gemeentelijke Gezondheidsdienst’ (GGD’), provided a written consent to participant observations in consultations. The German paediatricians and midwives ran their own practices and thus provided consent for themselves.
Informing and consent were focused on professional participants, because the initial explicit focus of this research was on how professionals assessed risk and dealt with uncertainty in decision-making. The potential presence of a researcher was explained to parent(s) before observations in the Netherlands and Germany and they were able to consent to or refuse this. The short, informal follow-up interviews with professionals after observations were also focused on decision-making from the professionals’ perspective and for this reason parents were not asked for consent. However, as later became evident in the analysis, decision-making was deeply interrelated with professional-parent relationships. For this reason, if the research was to be repeated, parental consent for the brief follow-up discussions would be important as well. The parents in the wards in the Polish academic hospital did not give their consent for observations. Observations in these wards are therefore not presented as specific cases but used as contextual findings. The two doctors in this ward did agree to walk us around and answer questions, in addition to the interviews.

3.9.2 Privacy

At the beginning of each interview, respondents were told that the data would be anonymized and that references that would reveal their privacy would be removed, in order to avoid any unfavourable consequences for the respondents in relation to what they revealed in interviews and observation (Hammersley and Atkinson 2007; Miles et al. 2013). The names of the professionals are thus fictive in order to protect their privacy and anonymity.

3.9.3 Harm

Ethical tensions within ethnographic research often arise from the clash between the ‘ethnographer’s field’ and the setting of the study, especially in case of ethnographic work in medical settings (Anspach and Mizrachi 2006). Researchers’ efforts to produce good research, in which being ‘critical’ and ‘distinctive’ is important within academic fields, might cause harm to those they study, for instance when they attempt to “demystify professional authority” (2006, p.715). Healthcare professionals can be offended when they read the research afterwards and informed consent did not include an expression of the risks of damaged self-
esteem and reputation, when professionals are pictured in disadvantuous ways (Anspach and Mizrachi 2006, p.716; see also Books 2001).

What I did to avoid or bridge such tensions was first to choose a theoretical framework that brings the child development perspective into the different conversations about family life and work (see page 12), with a focus on how conversations clash or overlap, rather than prioritizing one conversation over the other. Second, I brought some of these tensions into the interviews and follow-up interviews (Weiss 1994) after the participant observations, to include professionals’ own reflections (Van Duursen et al. 2004) on working with risk and dealing with mothers and fathers, and with parents with different social class and ethnic backgrounds, into the analysis. This revealed tensions and difficulties they faced in performing risk work, their own uncertainties and their ways of dealing with this. Third, I brought these reflections into the analysis to inform my understanding of healthcare professionals’ risk work in different professions and different institutional contexts. In attempting to write up ‘good research’ I kept in mind how the professionals who participated in this study would read these conclusions and how I could do justice to their work, while still being able to take a critical sociological perspective. In this sense, I attempted to use my own experiences – those of having previously worked with families as a healthcare professional myself, as well as my interactions with the professional participants in the field – to be sensitive to how these experiences connect us rather than only “how they set us apart” (Ellis 1995).

3.9.4 Ethical approval

The study received ethical approval under the ethics committee of the ‘European Research Council’ in 2010. As a part of the ethical screening process, the ethical committees of the University of Amsterdam and the Goethe-University Frankfurt am Main also approved the research proposal in 2010, respectively in 2014.
4 Culture and risk representations in pre- and postnatal healthcare and family policy institutions in the Netherlands, Germany and Poland. A cross-national policy comparison
4.1 Introduction

Context-specific institutions, as “enduring features of social life” (Giddens 1984, p.31) structuring social, economic and political relationships (North 1981; Nee and Ingram 1998) as well as individuals’ everyday interactions and meaning-making processes (Douglas 1986; Grunow and Veltkamp 2016; Broër 2008), develop out of cultural ‘thought styles’ (Douglas 1986), which become particularly apparent in varying institutional constructions of danger, risk, and responsibility within societies (Douglas 1992; Brown 2013). In this chapter, I examine potentially coherent and contradicting (Douglas 1986; Pfau-Effinger 2005) constructions of ‘risk’ in relation to mothers’ and fathers’ roles in family life and work over the course of pregnancy, childbirth and early childcare within Dutch, German and Polish institutions. In order to do so, I look at *pre- and postnatal healthcare policies* in the Netherlands, Germany and Poland on the one hand, and at *family policies* in these countries on the other hand and ask (see Boholm and Corvellec 2011):

1. How are ‘risk objects’ constructed, that is: which persons, behaviours or settings are considered to be ‘risky’, infused with risk, or are potentially posing a threat?
2. How are ‘objects at risk’ constructed, that is: who are considered as vulnerable objects, potentially being ‘at risk’?
3. How is the causal relationship between these constructions framed: how are risk objects understood to threaten and endanger the objects at risk?
4. How do these institutions suggest that ‘risks’ and ‘vulnerabilities’ should be addressed and by whom? Using Leitner’s (2003) concepts of ‘familialisation’ – meaning that the family is emphasized as the primary care provider – and ‘defamilialisation’ – which means that the formalisation and delegation of care tasks to the state is emphasised – (see also Christiaens 2008), I study in this respect the relationship between the family and the state, and/ or healthcare organizations as mediating between the state and families (Rose and Miller 1991), and accordingly the representation of responsibilities in the face of risk
5. How are categories of ‘being risky’ and ‘being at risk’, as well as related responsibilities, gendered or how do they function as a gendering strategy (Hannah-Moffat 2004)? And (how) do these categories intersect with social class and ethnicity within policies (Crenshaw 1981; Lutz et al. 2011)?
While institutions are based on – and frame – categories of sameness and of difference through policies (Douglas 1986; Harrits and Møller 2011; Bacchi 2009), this chapter brings to the fore three forms of categorizations within healthcare and family policies that potentially structure professionals’ knowledge of parents’ roles in family life and work: a) through categorizations of normality and pathology; b) through categorizations of vulnerability and responsibility, and c) through categorizations of gender and social class.

Furthermore, I examine in this analysis the degree to which the represented risks and the underlying assumptions within healthcare and family policy institutions are in line, in other words ‘coupled’, or in conflict, in other words ‘decoupled’, in the Netherlands, Germany and Poland, because coherent institutions – as “social mechanisms” – are said to produce stronger effects on individuals’ behaviour than contradictory institutions ((Nee and Ingram 1998, p.33; see also Grunow and Veltkamp 2016), which potentially informs the particular challenges that individuals face. This chapter thus highlights coherencies and contradictions within healthcare and family policy institutions, thereby clarifying the context within which pre- and postnatal healthcare professionals interact with (expecting) mothers, fathers and children, as well as how these interactions and mothers and fathers parenting roles are structured and informed by healthcare policies and/or family policies.

Hence, the contribution of my analysis, in which I partly build on existing literature about pre- and postnatal healthcare and family policies and partly use original policy documents (for an outline of the methods and data used in this chapter, see chapter 3, page 68), lies first in the cross-national comparison that integrates the separate policy domains of obstetric care, child healthcare and family policies, and second in the framework I use, which is focused on deconstructing cultural risk representations within these policies.
4.2 Results

The results are presented first as within-country comparisons, in order to show how cultural risk representations in the different policy domains do and do not relate to one another within the particular contexts. Reflections of between-country comparisons are brought to the fore in the within-country analyses in order to highlight and position the particularity of the country case. Second, the within-country analyses are succeeded by a between-country comparison in the conclusion in which cross-national similarities and differences in risk constructions related to pregnancy, childbirth and early childcare are highlighted and discussed.

4.2.1 The collaborative Dutch model: intensifying risk representations versus pregnancy, childbirth and early childcare as ‘physiological’ events in everyday life

4.2.1.1 Risk in Dutch obstetric care

Physiology as the guiding principle of Dutch obstetric care

Pregnancy, giving birth and the first weeks after birth are in the Netherlands approached as ‘physiological’ events in everyday life in which potential medical risks need to be selected by midwives (KNOV 2016; Verloskundig Vasemecom 2003) Hendrix et al. 2010), and increasingly also by obstetricians. The Dutch OC system distinguishes between ‘the first line’ of accessible close-to-home primary care, guided by midwives, in case of physiological ‘low risk’ pregnancies and births; the ‘second line’ of more specialist care in hospitals in case of higher levels of risk, where midwives guide women in collaboration with obstetricians, and the ‘third line’ of healthcare in highly specialized academic hospitals, in case of premature birth and high risk pregnancies (KNOV 2016). A central policy document, jointly accepted by the national Midwifery association (KNOV), the national General practitioners’ association and the national Obstetric and Gynaecologists association (NVOG) claims that:

“The basic assumptions are that pregnancy, childbirth and the postpartum period are physiological processes and that childbirth and the postpartum period can take place at home. Within the organization of midwifery, the expertise of the various obstetric
Caregivers must be optimally used. This means that the normal pregnancy, childbirth and the postpartum period belong to the area of the primary caregiver. The expected pathological pregnancy, childbirth and postpartum period fall under the tasks of second-line healthcare, principally after selection by the primary caregiver” (Verloskundig Vademecum 2003, p.37).

Accordingly, midwives – mostly working in local midwife practices – are responsible for the majority of all pregnancies (KNOV 2016; De Vries et al. 2013), and often also have the sole responsibility to manage deliveries in the hospital, with obstetricians being available to assist in cases of higher risk (Cronie et al. 2012). Home birth rates in the Netherlands have been the highest in Europe with 13 per cent in 2015 (Perined 2016), compared to 0-2 per cent in Germany and Poland (Zeitlin et al. 2010) and caesarean rates the lowest in Europe with 14 per 100 deliveries in 2009 (OECD 2011), compared to 31 in Germany and 23 in Poland in 2009 (OECD 2011). Hence, the emphasis on pregnancy, childbirth and postpartum care as ‘normality’ within Dutch OC policies is remarkably strong, and the spectrum of what is approached as ‘normality’ is relatively broad, whereas it is clearly demarcated what is considered as ‘expected pathology’.

High degrees of ‘familialisation’, in which the family is emphasized as the primary care provider (Leitner 2003; Christiaens 2008), have also been found in the institutionalisation of ‘baby-friendly’ measures that enable extensive physical contact – including the promotion of breastfeeding – between mothers and babies directly after birth, as promoted by Unicef and the WHO (WHO and Unicef 2009): 65 per cent of all Dutch hospitals, 40 per cent of Dutch midwifery practices and 97 per cent of Dutch postpartum care organizations were certified as ‘baby-friendly’ in 2011 (Landelijke Borstvoedingsraad 2012), compared to 8 per cent of German, and 20 per cent of Polish hospitals with a maternity ward in 2012 (Bosi et al. 2016).

Underlying assumptions of pregnancy as an event in everyday life and the importance of the home also apply to postpartum care. Dutch mothers who have given birth in the

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6 A steep decline can however be detected: from more than 30 per cent in 2004 (Zeitlin et al. 2010) to 13 per cent in 2015 (Perined 2016)
7 Caesarean rates in Poland have increased to 36 in 2014 (OECD 2015)
hospital under the supervision of a midwife can return home ‘immediately’ with their child in case the condition of mother and child allows it. All ‘families’ who deliver at home or return home within a few days after birth receive intensive hands-on care at home from a *postpartum care assistant* (‘kraamverzorgster’), which is the case for 90 per cent of all women who give birth in the Netherlands. The postpartum care assistant is present at the family home in the subsequent eight days, for 3 to 8 hours per day (Herschderfer et al. 2002; Wiegers 2006).

**Risk selection as risk object**

The physiological approach to birth in the Dutch OC system thus highlights that pregnancy, childbirth and postpartum care in the Netherlands are not perceived as being risky in itself, and posing a threat per se. It is rather the risk selection in relation to the health and development of pregnant women and children, as well as the progress within pregnancy and giving birth, that is highly salient within the Dutch OC system (see KNOV 2016; 2017; Verloskundig Vademecum 2003; Manniën et al. 2012; Amelink-Verburg and Buitendijk 2010). The selection of risk can therefore be seen as the ‘risk object’ within Dutch policies (see table 4.1, page 85), because several policy documents and interdisciplinary as well as public debates reflect on the potential consequences of not selecting risks properly.

Midwives, basing themselves on a ‘Midwifery Indication List’ (KNOV 2016; Verloskundig Vademecum 2003), have long functioned as ‘gate keepers’ assessing which pregnancies and deliveries were considered as ‘low risk’ and which pregnancies involved higher medical risks that should therefore be addressed by an obstetrician. An intensifying concern with pregnancy and birth has been detected: over the years, an increasing amount of pregnancies and deliveries has been defined as ‘pathological’ and ‘high risk’, which has led to an increase of medical interventions (Van Daalen 1988; Amelink-Verburg et al. 2009; Offerhaus 2015; Christiaens et al. 2013).

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8 Not all Dutch women leave the hospital directly after a spontaneous birth: it has been reported that in 2012, Dutch women stayed on average 1.9 days in the hospital, which is shorter than the average of German (3 days) and Polish women (3.9 days) (OECD 2014a).
Table 4.1 Dutch policies: constructions of risk and responsibility in pregnancy, childbirth and early childcare

<table>
<thead>
<tr>
<th>A. Risk object</th>
<th>B. Object at risk</th>
<th>C. Relationship A and B</th>
<th>D. Responsibility</th>
<th>E. Strategy</th>
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<td>OC</td>
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<td></td>
<td>Or: too early → consequences mothers’ influence on decision-making</td>
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<td>2. Parental influence</td>
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<td>Improper selection: intervening too late → consequences child health</td>
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<td>3. Inter-disciplinary</td>
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<td>CHC</td>
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<td>1. Parenting</td>
<td>1. Professional parenting or disadvantaged background → arrears, harm</td>
<td>1. Professionals</td>
<td>Collaborative negotiation:</td>
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<td>2. Risk detection</td>
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<td>3. Electronic Child Files</td>
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<td>Parents’ (un) employment</td>
<td>1. Labour market → less employment</td>
<td>1. Mothers’ dropping out → less employment</td>
<td>1. Parents</td>
<td>Collaborative negotiation:</td>
</tr>
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<td></td>
<td>2. Child development</td>
<td>→ less employment</td>
<td>2. State</td>
<td>1. Part-time work</td>
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<td>2. Low parental or day care quality → negative developmental outcomes and inequality</td>
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<td>2. Childcare</td>
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<td>3. Shared parenting</td>
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<td>4. Tax benefits</td>
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Source: own depiction, based on the relational theory of risk developed by Boholm and Corvellec (2011)

Intensifying concerns also apply to the risk selection processes itself, and the parties perceived as capable of doing that. After intense debates in which midwives and obstetricians fought over the gatekeeper position (Trouw 2016; de Volkskrant 2016), the Minister of Health decided in June 2016 that midwives are no longer alone in charge of the decision which pregnancies are ‘physiological’ or ‘pathological’, but

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9 This change was effectuated after the interviews that took place between 2011 and 2015.
they have to share responsibility with obstetricians (KNOV 2016; 2017a; Rijksoverheid 2016).

*Child health and mothers’ decision-making as objects at risk*

What is at stake, and thus the *object at risk* in Dutch OC policies, is first and foremost the health and survival of the unborn and new-born child. This object at risk has over the years been constructed as more vulnerable within Dutch OC, because research has been published (and debated) since 2003 suggesting that Dutch child mortality rates were comparatively high within a cross-national perspective, supposedly because of the Dutch OC system in general and the risk selection process in particular (Amelink-Verburg et al. 2009), and because parents have been expressing intensifying concerns about monitoring their pregnancy and the site of giving birth (Offerhuis 2016). The KNOV reports:

> “*We continue to commit ourselves to unnecessary perinatal mortality. High on the agenda are therefore: reducing premature deliveries, detecting growth restriction, prevention and healthy lifestyle combined with attention to vulnerable pregnancies.*” (KNOV 2016)

Furthermore, systematic risk assessment questionnaires have been implemented in midwifery care and post-partum care to also address psychosocial risks, in order to prevent child abuse by detecting ‘risk objects’ within families of: psychopathology, addiction, insufficient social support, partner violence, low educational level and parents having a history of child abuse or neglect (Vink and Detmar 2012, p.525; see also de Boer et al. 2008). This means that emerging risk categories that define pathology have been extended to the psychosocial domain.

What is at the same time at stake within Dutch OC policies is the relatively high degree of individual responsibility in terms of mothers’ possibilities to influence decision-making in the birthing and post-natal process, as well as choosing the site of birth (Hendrix et al. 2010; Sanders and Meijman 2012), which is perceived to be easily threatened by an increase of medical procedures and interventions.
“[Midwives] guard the physiology and ensure continuous good and safe guidance during pregnancy and delivery. When needed, [this is] supplemented with specialist care. This prevents unnecessary medicalization. [...] Women in the Netherlands want [...] to decide for themselves how and where they deliver” (KNOV 2016).

Responsibility in care and collaborative strategies
Within OC in the Netherlands, a high degree of responsibility is ascribed to parents – mothers in particular – in terms of decision-making and caregiving, and furthermore to midwives as the primary caregivers who guide ‘women’ and parents in making ‘informed choices’ (Sanders and Meijman 2012). Dutch OC policies report that midwives are primarily occupied with mothers, rather than also with fathers. In a policy report focused on the psychosocial aspects of Dutch midwifery, mothers are for instance framed as responsible for dealing with changes following pregnancy

“Midwife guidance during pregnancy is a coherent package of supportive activities focused on helping the pregnant woman to deal adequately with psychosocial and physical changes and potential problems due to the pregnancy, and in that respect to support their well-being.” (de Boer et al. 2008, p.4)

Such guidance includes for instance supporting women during pregnancy and giving birth, and preparing women for the delivery, for ‘motherhood’, disappointment and struggle, and for ‘attachment’ (2008, p.17-53). Fathers are in this and in other Dutch OC policy documents only mentioned explicitly in a few occasions, such as in relation to being present for the ultrasound and as pregnant women’s ‘partners’, and thus their direct environment. Within Dutch OC policies focused on postpartum care, the focus shifts somewhat: mother and child are still central, “but also the partner and family” (KNOV 2010, p.2). Hence, responsibility is to a stronger degree ascribed to both parents in this period, when the “mother recovers and takes up responsibility for the care for the new-born baby (together with her partner) and incorporates this care in her family situation” (KNOV 2010, p.2). The main aims of postpartum care are framed as: detecting health problems for mother and child early on, to support and teach breastfeeding and to help parents in learning new skills and adapting routines.
The ways in which responsibility in decision-making and caregiving is ascribed to mothers reflect cultural values about family life in the Netherlands, which include strong domestic values with women ideally having a high degree of autonomy (Kloek 2010; Van Daalen 2005; van den Berg and Duijvendak 2012). Scholars have argued that domestic ideals and ideals of female ‘autonomy’ still go hand in hand in the current Dutch society (Kloek 2010; van den Berg and Duijvendak 2012), which can be seen as reflected in the physiological model to pregnancy and childbirth with a leading role for midwives supporting mothers’ autonomy, the high portion of home births and pregnant women and their partners valuing the possibility to influence decision-making as the most important characteristic of OC (Hendrix et al. 2010).

Although obstetricians are becoming increasingly important in addressing the ‘risk’ of not making proper risk selections, understood as potentially endangering child health (NVOG 2013), Dutch obstetricians do acknowledge physiology – and to some degree mothers’ influence on decision-making – as the guiding principle of Dutch OC (Verloskundig Vademecum 2003). What stands out further is that interdisciplinary collaboration between obstetricians and midwives in policy-making and in everyday practice has since the past decades been a solid strategy within Dutch OC to assess and address ‘risks’ (Van Daalen 1988; De Vries et al. 2013; KNOV 2017; NVOG 2013).

Institutionalized collaborations and negotiations are therefore central in Dutch OC policies, and can also be found on other levels of Dutch OC. Professional-parent relationships are for instance typically distributed over several professionals. In 2015, almost half of the midwives in the Netherlands worked in independent practices, located in neighbourhood areas. The majority of these midwives worked in group practices with four or five, or with five or more midwives (van Hassel et al. 2016). Midwives alternate their consultations so that several midwives within the practice and the pregnant woman or expecting couple are familiar with each other. Which midwife will be present during birth depends on who is on duty that moment. Every pregnant woman has a midwife who is in particular responsible for her account and the development of the pregnancy, child and mother (KNOV 2016). In postpartum care, midwives are responsible for monitoring the health condition of mother and child, while checks are predominantly executed by postpartum care assistants.
Postpartum care assistants and midwives are therefore seen as partners in postnatal healthcare. Furthermore, midwives are responsible for transferring the family to CHC or a general practitioner when ending OC six weeks after birth (KNOV 2010). Within Dutch OC, a collaborative model can thus be detected in which responsibility in caring is typically shared and negotiated.

4.2.1.2 Risk in Dutch child healthcare

Public investment in children’s health

Every Dutch municipality provides low threshold CHC walk-in centres for all children between 0 and 19 years within the family neighbourhood. Municipalities implemented national protocols for child examinations, with fifteen meetings in the first four years according to a pattern of immunizations and developmental checks (NJC 2016). CHC in the Netherlands organizes a relatively large number of meetings: German paediatricians have seven preventive meetings with children in their first four years (and in addition six meetings solely for immunizations) (G-BA 2016) and Polish paediatricians ten (and in addition eight meetings solely for immunizations) (Pediatría 2016a).

Public investment in children’s health has a long tradition in the Netherlands. In 1901, paediatric healthcare was implemented in ‘consultation bureaus’ ['consultatie bureaus'] in nearly all Dutch cities and villages (Van Lieburg 2001), which is still the basic structure of Dutch CHC (Knijn and Hopma 2015). The focus within Dutch CHC was initially on children’s health, feeding and immunization, but pedagogic factors have become much more important since the 1990’s (Caris 1997; Knijn and Hopma 2015). Until the 1970’s pedagogic experts in the Netherlands assumed that children should be raised to become responsible citizens, but since the 1970’s children’s happiness has received most emphasis within Dutch professional literature on child raising. Expert-led parenting and a focus on children’s development, as promoted mainly by mothers, became dominant in Dutch parenting approaches (Wubs 2004) and a “scientisation of parenting” (Ramaekers and Suissa 2012) has been detected with an increasing focus on the parenting role, in line with scientific findings and ‘evidence based’ methods established in public health and developmental psychology research (Knijn and Hopma 2015).
Parenting as risk object and child development as objects at risk

The ‘scientisation of parenting’, in which parents are framed as ‘risk objects’, and child development as the ‘object at risk’, is specifically reflected in the reorganization of CHC in 2007. CHC centres were established from 2007-2011 by the former Youth and Family Ministry as a part of the ‘Every Opportunity for Every Child’ initiative, thereby replacing the former ‘consultation bureaus’ (Rouvoet 2007; ChildONEurope Secretariat 2013). The aim of this reorganization has been:

“[… to provide] all parents and children, including those without specific problems with access to an approachable, recognisable point of contact close to home where they can get advice and help on a range of parenting issues” (Youth and Family Ministry 2007, p.20, cited by ChildONEurope Secretariat 2013, p.59).

This is accompanied with intensifying risk representations about children’s development. Within Dutch CHC, all parents and children are approached as being potentially ‘at risk’, of specific problems and of a number of parenting challenges. Having all children under the scope of CHC is in that sense perceived as necessary to select those children who are at risk, as can be read in a JGZ factsheet:

“CHC participates in various [professional] networks to have a view on all children and provide tailored care to children at risk [list of risk factors attached to the factsheet]. (Keulen, van, 2012, p.1)

Collaborative strategies of risk detection and making parents responsible

Apart from providing parents and children with information and (minor pedagogic) advice, the aim of Dutch CHC is therefore also to identify problems at an early stage by means of observation, structured Electronic Child Files and the implementation of risk instruments.

“The digitization of CHC through the Electronic Child File should result in an improved exchange of information, an earlier identification of risks and a better
monitoring of the development and health of individual children.” (Keulen, van, 2012, p.1)

Dutch CHC policies thus reflect a ‘familialistic’ approach on the one hand, focused on accessible services close to home and related to everyday life ‘parenting issues’, while this is on the other hand combined with a more interventionist approach, ascribing more tasks in assessing child rearing to the state and healthcare professionals, which reflects a more ‘defamilialistic’ approach. The strategy used in Dutch CHC therefore reveals that the division between public and private spheres is not approached as a strict one (Van den Berg and Duyvendak 2012), but these spheres are negotiated in and through institutions.

Accordingly, the guideline describing what should be done in each consultation prescribes for the home visit in the second week after birth: “Assessing capacity and burden; Determining risk groups” (RIVM 2008). Moreover, the subsequent developmental examinations in CHC centres include an assessment of pedagogic observations, parents’ characteristics, parent-child interactions and the psychosocial situation (RIVM 2008), which are tracked in the Electronic Child File. Similarities between Dutch CHC and Dutch OC therefore concern policies in constructions of ‘risk’ and ‘strategies’ to address these risks through a sensitivity to familial responsibilities in everyday life on the one hand, and increasing interventions to safeguard children’s developments through contacts with parents and early risk detection on the other hand.

Similar to Dutch OC policies, Dutch CHC policies also reveal a collaborative model in which healthcare professionals (paediatricians and nurses) who generally work in larger teams alternate their consultations with parents and children. Families are thus structurally meeting with different doctors and nurses depending on working and visiting days. Children in families where risk factors are detected are provided with a professional who is specifically responsible for their ‘case’. In contrast to in Dutch OC policies however, parents’ influence on decision-making is not as much framed as vulnerable, or as an ‘object at risk’, within Dutch CHC policies, where a strong focus on child development is believed to legitimize professional interventions (see Postma 2008, and Hopma et al. 2014 for a more critical reflection).
Responsibilities in relation to particular ‘parents’

While the comprehensive CHC system with an intensifying focus on risk factors potentially compromises parental autonomy, it remains at the same time a voluntary close to home service with a voluntary immunization program\textsuperscript{10}. Based on a discourse analysis of Dutch CHC policy documents and on interviews with policy makers, it has been suggested that assumptions of ‘security’ underlying Dutch CHC inform a division between parents doing well, who are granted more autonomy, and parents from disadvantaged backgrounds who are targeted for more intense monitoring and interventions (Hopma et al. 2014), meaning that parental autonomy is compromised to distinct degrees. This is also reflected in ‘behind the front door’ policies that have emerged in the Netherlands over the past decades, in which professionals are positioned to see and understand what happens in a selective group of (multi problem) family homes in order to intervene in these families when deemed necessary (Cornelissen and Brandsen 2007). Categories of ‘pathology’ are in Dutch CHC policies therefore intertwined with ‘at-risk target groups’ (Møller and Harrits 2013), which is reflected in Dutch CHC instructions to categorize all parents along predefined population-based risk factors (NJC 2016; Postma 2008).

Different than in OC policies, a strong focus on mothers as the main caregivers has not been found in Dutch CHC policies, where parents are predominantly approached in gender-neutral terms. Dutch CHC centres are called ‘Centra for Jeugd en Gezin’ (CJG), meaning that the initial ‘mother-child’ centres were purposefully changed into centres for ‘youth and family’ in 2007. These broadening perceptions of who is and can be involved in childcare reflect Dutch norms of shared parenting (Kremer 2010), as well as a reflection on changing family forms (Rouvoet 2007). It has been argued however that using gender-neutral terms in parenting does not necessarily imply that parents are approached in gender equal ways (Daly 2013). Within Dutch CHC examinations, professionals are for instance instructed to assess interactions between parent and child (NJC 2016), while mothers are more likely to attend consultations during office hours, since most mothers work part-time in the Netherlands (Plantenga

\textsuperscript{10} The voluntariness is demonstrated by a currently (high, but) declining number of parents choosing to have their children vaccinated (Van Lier et al. 2016)
Gender-neutral parenting policies that do not reflect on gender roles could therefore also be seen as ‘gender blind’ (Daly 2013). Nevertheless, the framing of parental gender roles in Dutch CHC policies is explicitly left open to interpretation, emphasizing parents’ individual responsibility in dividing parenting tasks (Lewis et al. 2008; Veltkamp and Grunow 2012).

4.2.1.3 Risk in Dutch family policies

**Limited leave policies**

Similar to what has been found in Dutch OC and CHC policies, pregnancy and childbirth is in Dutch parental leave policies approached as a generally low-risk family event in everyday life, which is shown in the limited length of (fully paid) maternity leave (16 weeks) and paternity leave (2 days), as the only paid leave in Dutch family policies. The assumption underlying the difference in length of leave between mothers and fathers is focused on the physical event of giving birth: mothers’ maternity leave consists out of “pregnancy leave” ['zwangerschapsverlof'] and “delivery leave” ['bevallingverlof'] and fathers’ paternity leave consists out of “post-partum leave” ['kraamverlof'] (Rijksoverheid 2017a; 2017b), meaning the first days after the delivery. The municipality needs to be notified of the birth of a child within three days after birth (Rijksoverheid 2017), which is in practice often perceived as a task for fathers, performed during his paternity leave (Papa Worden 2017). Hence, providing Dutch parents with limited maternity and paternity leave resembles a practical perception of risks related to recovering and quickly moving forward to everyday life. Pregnancy and childbirth are therefore not approached as ‘pathology’ in Dutch family policies as well, which is reflected in maternity leave allowances being paid through social securities, and not through health insurance (Rijksoverheid 2017a), as is the case for German maternity leave allowances (BMFSFJ 2015).

Within Dutch family policies, parents are furthermore each entitled to 26 weeks of parental leave, which can be taken up in part-time. This leave is unpaid, unless an employer or collective labour agreement decides to pay for parental leave allowance.
themselves (Rijksoverheid 2017d). What this shows is that labour market institutions are privileged over ‘familialisation’ institutions. The main ‘risk object’ addressed in Dutch family policies concerns parents’ and especially mothers’ withdrawing from employment following pregnancy and childbirth, whereas the main ‘object at risk’ is labour market participation. Accordingly, parents’ dual working patterns are supported through tax benefits for dual-earning parents, combined with unfavourable taxes for stay-at-home parents and parents with small incomes (Belastingdienst 2017). The main labour market instruments used to facilitate work-family reconciliation and parents’ labour market participation are part-time work and government support for formal and informal day care.

*Part-time work and childcare facilities as strategies to address labour market risks*

Dutch family policies have since the 1990s facilitated female labour market participation through part-time work. Part-time jobs are in the Netherlands generally well paid, they offer good career perspectives and provide social security (Gornick and Meyers 2003). There is a high incidence of part-time jobs in the public sector, while a high share of part-time jobs concerns at least 24 hours per week. Moreover, part-time work fits well with the Dutch economy, because of the extensive service sector (Allaart and Bellmann 2007). The support for part-time work in the Dutch context does not only promote female labour market participation, but it has also been used to disseminate ‘shared parenting’ values in which fathers have also been encouraged to work part-time. Cultural values about fathers as (sole) breadwinners have been contested in the 1990s with a government campaign encouraging fathers’ active involvement in childcare (Kremer 2010).

Legal entitlements within Dutch family policies are defined in ‘gender-neutral’ terms and framed as employees’ rights in case of part-time work and parental leave, and as parents’ entitlements in case of childcare subsidy. Similar to a gender-neutral approach in CHC, one can expect that policies, although legally gender-neutral, interact with cultural values about gender roles and are differently used by mothers and fathers (see Daly 2013). Gender equality is however not as much emphasized in

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11 This is not common practice and very much dependent on occupational sectors (Knijn 2004)
12 In 2013, 61 per cent of employed women compared to 19 per cent of employed men in the Netherlands worked less than 30 hours per week (OECD 2017). Moreover, 57 per cent of all Dutch
Dutch family policy as an ‘object at risk’ when compared to German and Polish family policies. Accordingly, Dutch family policies do not particularly address gendered policy effects but rather focus on parents’ individual responsibility in sharing and distributing care as a matter of choice and negotiation (Lewis et al. 2008; Veltkamp and Grunow 2012).

It has been suggested that the Dutch part-time work model and its appeal, especially to women, is in line with historical values of domesticity, female autonomy and the ‘Dutch housewife’ managing the household in the Golden Age (Kloek 2010; van Daalen, 2005; van de Berg and Duyvendak 2012). It can in that sense be argued that while Dutch family policies do not reflect a strong ‘familialisation’ approach through parental leave, familialisation is reflected in the strong support for part-time work. At the same time, the ‘Dutch housewife’ as depicted from historical sources typically negotiated private and domestic spheres with public and merchandising spheres, while Dutch women according to this model had a high impact on both the household and their husbands’ – or their joint – working activities (Kloek 2010). Other historians have suggested that for instance in the village ‘Graft’ in the 17th century, a woman’s status was defined by two elements: her (former) marriage and her ‘work’ (Van Nierop and Van Deursen 1995). What we can at least see in current Dutch family policies promoting part-time work is an assumption of families negotiating public and private spheres, rather than devoting to one of them.

A ‘defamilialisation’ approach is in this respect reflected in the extensive provision of childcare through the private market, regulated by the government. Childcare is available for children aged 0-4 (starting either 6 weeks or 3 months after birth), for five days per week, 50 weeks per year with ‘all day’ opening hours. The Child Care reform in 2005 (Akgunduz and Plantenga 2014) stimulated competition and parental choice within a private market to obtain efficient childcare. Prices are under government control and have remained rather stable. All dual-employed parents are entitled to the same central government subsidy for childcare attendance: access to subsidy is
standardized and depends on the household income (Akgunduz and Plantenga 2014). Subsidy is paid via fiscal refunds, by which the government takes over a percentage of childcare costs, which has increased substantially since 2012 and gradually over the past three years (Rijksoverheid 2017e).  

Childcare services eligible for subsidy are day care facilities, playgroups, after-school care and paid individual childcare [‘gastouders’] registered in the national register for childcare and playgroups (Landelijk Register Kinderopvang 2017). Municipalities monitor the quality of childcare facilities, while subsidy is only provided for childcare that meets the criteria of staff-to-child ratio and location characteristics. Parents have the possibility to receive subsidy for different forms of childcare such as day care or paid individual childcare, in order to facilitate their choice for professional and group-based care or informal and small-scale care (Akgunduz and Plantenga 2014). Paid individual caregivers, who can – but need not be – someone familiar like a grandparent, provide informal and home-based care for a smaller number of children; they need to have a relevant diploma and meet specific safety criteria in order to be registered in the national register (Landelijk Register Kinderopvang 2017).

*Investments in childcare to address child development risks*

Childcare within Dutch family policies has mainly been designed as a labour market instrument focused on dual-earning, while putting constraints on potential risks for children by relating subsidy to a monitoring of quality. A downward trend in childcare quality, judged as insufficient in many cases, has been detected since 2005, especially concerning professional caregivers’ educational skills and opportunities for personal attention and sensitivity in baby groups (Helmerhorst et al. 2014; Akgunduz and Plantenga 2014). Over the past years the concern about positive and negative childcare

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13 In 2017, the government takes over 94 per cent for a first child and 95 per cent for a second child for parents with a household income of 23,000 euro or less per year, and 33 per cent of childcare costs for a first child and 84 per cent for a second child for parents with a household income of 100,000 euro per year. In 2014, these percentages were about 10 percentage points lower. In 2012 however, they were about 40 percentage points lower, meaning that parents with a household income of 100,000 euro per year did not receive subsidy for a first child.

14 In 2012, when most of the Dutch interviews for this thesis were performed, subsidies had just been declined and refunds were about 40 percentage points lower compared to the current subsidies (Rijksoverheid 2017d).

15 This quality decrease has been related to the expansion of childcare rather than to the childcare reforms in 2005 (Akgunduz and Plantenga 2014)
effects on children has been of increasing interest to Dutch policy makers. Early education initiatives have been established to provide more equal chances for children from disadvantaged and non-Dutch speaking families. To avoid segregation, these day care programs and playgroups have in 2016 been integrated with other day care facilities (SER 2016). Concerns about childcare quality, continuity in staff, staff-to-child ratio in baby groups and possibilities for parents to assess the quality of a childcare facility have been addressed within new regulations. In a letter to the Dutch parliament, the Minister of Social Affairs and Employment presented his proposals for innovations in childcare as:

“Good childcare is accessible to parents, promotes employment and offers children a familiar and safe environment where they can develop […] Together with involved parties, I want to give a strong impulse to the Dutch childcare sector, both in terms of access and in terms of quality. […] The main premise is that there should be more specific attention for children’s development” (Minister of Social Affairs and Employment 2016).

The trend in the past decade reflects that risk representations in CHC and family policies have moved in the direction of intensifying concerns about children’s developments as an ‘object at risk’, and defamilialising strategies to protect and monitor children through state-related interventions.

Incentives to share and negotiate responsibilities in caregiving
As in Dutch OC and CHC policies, the strategies facilitated through family policies to address employment risks and child development risks can be characterized by collaboration and negotiation, in which a high level of individual responsibility is ascribed to parents. Within Dutch family policies, this is reflected in terms of parents deciding and negotiating how many hours to work and how to arrange and divide working and caring tasks between parents and other parties, with comparatively little state instruments that prescribe or inform ‘dual caring’ practices (See also Lewis et al. 2008; Veltkamp and Grunow 2012).

Accordingly, professional day care is in the Dutch context since the 1980s increasingly perceived as a necessity, but only for a limited number of hours per week (Singer 1996;
Veltkamp and Grunow 2012). This has been related to a historical cultural distrust of professional childcare (Kremer 2010) and to the fact that childcare is primarily seen as the responsibility of parents (Knijn and Smit 2009; Verweij and Reimann 2016). In Dutch family policies, ‘responsibility’ is in this sense not focused on exclusiveness and protection within the parent-child relationship, but it allows for a sharing and distribution of care. Accordingly, it has been found that Dutch parents often compose ‘care packages’ in which childcare is from an early stage distributed between mothers, fathers, day care facilities and informal caregivers (such as grandparents) over the week (Knijn 2004; Verweij and Reimann 2016), reflecting encouragements in family policies to share childcare responsibilities collaboratively.

4.2.2 The protective German model: pathology, vulnerability and parental autonomy versus investment in the public arena

4.2.2.1 Risk in German obstetric care

Pregnancy and childbirth as risk objects

Different than in the Netherlands, Germany has a uniform organization of health services for pregnant women characterized by one dominant system in which the obstetrician is the main care provider (Hemminki and Blondel 2001). Pregnancy and giving birth has been approached as ‘pathology’ since the 19th century (Scheuermann 1995) and accordingly, German OC is focused on avoiding and addressing risks for pregnant women and (unborn) children. The German OC system can thus be characterized as one of “de-familialisation”, which emphasises the formalisation and delegation of care tasks to the state (Leitner 2003; Christiaens 2008). This is accompanied by a high degree of medical interventions, such as caesarean sections (OECD 2011; Zinsser 2016). Moreover, according to the WHO, only 8 per cent of 925 German hospitals are certified as ‘baby-friendly’ hospitals16 in the sense of hospitals having adopted regulations about direct physical contact between mothers and babies directly after birth, as opposed to prioritizing medical procedures (Bosi et al. 2016).

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16 This does not mean however that none of the ‘baby-friendly’ criteria were met; the biggest reported obstacles in 2012 were ‘exclusive breastfeeding’ (step 6) and ‘no use of artificial teats or pacifiers’ (step 9) (Australian Government Department of Health 2012).
### Table 4.2 German policies: constructions of risk and responsibility in pregnancy, childbirth and early childcare

<table>
<thead>
<tr>
<th>A. Risk object</th>
<th>B. Object at risk</th>
<th>C. Relationship A and B</th>
<th>D. Responsibility</th>
<th>E. Strategy</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2. Psychosocial changes for mothers</td>
<td>2. Changes → instability mother and child</td>
<td>2. Midwives</td>
<td>2. One-on-one medical and social care</td>
</tr>
<tr>
<td></td>
<td>3. ‘Vulnerable families’</td>
<td></td>
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<tr>
<td>CHC</td>
<td>1. Pathology</td>
<td>1. Pathology → medical complications</td>
<td>Paediatricians</td>
<td>1. One-on-one medical care</td>
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<td></td>
<td>2. Society</td>
<td></td>
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<tr>
<td>FP</td>
<td>1. Parents’ (un) employment</td>
<td>1. Dual employment → deficiency of parental care</td>
<td>State</td>
<td>1. One-on-one parental care: paid parental leave; child allowances</td>
</tr>
<tr>
<td></td>
<td>2. Low birth rate</td>
<td>2. Mothers’ dropping out → less gender equality, employment, independence</td>
<td></td>
<td>2. Investment in childcare</td>
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<tr>
<td></td>
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<td>3. Low parental/day care quality → social inequality and negative developmental outcomes</td>
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<td>3. Part-time work</td>
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Source: own depiction, based on the relational theory of risk developed by Boholm and Corvellec (2011)

**Dominant and parallel OC strategies to address risks for children and mothers**

The medical approach to pregnancy and childbirth within the dominant German OC policies reflects that pregnancy and childbirth is framed as a ‘risk object’ in itself, with an inherent potential risk to pathologies for child and mother as the ‘object at risk’ (see table 4.2). Accordingly, obstetricians have been the main care providers during pregnancy and childbirth within German OC over the past centuries and most
Midwives are trained and employed in hospitals (Stone 2012; Zinsser 2016; Scheuermann 1995).

Midwives working outside of the hospital in independent practices are allowed to address “all aspects of uncomplicated pregnancy, delivery and postpartum care for mother and new-born” (Scheuermann 1995, p.443). However, midwives are depending on obstetricians for ultrasounds and inter-disciplinary collaborations have traditionally been difficult. The national Midwifery Association (Deutscher Hebammenverband) reports on the website:

“According to the current maternity guidelines, all screening examinations during pregnancy can also be carried out by a midwife. The only exception is the ultrasound. For this purpose, the pregnant woman has to visit an obstetric practice. […] This development is problematic to many obstetricians. Cases have even been reported where doctors refused to share the pregnant women with midwives, because that also means a shared budget. […] According to the law, the pregnant woman herself can choose whether she wants to be prepared by a midwife or by a doctor. […] The reality, however, is often different because many pregnant women are not properly informed about this choice” (Deutscher Hebammenverband 2017a).

While it has been claimed that Germany has one of the oldest and strongest midwifery traditions in Europe (Scheuermann 1995), pregnant German women often receive care from an obstetrician and if they choose to, from a midwife in addition (Scheuermann 1995), resembling a weak institutionalization and/or recognition of midwifery. The latter is reflected in the high insurance costs that independent German midwives need to pay, especially when they want to supervise deliveries (Kötter and Maßing 2016). Midwifery practices outside of the hospital are thus mainly performed parallel to the dominant OC system. Expecting parents are able to opt for giving birth in a ‘birth house’, led by midwives, which provides a more women-centred environment and a focus on ‘natural birth’ (Main 2015). This is however not common practice: in 2012, only 1,5 per cent of childbirths in Germany were located outside of the hospital (Loytved 2012; Main 2015).
German midwives do have the leading role in birth preparation courses, counselling and postpartum care (Scheuermann 1995; Hebammenverband 2017b). In 2013, German women stayed on average 3 days in the hospital after childbirth to receive postpartum care from midwives working at maternity wards in the hospital (OECD 2014a). Once at home, women are entitled to postpartum care from midwives in the family home. In practice, women have the right to a daily visit of the midwife in the first ten days, and they can in addition ask their midwife for 16 consultations in the first 12 weeks. In case of questions about breastfeeding or nutrition, women can request for 8 more consultations, and further consultations can be negotiated with the general practitioner (Hebammenverband 2017b). This means that when women breastfeed or have other reasons for support, they can receive midwifery care for up to a year after birth (Thomas 2011).

Vulnerability and professional guidance
German midwives working outside of the hospital in independent practices approach pregnancy and childbirth as physiology, and not as a ‘risk object’ in itself, comparable to what has been found for the Dutch CHC system. What is similar between German midwifery policies and the dominant German OC approach is however the framing of children and mothers as vulnerable, and in that sense as ‘objects at risk’. Mothers’ vulnerability over the course of pregnancy and childbirth is in German midwifery policies assumed by a protective approach for an extensive period of time in which midwives ‘advocate for’ and ‘look after’ women.

“Today's midwives are professionals in pregnancy, birth and the time thereafter, seen as advocates of pregnant women and women giving birth. Considerate care from the beginning of pregnancy to the end of breastfeeding is a socially relevant contribution to the health of women and families: guidance from a competent midwife will strengthen the future health of the mother and child. […] Your midwife is an important contact person during your pregnancy and looks after you from the beginning of your pregnancy until the end of breastfeeding. […] The midwife will assist you during the first weeks of major physical and mental changes. She talks to you about the delivery and the first experiences with the child. […]” (Deutscher Hebammenverband 2017b)
Rather than strictly focusing on medical care, German midwives are taking an approach in which they focus on mother-child interaction, and ‘bonding’, as well as on the broader psychosocial changes and challenges.

“Apart from clarifying medical questions, the first days of life are mainly about the mother and child developing a good relationship with each other (bonding). The psychosocial aspect plays an essential role.” (Deutscher Hebammenverband 2017b)

Such an approach is in line with cultural values about gender roles in Germany which reflect a ‘mother cult’, in which the mother-child relationship is perceived as separate from the outside world (Vinken 2001). Especially in the former FRG, childhood has been perceived as a phase in which children most importantly need motherly attention (Leccardi and Ruspini 2006, cited by Thelen 2016, p.146) and in which ‘good mothering’ is understood from an ‘intensive mothering’ ideology, where mothers are expected to spend most of their time with their children, as the centre of their attention (Dechant and Rinklage 2016). Furthermore, there is an emphasis on a natural bond between mother and child and mothers knowing intuitively what a newborn child needs (Dechant and Rinklage 2016). Cultural values in Germany that concern fathers on the other hand have been predominantly focused on fathers as breadwinners, being responsible to provide the family with income. With gender egalitarian values becoming more widespread in Germany (Dechant and Rinklage 2016), cultural values depict fathers since more recently as both nurturing and breadwinning (Hofmeister and Baur 2015; Dechant and Rinklage 2016; Villa and Thiessen 2009), although a mismatch has been found between fathers’ nurturing ideals and their capabilities to put them into practice in the German context (Hofmeister and Baur 2015).

Within German OC policies, it is mothers who are consistently addressed, for instance within the information provided to parents by the German association of midwives, and a focus on mothers is also resembled in the fact that developments and examinations over the course of pregnancy, birth and the postpartum period are tracked in a document called the “mother pass” ['Mutterpass']. ‘Partners’ do come up however in the description of (a selection of) birth preparation courses particularly meant for both parents, and while postpartum care is firstly focused on mothers’
physical and emotional recovering and coping processes, the midwife “teaches parents how to care for babies” (Deutscher Hebammenverband 2009).

One-on-one relationships

The strategies to address both the medical pathology as well as the perceived social and interactional challenges following childbirth involve one-on-one professional-patient relationships, predominantly between obstetricians and mothers and between midwives and mothers, in which the professional looks after the health and well-being of mother and child. Within German parenting policies, these relationships have since more recently been perceived as also suitable to address ‘vulnerable families’, seen as a particular ‘at risk’ group. Since the past years, specifically trained ‘family midwives’ have been ascribed more extensive tasks in detecting and supporting ‘vulnerable families’ within one-on-one midwife-family relationships in order to prevent child abuse and promote equal chances and health outcomes for all children (Deutscher Hebammenverband 2017b; Ayerle et al. 2012; Bermaoui et al. 2012). This approach to vulnerability is different, and more private, than the risk selection and information exchange approach in Dutch CHC, and to a lesser extent OC, policies.\textsuperscript{17}

4.2.2.2 Risk in German child healthcare

CHC arranged in doctor’s offices

Before 1970, CHC services in Germany were provided by the public sector. This has gradually changed and these preventive services are now paid for by mandatory benefits of sickness funds, sponsored through employer-linked taxes. The uniformity of standards and financing is organized by a national regulation of resources (Kuo et al. 2006) and the Federal Ministry of Health is the overarching authority in Germany that regulates and monitors healthcare (Ehrich et al. 2016). Responsibility is shared between national government, counties and municipalities (Wieske et al. 2012). Health care provision, which also includes preventive measures, is organized under the responsibility of the 16 State Ministries of Health, while public health service centres (‘Gesundheitsamt) take care of local public health matters (Ehrich et al. 2016).

\textsuperscript{17} Although it is more similar to a module called ‘Stevig Ouderschap’ within Dutch CHC, in which specialized CHC nurses provide families ‘at risk’ with more extensive and personal care in the home situation, in addition to CHC services (NJI 2017).
Regular child examinations for children up to age 18 take place in doctor’s offices and are performed by primary care providers (Gortner et al. 2012). Paediatricians – whose training places particular emphasis upon infant care, preventive care and being child-friendly – see 90 per cent of the children under age 6 and general practitioners see the other 10 per cent. Most primary care paediatricians work full-time in private practices and they usually care for 60-90 children per day, offering treatment as well as preventive examinations. Different than in Dutch CHC, German children do therefore not visit a general practitioner in addition. Paediatricians mainly work alone and are supported by nurses or medical assistants. The waiting time for appointments is very short and if clinically indicated, access to the paediatric office can usually be arranged on the same day. The coordination of CHC in private paediatrician practices is organized by an association of Social Health Insurance for physicians (‘Kassenärztliche Vereinigung’); all physicians are represented in a federal physician’s chamber (Bundesärztekammer) that holds annual meetings about physician’s duties (‘Deutscher Ärztetag’) (Ehrich et al. 2016).

Pathology and parenting posing threats to child health and child development

There are in total nine preventive child examinations scheduled (‘Untersuchungen’) in German CHC for children aged 0-4. Midwives carry out the first two examinations within two weeks after birth and the first examination by the paediatrician (‘U3’) is scheduled at the paediatrician’s office, four to five weeks after birth. CHC examinations have until recently been focused on medical risks, motor and physical development and disorders, as ‘risk objects’, and on child health and child development as the ‘objects at risk’. Parental satisfaction with the child's development was taken into account within each examination, while children’s cognitive and emotional disorders were in general considered among a range of possible disorders (G-BA 2010: Kinder-Richtlinie 2010). A more medical approach to risk in German CHC in comparison to Dutch CHC is shown by the technical devises used – the first examination with a paediatrician in Germany four weeks after birth includes a head scan of the baby – and by the amount of diseases a child (aged 0-4) is immunized against (13 in German CHC compared to 11 in Dutch CHC and 15 in Polish CHC) (ECDC 2017).
More recently, standardized items in German CHC examinations have also come to include:

“Capacity and burden in the family; children’s social-emotional and cognitive competence; communication; affect and interaction with the primary caregiver” (G-BA 2016: Kinder-Richtlinie 2016, p.12).

In line with developments in Dutch CHC, we can thus see that risk representations in German CHC have become more encompassing in their scope by structurally considering psychosocial risks related to parents and children, as well as children’s interactions with their parents. This “turn to parenting” has also been detected by Bermaoui and colleagues (2012, p.1): “the Ministry of Family, Seniors, Women and Youth has in 2005 promoted and institutionalized positive parenting programs and attempts to safeguard children by means of strengthening parents’ competence, understood as: the ability to meet the child’s needs and promote the child’s independence; being self-reflexive and displaying self-efficacy”.

The preventive focus on children and turn to parenting in German CHC has moved from a “negative standard” of protecting specific children from parental harm, to a “positive standard” of stimulating all parents to perform in line with ‘positive parenting’ norms (Bermaoui et al. 2012, p.5). Comparable to Dutch CHC policies, German CHC policies offer a comprehensive system of provision for all parents, whereas families at risk are specifically targeted in additional programs (Gortner et al. 2012). In 2011, a new law\(^{18}\) was established to enable cooperation between paediatricians, Youth Care and day care centres in order to facilitate the prevention of child abuse and the stimulation of positive parenting (Bermaoui et al. 2012). Moreover, regular CHC examinations are nowadays mandatory in most federal states (Gortner et al. 2012).

\(^{18}\) This law also introduced the implementation of ‘family midwives’ for ‘vulnerable families’ (see page 103) (Bermaoui et al. 2012).
In an introduction to the German CHC system written by prominent German paediatricians, a contextualized approach to individual risk factors comes to the fore in which new challenges to German CHC are framed as:

“ [...] Controversies about children’s rights to health; protection of children; climate change; the ‘postmodern environment’, including ‘healthy environments’ in which there is an adequate relation with nature, history, social relations, sense and identity, and ‘unhealthy environments’ where such relations are lacking and environments generate violence and loneliness; exposure to unhealthy life styles such as bad eating habits; lack of physical activity; digital media; the overwhelming offer of material things; the constant shortage of time and parents packing time full with activities; much higher sensitivity of parents, teachers and physicians for psychiatric diseases; constant competition; technology and consumerisms being attractive to children and serving as a substitute for ethical thinking and acting; the German society being unable to tackle these challenges; risky life styles that influence behaviour and health; integration of migrant children and being sensitive to individual, national and multicultural ways of thinking; and other vulnerable children such as those living below the poverty level” (Ehrich et al. 2016, p.75-76).

Hence, whereas risk categories were in Dutch CHC documents communicated by referring to scientific evidence without further reflections on how these risks could be understood, this document of German paediatricians in contrast relates individual risks for children and parenting to overarching societal and historical trends and developments, thereby partly shifting the risks and responsibilities away from individual parents and individual interventions.

Private doctor-patient and caregiving relationships
What is furthermore particular to German CHC policy is that strategies to address risks are institutionalized within and focus on one-on-one professional-patient relationships. The German paediatrician, usually providing healthcare until children’s adolescence, can be characterized as a family doctor, representing more privacy and exclusiveness in a relationship in which one doctor is involved in a child and family’s life for a long period of time. These doctor-patient relationships resemble a high level
of parental autonomy, because parents choose their own independent CHC paediatrician or general practitioner, and parents therefore initiate contact with CHC. The relationship between a child and a primary care provider is thus only institutionalized to a limited degree in German CHC policies (Kuo et al. 2006). Moreover, German paediatricians working in independent CHC practices have more autonomy in relation to government programs. This enables more heterogeneity between paediatricians, in contrast to paediatricians working in the Dutch CHC system who are part of a larger governmental organization. Paediatricians in German CHC on the other hand are working alone; they do not structurally address ‘risk groups’ for all children, and children’s development is documented in a medical passport that is kept by parents (Ehrich et al. 2016) and thus more private than the Dutch Electronic Child Files. This means that even though intensifying risk concerns in relation to parenting and children’s development can be detected in German CHC, which makes professional intervention potentially more likely, parents are at the same time granted a relatively high level of privacy and autonomy within German CHC institutions and relationships.

In contrast to what we have seen in Dutch and German OC policies, ‘parents’ are in German CHC policies (as in Dutch CHC policies) addressed in gender-neutral terms. However, the German guideline for CHC examinations instructs professionals to assess how the child interacts with the “primary caregiver” (G-BA 2016). This can be seen as gendered and gendering, because this would in most cases assume – when taking German cultural values and gendered practices into account – that responsibility is ascribed to the mother. It also shows a privileging of ‘primary’ caregiving, and thus the more intimate and private, caregiving relationships above other caregiving relationships.

4.2.2.3 Risk in German family policies

*Protection of mother and child*

A protective focus in which mothers and children are constructed as vulnerable and in need of protection can also be detected in German maternity leave policies, while both employment and the lack of employment are framed as ‘risk objects’. Mothers
are granted 14 weeks of fully paid maternity leave (‘Mutterschutz’, literally translated as ‘maternity protection’) which:

“Has the task of protecting the mother and her child from hazards, excessive demands and health damage in the workplace, financial losses and loss of the job during pregnancy and some time after birth” (BMFSFJ 2015).19

Although the maternity leave period is shorter in Germany than in the Netherlands (16 weeks) and Poland (20 weeks), the protective approach is emphasized by pregnant women legally not being allowed to work from 6 weeks before birth until 8 weeks after birth. Furthermore, maternity leave is paid through health insurances (BMFSFJ 2017a), highlighting the medical approach to pregnancy and birth, whereas unemployment benefits are for instance paid through social securities (Bundesagentur für Arbeit 2017). Moreover, there is no equivalent leave for fathers specific to the event of childbirth.

**Investment in children and gender equality**

It has been argued that ‘investment in children’ is the leading principle of family and child policies in Germany (Hübenthal and Ifland 2011). Policy reforms in 2007 have introduced changes in parental leave, with the introduction of ‘Elterngeld’ as the most important element (Erler 2011; Bergemann and Riphahn 2011). While these policies still grant parents the option of a job-protected parental leave of three years stemming from former family policies, the financial compensation that has been introduced offers 67 per cent of the income loss for all parents20 up to 14 months in total, which includes the period of maternity leave. Parental leave is not only framed as accessible to each ‘parent’, but fathers’ exclusive entitlement to two months of parental leave is made explicit. This means that after birth, mothers as well as fathers have two months leave explicitly ascribed to them, and parental leave accessible to both of them.

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19 Mutterschutz has since 2017 been adapted, including the defined aim of Mutterschutz. The wordings of the text cited here are largely followed in the new description of Mutterschutz, but the focus is now on finding a balance between the protecting of mothers from dangers and respecting mothers’ rights in employment as a part of modern societies (BMFSFJ 2017a). This assumes a more recent shift in the framing of mothers’ roles in German family policies.

20 Previous policies offered low payment rates and income ceilings of parental leave that only made parents with lower incomes eligible to payment (Erler 2011).
“You can split the months freely among yourselves. A parent can claim at least two and a maximum of twelve months.” (BMFSFJ 2017b).

The gender equality ‘object at risk’ and motivation for the 2007 policy reforms, as a way to safeguard parents’ economic independence (Henninger et al. 2008), is thus reflected in the explicitly gender-neutral framing and set-up of German parental leave. Moreover, whereas efforts to influence the gendered use of ‘gender-neutral’ family policies has not been found within Dutch family policies, German policies have added a new form of parental leave (‘ElterngeldPlus’) since 201621, enabling parents to use the leave at the same time and in part-time22, framed as “the new generation of compatibility” ['vereinbarkat'] (BMFSFJ 2017c). The official website repeatedly mentions explicitly that this leave is meant for mothers and fathers who both work between 25 and 30 hours, and goes a step further by a section on the front page that states:

“ElterngeldPlus is particularly focused on fathers” (BMFSFJ 2017c).

The government website about parental leave furthermore makes the effort to show with statistics that the new leave policy works well in general, and in particular in relation to fathers, who have taken up more leave since 2016 (BMFSFJ 2017c), again showing that gender equality in parental leave, and thus in parents’ employment and caregiving, is a central concern within German family policies.

As in Poland, an important motivation for paid parental leave has furthermore been the low birth rate (1.33 births per woman in 2006) – as a ‘risk object’ – especially among higher educated women, and consequences of a declining population, such as a decreasing potential labour force and a weaker basis for public pension insurance (see Henninger et al. 2008). Policies offering paid parental leave therefore offer parents’ opportunities to care for their child at home in the first year after birth as a response to multiple risk objects.

21 This policy is introduced after the interviews for this study have been performed
22 In 2015, ElterngeldPlus and Partnerschaftsbonus have been introduced as a more flexible way of using Elterngeld, explicitly focussing on the father as well (BMFSFJ 2014b)
Privileging one-on-one caregiving relationships

What these leave policies furthermore express is an emphasis on the one-on-one caregiving relationship, thereby privileging strategies of parental care, which can be characterized as rather exclusive and private forms of care, in the early stages of childcare. As the Bundesministerium für Familie, Senioren, Frauen und Jugend states:

“The parental allowance ['Elterngeld'] makes it easier for mothers and fathers to temporarily or wholly or partially refrain from gainful employment and thus have more time to care for their child.” (BMFSFJ 2017b)

The cultural values reflected in this strategy can be traced back to the values that have been dominant especially in the former FRG, in which parental autonomy has been emphasized and state influence in family life has been rare (Thelen 2012). Childhood and childcare was valued and experienced as the realm of the private sphere and seen as a pre-political phase in which children mainly needed parental care and (motherly) attention (Leccardi and Ruspini 2006, cited by Thelen 2016). This has previously been institutionalized in leave polices which allowed parents, in practice mothers, to stay at home for three years after child-birth with job-protected employment interruptions (Erler 2011) and has now become more strongly focused on fathers’ inclusion in parental leave.

State interference in childcare: contradicting policies and values

Investments in the facilitation of day care for children older than age one on the other hand mainly resembles concerns about overcoming inequality through children’s ‘early education’. Children between one and three years old are granted the legal ‘right’ to day care and early education since 2013 (Müller and Wrohlich 2015). Most of the expenses for day care are subsidized (Dechant and Rinklake 2016), unconditional on parents’ income or employment status (Müller and Wrohlich 2015). In Germany, there has been a shortage of public day care facilities for children under the age of three (‘Kinderkrippe’) since decades, while opening hours are often limited to half days. Large regional and local variations in access to day care can be found (Hübenthal and Ifland 2011; Müller and Wrohlich 2015; Evertsson 2016) and childcare services in the private sector are rare (Dieckhoff et al. 2016). Furthermore,
the field of early childcare has been neglected for decades, which resulted in low levels of educational attainment, low wages, high workloads and poor standards (e.g. staff-child ratio) in day care facilities (Hübenthal and Ifland 2011).

Already since 2003, there has been commitment of the federal government to invest in the extension of public day care facilities (Evers et al. 2005; Ciccia & Bleijenbergh 2014). This has been challenging since day care is organized and provided on local levels, under the influence of local authorities, (religious) non-government organizations and volunteers, who have traditionally had a strong influence on decision-making (Evers et al. 2005). Although a shift away has been detected from the decentralized bottom-up model with a large influence of the voluntary sector – some municipalities, for example, transformed the provision of funding directly to children instead of to day care centres – the federal government’s intervention in the balance of childcare provision on the local level has also caused opposition (Evers et al. 2005). Such opposition is in line with cultural perceptions, predominantly in the former FRG and current Western part of Germany, about child raising and children’s moral education (‘Erziehung’) being the responsibility of parents, in which the state should and could not intervene (Gottschall 2004, cited by Thelen 2012).

In the former DDR on the other hand, a prominent modernist belief has stimulated education as a way to mould people, while childhood and parenting practices became more public in the post-war period until the 1980’s. After the reunification in 1989, cultural values of the former FRG came to be leading in the organization of German policies (Thelen 2012), however the ‘turn to parenting’ is said to reflect an approach that prioritizes state interventions over parental rights; centralism and homogeneity over decentralisation and heterogeneity, and collective childcare and early education over mother-child-bonding (Bermaoui et al. 2012, p.5). Both conflicting strategies are reflected in German policies, while particular underlying cultural values can still be found in the different parts of Germany. There are more day care facilities in former East Germany than in former West Germany, and the belief that a child is harmed when his or her mother works is much stronger in former West Germany compared to former East Germany (Hofmeister and Baur 2016).
Separate German family policies are believed to counteract one another in terms of their desired effect, reflecting contradictory constructions of ‘risk objects’ and ‘objects at risk’, as well as different strategies to approach these risks. The aim to achieve gender equality in the labour market and at home through paid parental leave and public day care investment are for instance said to be counteracted by labour market arrangements and high childcare allowances (Wrohlich and Müller 2015). The German labour market provides high employment protection, high collective bargaining coverage and a tax system that favours an unequally distributed income between spouses with one higher and one lower income (Evertsson 2016). Part-time work, often for less than 24 hours per week (Allaart and Bellmann 2007), has been perceived as having relatively few disadvantages in the German context 23 (Dieckhoff et al. 2016), which combined with the tax system supports mothers to opt for small jobs.

Since 2013, parents who do not use subsidized childcare can also receive financial compensation (‘Betreuungsgeld’) for children under age three, a policy designed to promote equality between those parents who choose to return to employment and those parents who choose to stay at home for a longer period (Müller and Wrohlich 2015). German family policies thus show a relatively high number of risks objects and objects at risk addressed in a mixture of policies that move in different directions. 24 Among these directions, a protective approach to children’s needs contradicts with a public investment approach designed to enhance gender and social equality. While parental leave serves as a means to combine protective parental care with gender equality, the contradiction in policies emerges especially after parental leave.

23 When compared to the Netherlands however, part-time jobs are less widespread, manufacturing accounts for a larger part of total employment and there is a lower share of part-time jobs of at least 24 hours. Moreover, there is more reluctance among employers to meet workers (part-time) preferences compared to in the Netherlands (Allaart and Bellmann 2007).

24 Within this mixture of policies, German parents have been reported to use strategies in reconciling family and work after parental leave which include the use of (additional) informal childcare, such as grandparents or home-based care (‘Tagesmütter’); (Polish) migrant women filling the gap of the employed mother (Lutz and Palenga-Möllenbeck 2011), and mothers adapting their employment around the availability of childcare services and half-day schools (Pfau-Effinger 1998; Spiess et al. 2003).
4.2.3 The Polish reform model: rethinking state interventions and embedding women’s autonomy, fathers’ roles and familial responsibilities

4.2.3.1 Risk in Polish obstetric care

Hospital-based OC with pregnancy and childbirth as risk objects

As in Germany, the OC system in Poland takes a medical approach to birth (Pendleton 2015), with pregnancy and giving birth located in hospitals under medical supervision of obstetricians. During pregnancy and childbirth, pregnant women are almost exclusively seen by their obstetrician (Bayley 2007; Bray et al. 2010) in one-on-one professional-patient relationships. Accordingly, midwifery-led care has been perceived as ‘sub-standard’ by Polish women who migrated to other countries (Pendleton 2015). The OC system in Poland defines pregnancy and childbirth in medical terms, in which ‘hazards’ for pregnant women and children – as ‘objects at risk’ – are perceived as inherently related to pregnancy and childbirth – as ‘risk objects’ (see table 4.3, page 114). Polish OC can be framed as a model in which “de-familialisation” is central, with an emphasis on the formalisation and delegation of these healthcare tasks to the state (Leitner 2003; Christiaens 2008). In the past decade, 95 per cent of children in Poland have been born in maternity wards of public healthcare facilities (Kowaleska et al. 2014). Close to no births at home have been reported, while medical interventions are performed relatively frequently (Zeitlin et al. 2010), resulting into comparatively high caesarean rates of 36 per 100 births in 2014 (OECD 2015). Moreover, Polish women stay relatively long in the hospital after birth: on average 3.9 days in 2012 after a spontaneous birth, compared to an average of 3 days for German and 1.9 days for Dutch women in that year (OECD 2014a).

A shift in risk objects and risk subjects: changing OC standards

The Polish healthcare system was developed partly under the influence of the socialist regime (1945-1989) (Mokrzycka et al. 2016). After the regime transformation since 1989, healthcare reforms resulted into the emergence of a private healthcare sector, reorganizations that reduced personnel costs, and a shortage of midwives. Scholars have argued that because of the routinizing of obstetric activities and the ‘desacralization’ of childbirth within this process, the purely biomedical obstetric risk approach lost its impact, enabling the acceptation of natural childbirth as ‘safe’ as well. Moreover, the regime transformation created space for Western European values
and standards of individualization and equality to enter the OC system, as was promoted by social movements and non-government organizations in Poland in the 1990s (Gajewska and Pawliszak 2013).

Table 4.3 Polish policies: constructions of risk and responsibility in pregnancy, childbirth and early childcare

<table>
<thead>
<tr>
<th></th>
<th>A. Risk object</th>
<th>B. Object at risk</th>
<th>C. Relationship A and B</th>
<th>D. Responsibility</th>
<th>E. Strategy</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CHC</strong></td>
<td>Early childhood 1. Diseases 2. Disorders 3. Parenting</td>
<td>Child development</td>
<td>Early childhood problems (\rightarrow) disruptions in child development</td>
<td>1. Paediatricians 2. Parents</td>
<td>One-on-one professional-family trust relationships</td>
</tr>
</tbody>
</table>

Source: own depiction, based on the relational theory of risk developed by Boholm and Corvellec (2011)

Particularly effective were public campaigns that revealed ‘humiliating’ stories of hospitalized pregnant women who were treated as medical objects, with practices of clothes being taken away, routinized shaving of women’s pubic hair, and women being separated from their new-born baby (Offnatowska 2009, p.36-39, cited by
As a result, social movements and non-governmental organizations in Poland have been successful in changing OC standards and related risk perceptions, within the OC system, in line with WHO standards (Gajewska and Pawliszak 2013; WHO 2015). The WHO reports:

“In 2011, as a result of the “Childbirth with Dignity” campaign and many years of advocacy, the Polish Ministry of Health issued the first national Perinatal and Postnatal Care Standards, in line with WHO guidelines. The standards outline a woman’s right to choose the place and method of birth, to decide who is in the delivery room, and to be with her new-born at least 2 hours after the birth, among others” (WHO 2015).

Within Polish OC policies over the past years, a purely biomedical focus perceived as approaching women as ‘medical objects’ has become a ‘risk object’ itself, while women’s rights to influence decision-making and to be with their child have become ‘objects at risk’. The developed strategy resembles the incorporation of these new risks within the hospital-based OC system, and in that sense a change within this system. Social movements and non-governmental organizations have thus succeeded in challenging the medical perception of risk in pregnancy and childbirth by altering the public image of women as ‘passive bodies’, which is now framed as humiliating. Hospitals, physicians and midwives were on the one hand pressured to change their relationships with pregnant women, allowing them more equality and influence, and on the other hand to promote alternative practices such as natural birth and baby-friendly hospital environments to support breastfeeding and attachment (Gajewska and Pawliszak 2013).

Expansion of strategies and responsibilities
Accordingly, the new standards granted more responsibilities to midwives rather than only to obstetricians within hospital practices (Belowska et al. 2014). In addition, childbirth schools have been opened, run by midwives and obstetricians, in order to facilitate new forms of knowledge and different approaches to educate pregnant
women and their partners (Gajewska and Pawliszak 2013). A policy document describing standards and competences of Polish midwives, established by two teachers in OC at the Lublin University, one of them being the head of the National Association of Midwives in Poland, states that:

“The midwife in Poland has a professional responsibility in working together with women, providing them with the necessary support, care and information during pregnancy, childbirth and postpartum, with their own responsibility in childbirth and in providing care for the new-born infant” (Krysa and Iwanovich-Palus 2008, p.25).

In line with the reforms in Polish OC, this reflects a sharing of responsibilities within collaborative relationships between Polish midwives – being the professionals – and mothers. In the standards for Polish midwifery care a more explicit focus on the wider family context and community can be detected when compared to the standards for Dutch and German midwifery care.

“Midwifery care, as a basic healthcare service, is aimed at the whole family. This kind of educating the family is not only necessary in the hospital, but also in the home environment. […] The midwife has an important task as a counsellor and educator, not only for women, but also the family and society. This should include advice about preparing for parenthood” (Ivanowicz-Palus et al. 2013).

As an important aspect of ‘modern obstetrics’, the Polish OC system no longer just facilitates deliveries with only the mother present, but also ‘family labour’: deliveries in which a family member, such as the father, is present (Wielgos et al. 2007; see also Kaźmierczak et al. 2005). In post-partum care, this results into a mixture of some tasks being ascribed to ‘parents’ whereas in other occasions tasks are exclusively ascribed to mothers.

25 In line with these developments, some have referred to natural birth as the new desired Polish standard for perinatal care (Szumilewicz et al. 2013). The WHO reports that in 2012, 20 per cent of 450 hospitals with maternity wards in Poland were certified as ‘baby-friendly’ (Bosi et al. 2016).
“Knowledge of postnatal care includes aspects such as: nutritional needs of the child, the parent-child relationship and ways to promote positive relations between them […] education of parents about the symptoms of life-threatening dangers and child health […] education of parents about child development and childcare and about obtaining social support when necessary […] education of the mother in caring for her own health and the health of the child, including nutrition […] knowledge about adapting to life with a new-born, meeting basic physiological needs such as respiration, nutrition and mother-child bond” (Krysa and Ivanovich-Palus 2008, p.34-36).

As we have also seen in Dutch and German midwifery documents, mothers’ care is privileged in emphasizing a ‘mother-child bond’. The latter sentence reflects that this bond is in Polish midwifery care considered as a ‘basic physiological need’ of children. When compared to strategies in German OC policies, Polish OC policies reveal a stronger investment in mothers’ influence on decision-making and in family relationships, as well as in interdisciplinary collaborations among midwives and obstetricians. When compared to strategies in Dutch OC policies however, Polish OC policies reflect a stronger focus on one-on-one relationships, and a sharing of responsibilities within these closer relationships, in a medical system in which educating parents and expert knowledge is emphasised.

4.2.3.2 Risk in Polish child healthcare

The implementation of Polish CHC: specialized doctors’ offices
Following several occupations in Polish history, Poland inherited a primary healthcare system centred on treatment rather than prevention, which Polish scholars qualified as ‘poorly arranged’. After the collapse of the socialist regime, investments were made to improve the role and the quality of primary healthcare (Mokrzycka et al. 2016). The introduction of family medicine as a specialisation within the Polish healthcare system is relatively new: it was established in the 1990s. Up until that point, internists, paediatricians, physicians with other specialisations or without any vocational training performed primary healthcare (Windak & Palka 2015). In tandem with social movements and non-government organizations that advocated for attention to individual rights and family relationships in OC (Gajewska and Pawliszak
2013), a focus on children and families also emerged within Polish primary healthcare.

Pioneering paediatricians went to European countries to learn more about education, research and healthcare practices in family medicine. In 1995, the first independent and publicly financed CHC practice was founded in the southwest of Poland, and thousands of CHC practices followed in the subsequent years, having currently reached high academic standards. The implementation of CHC in Poland was facilitated by the Polish government and local authorities, and after the unification with the EU in 2004 by EU funding and a loan from the World Bank (Windak and Palka 2015). CHC in Poland is performed by general practitioners and (specialized) paediatricians and nurses, mostly in public and private CHC practices. Nurses provide preventive health visits at home, health education and screening tests. Paediatricians are the main care providers, offering preventive and curative medical advices, preventive health services and health assessments, immunizations, diagnostic tests and referrals (Mokrzycka et al. 2016).

*Early childhood risk objects threatening child development*

The Ministry of Public Health has determined the content of preventive examinations and paediatricians’ tasks in Polish CHC. Ten preventive examinations are scheduled in children’s first four years. The aims are:

“Monitoring whether the child develops properly in this extremely crucial period of its life, and preventing disease, which can disrupt children’s development; systematic collection of the child’s history and conducting a medical examination, which allows for early detection of initially subtle symptoms of developmental disorders and diseases of the child and for a quick start of treatment in order to have minimal negative impact on the development of the child; vaccinations, which are the most effective way to prevent illnesses and severe infectious diseases; principles of feeding the baby, and proper diet of the nursing mother; the principles of caring and playing with the child, to ensure a harmonious and proper mental and physical development – it is very important that good relationships are built between parents and children, and between siblings, and the paediatrician can play a large role in this respect.” (Pediatria 2016a)
These aims show that ‘children’s development’ is constructed as the ‘object at risk’. The ‘risk objects’ are related to the perception of early childhood as an ‘extremely crucial period’, which resonates with current debates within biomedical, behavioural and pedagogic sciences (see da Cunha et al. 2015). More specifically, risk objects are defined as diseases, disorders and the quality of care in parent-child relationships. When we look at the topics defined to be structurally assessed in the examinations, only the medical and physical ‘risk objects’ are addressed, while this includes food and parents’ roles in feeding:

Assessing children’s medical history; growth; physical and motor development; sleeping; food, (parental) overweight; breastfeeding; food and life style advice (such as to quit smoking); speech; immunizations. (Pediatrics 2016a; Pediatrics 2016b, p.4-6)

When compared to Dutch and German CHC policies, a relatively strong medical focus is displayed within Polish CHC policies: immunization is provided against the largest amount of diseases (15, compared to 13 in German CHC and 11 in Dutch CHC) (ECDC 2017) through a compulsory immunization program (Haverkate et al. 2012)26, and relatively strong statements are used to express concerns about children’s physical development and health, and accordingly about parents’ responsibility to promote and ensure children’s health adequately. Although the aim to promote caring relationships between parents and children has not been translated into explicit items of examination in Polish CHC, concepts of ‘developmental support’, ‘positive parenting’ and ‘sensitivity’ in relation to disciplining children have been claimed to be increasingly popular in Polish child health services (Wójtocicz-Dacka and Miotk-Mrowzowska 2016).

The Nobody’s Children Foundation has advocated for prevention of child abuse in Poland, by organizing conferences about the prevention of abuse of young children. Healthcare professionals are seen as holding the relevant position for facilitating the prevention of child abuse (Prevention of Young Child Abuse 2011), but different than

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26 In June 2017, protests have been organized against the mandatory approach to vaccinations in Poland (see Stop Nop 2017)
in Dutch and German CHC policies, no signs of systematic implementation of risk strategies or instruments designed to signal and address psychosocial risks have been found within the Polish CHC policy documents used for this study. This suggests that the institutionalization of parenting as a ‘risk object’ in Polish CHC policies is less formal and pronounced when compared to Dutch and German CHC.

Addressing risks in doctor-patient trust relationships, especially with mothers

The strategy to address risks related to early childhood in order to prevent ‘disruptions’ in children’s development concerns a one-on-one professional-patient relationship, similar to the strategy employed in German CHC. Polish parents choose their own primary care provider within CHC, which is usually a paediatrician working in an independent practice who becomes a family doctor for a long period of time, until a child’s adulthood (Mokrzycka et al. 2016; Windak and Palka 2015). Within these relationships parents’ autonomy and levels of ‘trust’ and exclusivity are emphasized. This comes to the fore in national information about Polish CHC services provided to parents:

“Before the baby is born, choose a doctor who will provide medical care in a way you feel comfortable with. The basic paediatric care is provided by a GP, paediatrician or family doctor. When choosing a doctor, do not only look at his competence, but also at his attention and capacity to connect with the parents and the child. Intend to keep the child under the care of a doctor you trust, and who knows your child” (Pediatria 2016a).

The particular emphasis in Polish CHC on family autonomy, trust and attention to the individual child is in line with cultural perceptions and values about the (changed) relationship between the family and the state in Poland, as well as about the centrality of the family, strengthened throughout several occupations over the course of Polish history (Titkow and Duch 2004).\footnote{The family has since long been an important institution in Poland and while having developed weak civil institutions throughout history, the family is framed as central in transmitting values and skills belonging to Polish national identity (Titkow and Duch 2004). It has therefore been perceived as the first and foremost base of security and protection. Under the socialist regime, communist ideology co-existed with values promoted by the Catholic Church and its cultural tradition – symbolically strongly connected to family ideology – while the communist ideology did not manage to eliminate traditional family values and gender roles in Poland (Ryndyk and Johannessen 2015). As part of the socialist legacy, negative public}
opinions have been shaped towards the state dominating caring relationships (Gajewska and Pawliszak 2013), while Western European values of individualization have been integrated in family life (Wejnert and Djumabaeva 2005), and it has been advocated that children need someone to ‘really be with’ them (Keryk 2010). Others have pointed to a stronger sense of institutionalized ‘distrust’ in relation to government and parenting institutions (Löfmarck 2014).

In the framing of professional-family relationships, gender-neutral definitions are used to approach ‘parents’. The Polish guide for CHC states however that “the doctor wants to talk with you about how you deal with breastfeeding” (Pediatrica 2016b), thereby implicitly speaking to the mother. This focus on mothers, stronger than in Dutch and German CHC information provided to parents, can be understood from cultural values detected in Poland about the ‘Matka Polka’ (‘Polish mother’), an image about domestic matriarchy and capable mothers (Hardt et al. 2011), which has been linked to a cultural-historical glorification of women’s self-sacrifice for their family (Wejnert and Djumabaeva 2004, p.150; see also Reimann 2016). Because the image of the ‘Matka Polka’ is said to be “deeply embedded in Polish society” (Wejnert and Djumabaeva 2004, p.150), a gendered focus on mothers within the Polish CHC context can be intertwined with these particular notions of motherhood. At the same rime, similar to the approach to parents found in Dutch and German CHC documents, the framing of ‘parents’ in the Polish CHC information used for this study remained relatively open and left space for parents to negotiate how they would fit in the ‘parent’ category.

4.2.3.3 Risk in Polish family policies

*Parental leave facilitating family roles, child development and labour market risks*

A facilitation of families’ central roles in caregiving has since 2013 been translated into an extension of parental leave within Polish family policies. Maternity and paternity leave is generous with 20 weeks of fully paid maternity leave and 2 weeks of fully paid paternity leave28 (compared to 16 weeks maternity leave and 2 days

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28 The parental leave reforms in 2015 offered 26 weeks maternity leave, of which 6 weeks could be transferred to fathers and another six weeks were optional and could be used by both parents. These optional 6 weeks have in the latest reforms since 2016 been added to parental leave to improve the clarity of the leave policies for parents (Topińska 2015)
paternity leave in the Netherlands, and 14 weeks maternity leave and 0 days paternity leave in Germany. Paid parental leave is also extensive with 32 weeks, on top of maternity leave and paternity leave. Parental leave has been doubled since 2013, and it has come to include fathers’ entitlement to the leave (Rybińska and Szoltysek 2014).

The renewed Polish leave policies have a complex structure which have integrated parental choice and decision-making, while policies have been adapted several times over the past years to improve levels of flexibility. Since the latest revisions from 2016, leave can be taken up in blocks, in part-time and it can be easily exchanged between parents (Topińska 2015). For instance, 14 weeks of the 20 weeks maternity leave can be taken up exclusively by mothers, while 6 weeks of maternity leave can be transferred to fathers. The level of payment also depends on parents’ choice: parents can take up maternity/paternity leave with a 100 per cent payment of their income plus parental leave with a 60 per cent payment, or mothers can take up the total of the leave (apart from two weeks paternity leave) with an 80 per cent payment.

Hence, we can see that creating suitable leave policies has been a rather intense concern for the Polish government. ‘Risk objects’ underlying this concern are related to mothers’ difficulties in balancing working and caring tasks within a full-time dual-worker economy, and low birth rates. ‘Objects at risk’ are on the other hand constructed as mothers’ labour market participation, children’s perceived needs and gender equality in mothers’ employment and fathers’ involvement in care (Topińska 2015; Wejnert and Djumabaeva 2005).

As in Germany, the emphasis on parental care reflects a mode of caring that privileges one-on-one caring relationships. Although this also suggests a relatively protective approach towards children when compared to Dutch family policies, less emphasis on protecting mothers against ‘hazards’ has been detected within Polish family policies. Maternity and paternity allowances are in Poland for instance paid through social insurance, and not through health insurances (European Commission 2013), thereby

29 Although German fathers are exclusively entitled to two months parental leave with a 67 per cent compensation of their income loss (Erler 2011)
moving away from a depiction of pregnancy and childbirth as pathology in family leave policies.

Contradicting values about gender equality and traditional family forms

As reflected in German family policies, Polish family policies include efforts to encourage fathers explicitly to take up leave. The governmental website illustrates the different leave entitlements with pictures: a woman holding a baby in relation to basic maternity leave; a man driving a car with a baby in the backseat in relation to paternity leave; a woman handing over a baby to a man in relation to additional maternity leave and a man and a woman walking behind a stroller with a baby in relation to parental leave (Ministerstwo Pracy i Polityki Społecznej 2017). It has been claimed that within Polish cultural values about gender roles within the family, attitudes are thus shifting, with a renewed acceptance of dual earning practices (Ryndyk and Johannessen 2015). The European Union has furthermore pressured Poland to develop family-friendly policies to support women’s access to the labour market (Keryk 2010).

At the same time, we can see that mothers are prioritized in Polish leave policies (different than in German leave policies): first in relation to their exclusive entitlement to more weeks of leave than fathers, and second because only mothers have the possibility to take up 52 weeks of leave in total at once, with an allowance of 80 per cent of their income (Rybińska and Szoltysek 2014). This points to contradicting perceptions about risks in relation to gender roles in the family. Although it has been claimed that cultural values in Poland have moved towards Western European democratic values, with egalitarian ideals and a preference for small nuclear families, a revival of traditional cultural values about family life and parent-child relationships has also been detected (Wejnert and Djumabaeva 2005). It has for instance been shown that Polish parents prefer to stay at home with the youngest children (Plantenga and Remery 2009). Yet, fathers are on the other hand more actively involved in childcare and they are persuaded to do so by their partners and by the Catholic Church. The latter influential organization promotes and emphasizes fathers’ active involvement in caregiving and the household. Studies about low birth rates and about mothers being overburdened have furthermore contributed to the current policy focus on fathers (Wejnert and Djumabaeva 2005).
Challenges of a low birth rate and full-time labour market economy

In a policy report on behalf of the European Commission, Topińska (2015) reports:

“In recent years, maternity/paternity/parental leave schemes have been considerably developed in Poland, mainly in response to the challenge of increasing a very low fertility rate. In order to develop these schemes, the relevant provisions of the Labour Code were thoroughly revised several times.” (European Commission 2015)

The birth rate in Poland has been 1.27 births per woman in 2006 and increased to 1.30 births per woman in 2011 (compared to 1.36 births per woman in Germany and 1.76 births in the Netherlands in 2011 (OECD 2014b). In contrast to the Dutch and German labour market contexts, full-time employment is the norm in Poland and a relatively large wage gap exists in hourly wages between full-time and part-time jobs. Part-time work is concentrated in low-skilled jobs and is not widespread: part-time workers are mainly pensioners, young people who enter the labour market and people receiving welfare support. Moreover, as a post-communist welfare state, the level of government programs and investment in social well-being is lower in Poland than in most other EU countries (Mateazzi et al. 2014), such as the Netherlands and Germany. The Polish labour market in itself therefore offers employees few opportunities to combine employment with caring tasks. Polish parental leave policies can thus be seen as a strategy to address labour market risks and maintain a dual-earner norm, without compromising the central role of families in childcare, especially in the early stages after birth.

Challenges of informal and formal childcare provision

The centrality of the family in Polish work-family reconciliation strategies is furthermore reflected in childcare provision being mainly informal and home-based, with grandparents or other relatives as important caregivers (Keryk 2010). Female migrant workers and grandmothers are for instance also providing informal care for families where mothers are employed abroad (Lutz and Palenga-Möllenbeck 2011). The focus on informal and home-based care can be related to negative opinions expressed within the Polish media and in public debates about the lacking quality of day care and negative associations with day care framed as a ‘factory’ in the former
socialist regime (Keryk 2010), while childcare services have in many occasions been closed after the collapse of the socialist regime (Szelewa & Polakowski 2008). Accordingly, the Polish government has only invested to a limited degree in childcare facilities, as a half-hearted strategy to address labour market risks, child related risks, and work-family reconciliations risks. Recent policy reforms aim at less strict requirements for day care facilities, enabling new forms of childcare in which individuals can more easily provide private childcare services, which slowly leads to an increase of facilities (Rybińska and Szoltysek 2014).

Professional day care for children under the age of three years old is organized in nurseries, and day care for children aged three to five years old is organized in preschools (Keryk 2010). Most of the facilities are provided by the local government: 95 per cent of nurseries and 85 per cent of preschools, whereas the remainder of facilities is provided by private parties (Plomien 2009). Yet, the demands for nurseries and preschools are high and increasing (Keryk 2010), and available slots in day care facilities are scarce, especially for nurseries, while waiting lists are typically long (Keryk 2010; Plomien 2009).

Within the public and private sector, there are legal barriers to extend the amount of day care facilities. Childcare costs for private facilities are high and costs have in general increased with 22 per cent between 2005 and 2012 (Rybińska and Szoltysek 2014; Plomien 2009), making childcare relatively unaffordable (Keryk 2010). Accordingly, day care attendance of children under the age of three is much lower than in the Netherlands and Germany: 5 per cent of all Polish children up to three years of age attended day care in 2014 (compared to 45 per cent of all Dutch and 27 per cent of all German children in this age group) (Mills et al. 2014). Hence, the main strategies within Polish family policies to promote children’s development and work-family reconciliations concern parental leave and informal home-based childcare. Within a full-time dual-earner labour market economy, it has been argued that when Polish women cannot rely on their families or relatives for informal care after parental leave has ended, they often see few opportunities but to withdraw from the labour market (Keryk 2010; Reimann 2016), while the necessity to work is often strong at the same time (Ryndyk and Johannessen 2015).
4.2.4 Cross-national comparison of cultural risk representations within Dutch, German and Polish pre- and postnatal healthcare and family policies

4.2.4.1 Cross-national comparison of risk representations in separate policy domains

The within-country analyses of policies in OC, CHC and family policies in the Netherlands, Germany and Poland presented in this chapter show first that ‘risk objects’ and ‘objects at risk’ (Boholm and Corvellec 2011) in policies related to pregnancy, childbirth and early childcare differ between the studied countries. As institutions, they reflect and are intertwined with particular cultural ‘thought styles’ (Douglas 1986). Second, these risk representations reveal cultural coherencies on the one hand, and cultural contradictions on the other hand (Douglas 1986; Pfau-Effinger 2005) which have been found to move across the separate OC, CHC and family policy fields.

An important cross-national difference within OC policies is that pregnancy and childbirth is in the Netherlands approached as ‘physiology’ in everyday life, addressed by an interdisciplinary and collaborative system in which professionals’ adequate risk selection and mothers’ (and their partners’) decision-making are seen as salient, while pregnancy and childbirth is in Germany and Poland first and foremost framed as pathology, addressed in a hospital-approach and in one-on-one doctor-patient relationships mainly between obstetricians and mothers and between midwives and mothers (see table 4.4, page 127). The strongest emphasis on risks, vulnerability and protection has been found in the German OC system. Within Polish OC policies, reforms following the collapse of the socialist state in 1989 have changed risk perceptions in which a purely biomedical approach has come to be perceived as posing risks to women’s rights and family relationships. Hence, within new Polish OC standards, mothers’ influence on decision-making, time for family relationships directly after birth and a larger role for midwives, mothers and the wider family are institutionalized within the medical model, thereby making Polish OC an in-between case in relation to Dutch and German OC.
Table 4.4 Cultural risk constructions within pre- and postnatal healthcare and family policy institutions in the Netherlands, Germany and Poland

<table>
<thead>
<tr>
<th>The Netherlands</th>
<th>Risk objects</th>
<th>Objects at risk</th>
<th>Cultural coherency</th>
<th>Cultural contradictions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk selection</td>
<td>Child health</td>
<td>Collaboration</td>
<td></td>
<td>Limited opportunities for (full-time) parental care in the first year(s) vs Increasing emphasis on parental role and attachment in early childcare</td>
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Source: own depiction, based on the relational theory of risk developed by Boholm and Corvellec (2011)
CHC policies in all three countries have framed child development as the main ‘object at risk’ that is to be protected and enhanced. As ‘risk objects’, policies in these countries have recognized ‘parenting’ as potentially posing a threat to child development. Within the Dutch policies predefined population-based risk factors informed CHC examinations for all children; within German policies individual parenting risks were seen as intertwined with broader societal developments, and within Polish policies parenting was assessed less formally in examinations and mainly focused on medical and physical elements in caregiving. A medical focus on diseases and disorders was generally stronger in German and Polish CHC policies.

The more protective approach within German and Polish institutions was reflected in the fact that children’s needs were a more central ‘object at risk’ within German and Polish family policies, addressed through parental caregiving in one-on-one relationships by extensive paid parental leave policies within both countries. Moreover, while German and Polish family leave policies were explicitly focused on enhancing gender equality, these efforts were not made in Dutch family policies in which a stronger emphasis on individual responsibility was found. In Dutch family policies, children’s needs have been a much more recent concern and only in relation to childcare facilities, while the more pronounced labour market risks have been addressed by facilitating parents to negotiate and share caregiving responsibilities early-on through part-time work and subsidized childcare. German family policies and especially Polish family policies were on the other hand not as focused on and as successful in investing in childcare facilities compared to Dutch family policies.

4.2.4.2 Situated coherencies and contradictions in risk representations

In general, an increasing focus on ‘risk objects’ and ‘objects at risk’ was detected in all three countries and within the various policies (see also Rothstein 2006). However, I have shown that the kinds of risks represented within policies and the contradictory ways in which these risk constructions played out were context-specific. Cultural values that came to the fore in this respect revealed particular patterns and changes in ‘public-private’ divisions and negotiations (McLaughlin 2007; Mahajan 2009). Accordingly, this study confirms that the public-private distinction can be seen as a key organizing principle of social life, concerned with degrees of exclusivity and
openness and modes of social encounter (Madanipour 2003). Moreover, Madanipour (2003) argues that the family acts as an intermediate, protecting its members from the impersonal world, while boundaries between the public and the private are opened and closed within these practices (Simmel 1994). This chapter shows that these family practices are likely to be informed by context-specific constructions of risk within institutions, not least those of pre- and postnatal healthcare and family policies.

The main contradictions found in the policy document analysis within the Dutch case concerned on the one hand a low-risk, everyday life approach to pregnancy, childbirth and early childcare, and accordingly limited opportunities through family policies to enact parental caregiving roles in early childcare, while the parental role and attachment relationships have on the other hand been increasingly emphasized within OC and CHC (risk detection) policies. The latter developments therefore imply a more protective approach to parenting and child development which does not fit with the current Dutch family policies. Indeed, recent public debates show that prominent scholars in Psychology and Pedagogics have advocated for one-year parental leave and stronger parental involvement in the early years in order to facilitate parent-child attachment relationships and children’s development (see NJI 2015), whereas some political parties have suggested (and others have later on withdrawn proposals for) substantial extensions of parental leave schemes (see D66 2016).

In the German case, we can find two main risk approaches, and in fact multiple risk constructions, contradicting one another. On the one hand, the protective approach to children, mothers, and the family, as well as an emphasis on bonding and exclusive (professional and family) relationships, is particularly strong and facilitated through healthcare institutions and parental leave policies. On the other hand, a more recent public investment approach can be detected which intends to enhance gender equality and social equality through state influence on childcare facilities and early education. These contradictions play out on local levels of for instance decision-making about childcare services (see Evers et al. 2005). The German case is complicated further through family policies which offer additional allowances to ensure social and financial equality between those parents who use one arrangement (childcare) and those who use the other (caregiving at home) (see Wrohlich 2008).
In the Polish case, a full-time dual earner economy and state investment model in family life can be traced back to the socialist legacy, which still informs Polish healthcare, labour market and family policy institutions. Already under communism, these institutions functioned parallel to and have been balanced with the central role ascribed to the family, and to mothers in particular, as intertwined with the central position of the Catholic Church (Reimann 2016). Within contemporary (reformed) policies aimed at pregnancy, childbirth and early-childcare, these contradictory values – now entangled with Western European values of individualization – can still be found. On the one hand, policies reflect a public investment approach to full-time dual earning and gender equality in the labour market, while policies on the other hand emphasize a protective approach to children through prioritizing parental care, fathers’ involvement in caregiving, attachment relationships and assuming informal care within the family.

Risk representations in OC policies were in all three countries clearly intertwined with categories of gender, in framing mothers as primarily ‘at risk’ (although cross-national variation was found in ‘from what’) and as responsible to address risk (although cross-national variation was found in what constituted this responsibility). Within CHC and family policies, ‘gender-neutral’ definitions were (to varying degrees) more common in all three countries, while explicit gender equality frames were included in German and Polish family policies. However, much is still left open to interpretation about cultural risk assumptions of what involves parenting roles, and how this is gendered and intersecting with other ‘categories’ such as social class and ethnicity.

4.3 Conclusion and discussion

Through the within- and between-country analyses presented in this chapter, I have shown how pre-and postnatal healthcare and family policy institutions are context-specific, and how they differ cross-nationally. While other studies have focused on cross-national comparisons of family policies in relation to cultural family models (Pfau-Effinger 2005; Grunow and Evertsson 2016), cross-national comparisons have not yet integrated the separate policy domains of OC, CHC policies and family
policies. Moreover, the deconstruction of risk representations within these policies has been especially insightful to demonstrate how culture constitutes institutions. It is in the framing of ‘risks’ that particular future consequences are anticipated and valued more than others (Douglas 1992; Boholm and Corvellec 2011; Brown 2013), and it is in the face of these risks that particular responsibilities and strategies – enhancing protection and exclusivity or enhancing openness and multiple options (Madanipour 2003; Simmel 1994) – are deemed appropriate to address risks in a given context.

In the previous comparative section, I have discussed the variation that was found in the degree to which pregnancy, childbirth and early childcare were framed as ‘pathology’ (predominantly in German and Polish policies), and thereby as risk objects, or as ‘physiology’ (in the Netherlands) thereby reflecting lower levels of risk in itself, in which ‘risk selection’ in turn became highly salient. Accordingly, variation was also shown in the degree to which mothers and/ or children were generally depicted as ‘vulnerable’ and in need of protection, which was strongest in German policies and weakest in Dutch policies, or whether investments were made to detect the particular children being ‘at risk’ in relation to predefined risk factors, which was strongest in Dutch and weakest in Polish policies.

Strategies to address these risks showed variation on four levels: 1) the extent to which medical and/ or (psycho)social approaches were presented as appropriate, 2) responsibility being framed in relation to the state and/ or the family, 3) privileging more exclusive and private (professional-family, and parent-child) one-on-one relationships, or collaborative models of sharing responsibility and distribution of care and 4) ascribing responsibility solely or primarily to mothers, to parents in general, and/ or explicitly to mothers and fathers. Interestingly, the within-case patterns of coherent and contradictory cultural risk representations in this study were not bound to the policy fields of either OC, CHC, or family policies, but they emerged across these fields as overarching themes. Therefore, the coherencies found within cultural risk representations point to comprehensive cultural ‘thought styles’ (Douglas 1986), to which new risk representations, for instance childcare reforms, have to relate, adapt or contrast (Douglas 1986; 1992). At the same time, cultural risk representations within and across the policy fields in this study were far from static; they were dynamic and sensitive to change over time (Douglas 1992; Logue et al. 2011).
The policy documents, publicly provided government and healthcare information, and scientific literature used for this study were purposively sampled in relation to the research design and theoretical framework and offered insightful information for the analysis and country-comparison. The data provided enough richness and depth to include ‘negative cases’ (Katz 2015 [1981]; Tavory and Timmermans 2009), that is: policy information that did not immediately fit with my initial expectations and theoretical understandings, thereby enhancing an ongoing collection and analysis of material and a further construction of theories in which an overarching understanding of various policy findings could be developed.

Although my approach has been suitable for the purpose of this study – with policy document analysis not being the primary purpose of this dissertation – the collection of policy documents and further material about healthcare and family policy institutions in the selected countries does not attempt to offer a complete and full-scale analysis of Dutch, German and Polish policies regarding OC, CHC and family policies. This can be seen as a limitation of this study, because the selection of specific documents makes the findings and claims I make in this chapter more tentative. In particular, whereas my analysis has taken characteristics of overarching OC systems into account, the focus in this study has been on midwifery policy documents within these OC systems, rather than on obstetrician-focused policy documents. Moreover, saturation was reached in the analysis of the selected documents in the sense of detecting recurring themes (see also Møller and Harrits 2013), but not necessarily in terms of having enough data to fully characterize the policy domains. This was in particularly the case with the German and Polish documents, because I was less familiar with the German and Polish institutional contexts and languages (see chapter 3, page 67). The patterns that have been detected in my study can therefore be investigated further by a more encompassing analysis of the full scale of policies within these policy fields. Further research could also examine cultural risk representations within a model that integrates OC, CHC and family policies and applies this to other countries.

Suitable for the purpose of this multi-level study, I have shown in this chapter how within OC, CHC and family policy institutions situated cultural risk representations
and categories of normality and pathology, gender, and public and private divisions are established and negotiated in different country contexts. While we can assume that such categories impact on professionals’ knowledge and professional-family interactions, with institutions alone we cannot identify how these categories resonate in professionals’ accounts and influence inter-subjectivities between professionals and families. Neither does this tell us which institutions are most influential and how professionals deal with cultural and policy contradictions. Therefore, it becomes highly salient to examine how risks, categorizations and responsibilities in relation to pregnancy, childbirth and early childcare are framed and managed in practice (Woolgar and Pawluch 1985) and therefore how the context-specific macro-level institutions discussed in this chapter relate to and play out in micro level professional-family interactions (Harrits and Møller 2011) within the Netherlands, Germany and Poland. This latter analytical orientation is pursued in the following chapters.
Dutch, German and Polish professionals negotiating medical and cultural institutions and parenting categories in ideal-typical risk knowledge. A qualitative cross-national comparison
5.1 Introduction

In the previous chapter, I have shown that a deconstruction of macro level institutions of obstetric care (OC), child healthcare (CHC) and family policies in the Netherlands, Germany and Poland sheds light on how ‘risk objects’, potentially posing a threat, and ‘objects at risk’, potentially being in danger from this threat (Boholm and Corvellec 2011) are culturally constructed (Douglas 1992) in relation to pregnancy, childbirth and early childcare. Variation was found in the framing of pregnancy, childbirth and early childcare as ‘pathology’ (in German and Polish policies), and thereby as risk object, or as ‘physiology’ (in the Netherlands) thereby reflecting lower levels of risk per se, although ‘risk selection’ became highly salient. Variation was also shown in terms of strategies and responsibilities to address risks in: a focus on medical and/ or (psycho)social approaches; the framing of responsibilities for the state and/ or the family; privileging more exclusive relationships or collaborative models of sharing and distributing care, and in ascribing responsibility to parents in general, and/ or explicitly to mothers, fathers or to both. The findings of the previous chapter therefore show that professional-family interactions, as well as healthcare professionals’ discretionary judgement and decision-making (Freidson 2001; Lipsky 1980) concerning parents’ caring practices, are already influenced through these combined policy contexts.

At the same time, policies are shaped on the spot through public service workers, in our case healthcare professionals, who follow national policies on the one hand, while making assessments on a case-by-case basis on the other hand. In doing so, they develop strategies to cope with tensions between macro level regulations, focused on populations, and concrete micro levels interactions, for instance through ‘stereotyping’ (Lipsky 1980), and using ‘ideal-typical knowledge’ to understand and address other people’s meanings and actions (Schutz 1972; Brown 2015b). There is still much to learn about how different ‘risk knowledges’ shape professional decision-making practices (Valverde 2003), and how categories of ‘risk objects’ and ‘objects at risk’ (Boholm and Corvellec 2011) – in the sense of professionals perceiving parenting as potentially ‘risky’ in relation to children’s developments, and professionals perceiving parents and/ or children as vulnerable and ‘at risk’ from other developments – are gendered and function as a gendering strategy when
professionals relate differently to mothers than to fathers (Hannah-Moffat 2004; Featherstone 2009).

In this chapter, I analyse ideal types of risk among pre-and postnatal healthcare professionals in the Netherlands, Germany and Poland, as ‘generalized’ and ‘anonymized’ forms of knowledge (Schutz 1972, p.186, 187), constantly produced and reproduced in their situated interactional experiences. My aim is to understand how ‘parenting’ (mothering/ fathering) and ‘parents’ (mothers/ fathers) are depicted through risk knowledge, and what similarities and differences in ‘risk knowledges’ can be found. Moreover, this chapter examines how – and which – policy institutions and discourses ‘resonate’ (Bröer 2008) in the healthcare professionals’ ideal-typical knowledge about risk, as related to a) categories of pathology and normality, 2) categories of gender and social class, 3) assumed divisions of responsibilities between the state, professionals and families.30

To that aim, I employ a thematic (Boyatzis 1998) within and cross-case analysis (Miles at all. 2013; Onwuegbuzie and Dickinson 2008) based on in-depth interviews and participants observations to investigate professionals’ risk knowledge as situated in the institutional contexts in which the professionals work (outlined in chapter 4): on the one hand in different countries with specific healthcare policies and family policies, informed and contested by cultural values about risk in gender roles, parenting and child development, and on the other hand in different professions, resulting in different approaches and different moments of involvement in the lives of young children and their ‘parents’ (mothers and fathers). The data and methods on which the analysis in this chapter is based are discussed in chapter 3 on page 70.

When examining professionals’ ideal-typical knowledge, we can expect that professionals use and refer to different ‘sources’ of knowledge: the formal and scientific knowledge they base themselves on according to classic theories on professionals and professionalism (Freidson 2001; see Harrits 2016); knowledge related to their professional organization and education, and broader cultural

30 In the next chapter, I examine the fourth dimension that came to the fore in chapter 4, namely: assumed ‘one-on-one’ or ‘collaborative’ models of care.
knowledge (Harrits 2016). Moreover, it has been argued that professionals combine abstract and rational forms of knowledge with tacit, emotional and more intuitive ways of knowing (Zinn 2008b; Harrits 2016) when making sense of the world and of mothers, fathers and children, reflected in the interpretive and ideal-typical knowledge frameworks they use (Schutz 1972; Brown 2015b) about parenting and risks. Lastly, scholars have shown that processes of ‘medicalization’, in which medical definitions become increasingly important to describe phenomena (Brubaker and Dillaway 2007), are in everyday life, especially outside of the clinic setting, much more pragmatic and focused on practical challenges and resolving conflicts (Bröer and Besseling 2017; Lupton 1997a). This makes an investigation of how professionals negotiate ‘medical’ categories and anticipated outcomes as situated and intertwined with cultural knowledge on families, gender and social class especially salient.

5.2 Results

The analysis of how and to what extent professionals’ ideal-typical knowledge about risk in the data set can be related to their institutional context is shown in two main themes which are presented in this chapter. The first theme is closest to the previous chapter in showing how professionals negotiate and make sense of the healthcare policy framework in which they are situated on the one hand and their everyday work in which they are dealing with individual cases and pragmatic challenges on the other hand. In particular, I show in this section how the professionals reflected on categories of ‘normality’ and ‘pathology’, and how this related to categories of gender. Within this theme about ‘medicalization and medical risks’, the strongest ‘cross-case’ variation was found (cross-nationally and crossprofessionally) and these types of risk knowledges as derived from the professionals’ accounts often appeared to be most frequently mentioned or shown in practice, by most of the professionals and often with the most emphasis. Hence, I show in this section that healthcare policy frameworks affected the central aspects of professionals’ ideal-typical risk knowledge in my data, although to varying degrees.

In the second theme, I show how the professionals related risks in parenting to broader societal processes – which can be characterized as processes of ‘reflexive
modernity’ (Beck 1992; Giddens 1991) – in pointing to developments that resembled ‘individualization’, changing roles and communities, and a clustering of problems and vulnerabilities for some particular groups. Within this theme, the variation found was mainly (but not solely) cross-nationally, while particular healthcare policies were shown to be intertwined with cultural perceptions of society, socioeconomic inequality and family roles, thus resulting into specific demarcations of categories of gender and social class, and related framings of responsibilities for professionals and/or (particular) parents.

5.2.1 Negotiating ‘medicalization’ and ‘medical risks’, potentially endangering women/parents and children

5.2.1.1 Professionals relating to their medical context in obstetric care

A central part of the healthcare professionals’ ideal-typical risk knowledge concerned their reflexivity about working in a context where medical and psychosocial risk policies were dominant in the framing of risks regarding pregnancy, childbirth and early childcare on the one hand, while they perceived it as crucial to their profession on the other hand to properly assess such medical and psychosocial risks. Reflexivity about ‘medicalization’, while working with medical risks at the same time was in particular salient to midwives, in all three countries, although in different ways. The German midwives placed the strongest emphasis on risks following from the increasing ‘medicalization’ of pregnancy and childbirth which they experienced in German OC. As visualized in figure 5.1, most of the risks and threats mentioned by the German midwives were related to a medical approach to birth. Jana, a German midwife, stated:

“Women are very much pathologized through German prenatal screening. [...] It is simply a different approach in our medical system. [...] Among doctors, the focus is more on risk. And on pathology. It is often misdiagnosed as a false positive. Luckily, but [...] on the other hand, this leads to an even stronger uncertainty of the pregnant woman or the couple [...] and the self-confidence of: ‘I can deliver a child’, which was self-evident only two, or two and a half, generations ago.” [Jana, German midwife, Q-0131]

31 See Appendix H, page 329 for the verbatim quotations in the original language, ordered by Q-number
Source: own depiction, based on ideal type scores (see appendix G, page 323). For the methodical approach to the use of ‘ideal type clouds’ see chapter 3, page 72.

Hence, a rather straightforward framing could be detected in the German midwife interviews between medicalization as a ‘risk object’ and women’s uncertainty and fear as an ‘object at risk’. Moreover, this was seen as threatening the perceived importance of mothers and babies being together directly after birth. Ute, one of the few German midwives in our sample who performed deliveries\(^{32}\), contrasted the hospital approach to her own approach to childbirth:

“Child comes out, […] chop chop, child away, weigh it, measure it and what not. It’s rare that clinics grant women even half an hour with their child alone […]. While I first take the baby, perform the U1, weight it, measure it, examine it more thoroughly: usually on the mother’s belly, or directly next to the mother, I’m doing all my things around the bed.” [Ute, German midwife, Q-02]

Ideal-typical knowledge pointing at a medicalization of women, pregnancy and childbirth, considered as risky in itself, can be understood from the position of (independent) German midwives within the German OC system. German midwives see themselves as offering a more women-centred and physiological practice within

\(^{32}\) Midwives in Germany are currently facing challenges of very high insurance costs, especially when they want to supervise deliveries independently. For many midwives, these insurances are not affordable, and guiding deliveries is in these cases not a part of their curriculum (Kötter and Maßing 2016)
OC, parallel to the dominant hospital-based and obstetrician-led approach (Deutscher Hebammenverband 2017b). In the German context, there is a scarcity of (independent) midwives (Kötter and Maßing 2016) and the midwives in this study perceived difficulties in paying high insurance costs necessary to perform their job, reflecting a weak institutionalisation of midwifery practices. This risk knowledge therefore resembled a strong counter narrative to the dominant OC system. Accordingly, the midwives framed mothers in the interviews as being ‘at risk’ from the medical system rather than from medical complications. It was found that the German midwives often aimed to protect mothers through their discretionary space in offering them more woman-centred practices, and in supporting them to take a more autonomous position towards their obstetricians.

Imke says that the woman should go back to her gynaecologist to clarify questions.  
[German field notes – observation 6; Imke, German midwife]

At the same time, it became clear in the participant observations of the German midwives that these midwives did structurally assess the health of mother and child, while checking potential medical complications and safety risks in pregnancy and post-partum care, as a part of their everyday work. Midwives were for example engaged in physical examinations of mothers, in ensuring the right temperature of the baby, of the water when bathing the baby, and of the air when drying the baby, and in answering questions and providing advices about health and potential illnesses.

The mother is now asking questions about body hygiene. Isabella answers the questions in a very detailed manner. To this question, she explains potential infections and she explains biological processes. [German field notes – observation 8; Isabella, German midwife]

That these medical elements were not stressed in the interviews resembled a different positionality when midwives were interviewed as experts within their obstetric field on the one hand, and when practicing the profession in relation to mothers and children on the other hand. In interviews as well as in observations, mothers and children appeared to be the central focus of the German midwives, in line with German OC policies (see chapter 4). While fathers were to some extent involved in consultations during pregnancy and postpartum care, they were never approached as
being ‘at risk’, from the medical system, from medical complications, or from other threats.

Within the Polish midwife interviews, the emphasis in risk knowledge was reversed. Although similar ideal types about medicalization, a caesarean ‘epidemic’ and women’s increased fear in giving birth were expressed, ideal-typical knowledge about possible medical complications in pregnancy, childbirth and post-partum care and how to prevent them was stressed more strongly and coherently in the interviews. Accordingly, within the accounts of all the interviewed Polish midwives’, the framing of pregnancy and childbirth as risk objects in itself ‘resonated’ strongly in the ideal-typical knowledge they presented.

Interviewer: “And how important is it to pay attention to risk and how do you calculate risk? [...] Very generally, or maybe also dangers?”

Krystyna: “Danger is always big; in every physiology there may be big danger. If we talk about physiological birth then we do not know for sure if this is normal, straight physiology, right? So, dangers are simply always there. Of course, the patient should know about dangers, but we inform them only when it’s necessary, so as not to... simply not to stress the patient from the start or anything. Dangers are everywhere and can always appear.” [Krystyna, Polish midwife, Q-03]

As reflected in this quote, the main tension for Polish midwives in working with these risks, particularly in hospital settings, appeared to be between their knowledge about medical complications on the one hand, and knowing that this might cause insecurity on the other hand.

“Well, we say to women, to simply, if they are recommended to stay in an uplifted bed, then we pay attention if she lies down. If we see that she is sitting, we tell her she nevertheless should lie down, for her safety and the child's. However, this staying in bed gives a lot..., because practically, if the patient doesn't lie down but sits, then the danger increases and there may be unnecessary complications. As we also half-jokingly say not to stroke that belly. But it is really the case that when you irritate the uterus, contractions might appear; the patient has a particularly high risk of giving this premature birth.” [Ewa, Polish midwife, Q-04]

While these differences might partly stem from the interview topic about risks for children, a question that was posed to Polish and Dutch professionals and not to German professionals (see chapter 3, page 55, an overall different approach to medical risks was found in the Polish professionals’ accounts in which the medical
institutional setting of hospitals in which most of the Polish midwives worked came to the fore, as well as a valuing of medical expertise and a focus on educating parents.

Figure 5.2 ‘Ideal type cloud’: ideal-typical risk knowledge Polish midwives

Source: own depiction, based on ideal type scores (see appendix G, page 323). For the methodical approach to the use of ‘ideal type clouds’ see chapter 3, page 72).

It has been argued that social movements have been influential in Polish OC since the 1990’s in promoting women as social actors, creating space for ‘dignity’, family relationships and midwives’ roles (Gajewska and Pawliszak 2013; WHO 2015, see chapter 4). However, midwives’ ideal types of risk knowledges in this study resembled a rather strong focus on pathology and risk prevention, as well as on telling mothers what to do. The above quote shows that midwives were at the same time careful in not wanting to be too directive, while giving risk instructions “half jokingly”. Moreover, it was shown that these medically informed concerns had to be negotiated in relation to practical challenges (see Bröer and Besseling 2017), of for example persuading women to stay in bed and lie down, when they wanted to sit.

As we have seen with German midwives, some of the Polish midwives also approached mothers and children as being ‘at risk’ both from medical complications
and from the focus on pathology. However, there was a stronger simultaneous focus on children being ‘at risk’ from mothers’ ‘risky’ behaviour (which is worked out further in the third section of this chapter). When considering medical risks, fathers were barely included in either of these categories. One of the midwives did frame fathers as potentially ‘risky’ in childbirth, and she prioritized medical expertise, educating parents, and the proper progress of labour over father’s role in childbirth:

“When parents are determined to have a family labour\(^{33}\), and they do not go to birth preparation classes for instance […], then the partner should not, in my opinion, participate in this delivery. Because he is completely unprepared, emotionally and mentally, simple as that […], it is such a process to prepare this partner for labour, and they are very often actually unprepared and so offhand, off-the-cuff, so to speak. They participate in this labour, while it’s just a difficult thing for a man.” [Krystyna, Polish midwife, Q-05]

It was thus shown in the data that the focus on medical risks, medical expertise and medically-informed training in the Polish midwives’ accounts resulted into gendered categories of risk emphasising mothers’ roles and not fathers. Although fathers’ engagement in childbirth and childcare was valued and encouraged, fathers’ roles were much less prominent within the professionals’ risk knowledge.

The Dutch midwives mainly expressed concerns about a medicalization of birth, and not of pregnancy or women in general, reflecting the Dutch context in which pregnancies are frequently and traditionally midwife-led (Amelink-Verburg et al. 2010; Christiaens 2008). Similar to the German midwives, ideal-typical concerns were expressed about the hospital, where most deliveries take place in the Netherlands, as a place that can be unfavourable for giving birth, since it could affect labour negatively and promote the need for medical interventions.

In line with the framing of women’s influence on decision-making as ‘objects at risk’ in Dutch OC policies, the perceptions of medicalization and medical risks by the Dutch midwives particularly included the importance of ‘women’ – and to a limited degree also ‘parents’ in a more general sense – enacting their choice and having

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\(^{33}\) In the Polish OC system, a distinction is made between deliveries with only the mother present and deliveries in which a family member, such as the father, is present, as an important aspect of ‘modern obstetrics’ (Wielgos et al. 2007; see also Kaźmierczak et al. 2005)
influence on giving birth, even more so when they chose the medical context of the hospital.

Interviewer: “Are other themes discussed, or do you find themes important [in birth preparation classes]?”
Nienke: “Yes, the most important theme in my view is that people understand how a delivery works in terms of hormones, […] Knowing that hormones decline for instance with shame, the feeling you’re being watched, bright light and things like that, you really need to be considering: when I want to go to the hospital, how am I going to create a safe environment and what do I need for that […] to keep the oxytocin on a high level, and well, the adrenaline low.” [Nienke, Dutch midwife, Q-06].

Women’s decision-making was thus constructed around applying and negotiating medical, or biophysical, knowledge in the setting of their choice.

**Figure 5.3 ‘Ideal type cloud’: ideal-typical risk knowledge Dutch midwives**

Source: own depiction, based on ideal type scores (see appendix G, page 323). For the methodical approach to the use of ‘ideal type clouds’ see chapter 3, page 72).

The Dutch midwives furthermore stressed ‘risk selection’ as central to their professional role, meaning they needed to decide in time (not ‘too early’, not ‘too late’) when a situation could still be framed as physiological and when medical complications suggested a referral to the hospital. Hence, this straightforwardly reflected the framing of ‘risk selection’ as a ‘risk object’ in Dutch OC policies and debates. For the Dutch midwives, their responsibility in risk selection during the delivery was tailored towards the health of mother and child on the one hand, and to
parents having influence on decision-making in childbirth on the other hand. This reflects that facilitating parents’ influence on decision-making, as an ‘object at risk’, resulted in a slightly less gendered category, since the decision-making in pregnancy and childbirth in several occasions included parents as a couple. In terms of selecting health risks however, the focus of the Dutch midwives was clearly on mothers.

“[An important aim is] that you do your risk selection in time. [...] Like, ok is this still normal, and can this still be done within my operative range, or should I transfer to an obstetrician? [...] The aim then is, I believe, [...] very simply put, the aim is of course eventually a healthy mother and a healthy child. And satisfied people, you know. That people feel they’ve been supported, that they were listened to, that they’ve had a voice in how it went, and not that it happened to them.” [Joan, Dutch midwife, Q-07].

Both ‘objects at risk’ came to be seen as especially vulnerable when the framing of childbirth shifted from ‘normal’ to ‘pathological’ over the course of the delivery. While this shift legitimized and asked for the emergence of the medical context, it was as the same time perceived as a potential threat to parents’ influence on decision-making. In the Dutch practice, the up-scaling of care from a midwife to an obstetrician during a home birth had a direct impact on midwives and families, because it meant a transfer from the family home to the hospital during labour. One of the Dutch midwives expressed her sensitivity to potential threats and her responsibility in addressing these threats during childbirth.

"Especially selection of risks, and that’s what you’re constantly doing. Actually, already when you walk through the door you’re observing: ok, where are the windows and doors here, what if someone needs to get out of here? What do I do... when you would have a bleeding... where can I reanimate a baby here? You’re just... everywhere [laughs], you don’t mention this when you’re stepping inside a place, but that’s the first... You have a few doom scenarios and well, the first thing you do is observing: what am I going to do with that in this house? [...] And that’s usually during the entire delivery, well selecting for risks and observing whether it progresses normally. And when that’s not the case, yes, we have to intervene. Sometimes by going to the hospital. It can be done in different ways, sometimes it can also be done at home, you know, you pull a few tricks to get [the labour] to progress again.” [Sophie, Dutch midwife, Q-08]

Hence, working in contexts were medical definitions were important in these midwives’ every day practice concerned not only a pragmatic dealing with specific challenges (Bröer and Besseling 2016), but also a concrete and practically informed anticipation of diverse individual risk scenarios was exactly part of the Dutch midwives’ risk selection. Dealing with someone’s particular house, in relation to more
flexible and dynamic categories of ‘normality’ and ‘pathology’, added in this sense a different dimension to ‘risk work’ compared to the midwives who worked in a setting in which anticipated dangers had to a large extent already been addressed through locating childbirth in the relatively uniform clinical setting of hospitals, with medical instruments embedded in the direct environment.

The Dutch post-partum care assistants, who commonly provide postpartum care in the week after birth in the family homes (Wiegers 2006), proved to be a specific case. The ideal-typical risk knowledge expressed by the postpartum care assistants generally moved further away from – and was therefore less often building on or contrasting to – a medical approach to childbirth and early childcare. Some of the Dutch postpartum care assistants expressed in rather casual ways that detecting medical complications in the health of mother and child was part of their everyday work, in cooperation with and under the responsibility of the midwife.

**Figure 5.4 ‘Ideal type cloud’: ideal-typical risk knowledge Dutch postpartum care assistants**

Source: own depiction, based on ideal type scores (see appendix G, page 323). For the methodical approach to the use of ‘ideal type clouds’ see chapter 3, page 72).

Alongside other concerns, the physical and emotional vulnerability of mothers, seen as characteristic to the post-partum phase, and how this could be addressed was more
central to their risk knowledges than the medical context. For the Dutch postpartum care assistants – involved with families in this particular period directly after birth – the recovering of the mother and good start of the baby and family together were the main ‘objects at risk’ whereas persons and things being perceived as causing distraction and stress were framed as ‘risk objects’.

“You sometimes [...] have such situations between the family-in-law and- and the own mother... you know, like: ‘the one is allowed to come over again, and the other... [...] And [when the family comments on that] you see such a woman completely... - you know, when you are a postpartum woman, you’re just, you’re not steady on your feet, so you’re quite... such a postpartum woman is then completely upset [...], so we try to soothe a bit in these cases.” [Evelien, Dutch postpartum care assistant, Q-09]

As this quote reflects, pragmatic and practical concerns – such as interacting with women perceived as unstable, and with families perceived as spending their time and performing care in certain ways – appeared to be stronger and more central risk ideal types than medical or medicalization risks, in the absence of an influential medical framework. Moreover, references to fathers as vulnerable – due to being tired and being in an unfamiliar situation as a family – also came to the fore more clearly.

“[What I stimulate is that] [...] when they’re having a nap in the afternoon, I say to the father, you know: ‘jump in and lie down with your wife, because hey, you don’t know how the night will be.” [Sandra, Dutch postpartum care assistant, Q-10]

Hence, within a weaker medical context and Dutch postpartum care assistants being confronted with everyday risks in the family home, while only being involved with families in the post-partum period, resulted in to ‘at risk’ categories which were more inclusive to fathers.

5.2.1.2 Professionals relating to risk frameworks in child healthcare

In contrast to risk ideal types of midwives, there was no similar framework detected about medicalization and professionals stressing potential risks in relation to their medical context within the interview and observational data of paediatricians and nurses in CHC in this study. The Dutch paediatricians and nurses denoted the strongest tension between the responsibility in particularly psychosocial risk assessment ascribed to them by the government on the one hand and their awareness of parents’ perceptions, as well as their experiences with limited opportunities to
assess risks, on the other hand (see also chapter 7). Despite of this reflexivity, both the Dutch paediatricians and the Dutch nurses strongly and coherently expressed how assessing children’s physical and psychosocial development was central to their professional role in CHC. This reflects a high degree of institutionalization of exactly these tasks within the Dutch CHC system, and a strong risk detection framework related to this. The tensions paediatricians and nurses pointed out were dissimilar: paediatricians mainly perceived a conflict between the risk responsibility for the children attending their service versus potentially being perceived as meddlesome and not being able to reach everyone.

“The government always says: with 80 per cent of the children it’s going well, with 20 per cent it’s not going so well and 5 per cent of those really need referral and extra intervention, so we only need to look at the 5 per cent. But that’s not true of course, because these 95 per cent, or 80 per cent, include children who can become an at-risk child at a given point in time. And the other way around is also possible, so labeling an at-risk child is very tricky, because it’s not a fixed fact. […] The main uncertainty to me is: do we really reach the children we want to reach? I always wonder. I actually believe we only see a tip of the iceberg, who we can really offer good help and support.” [Ellen, Dutch paediatrician, Q-11].

Figure 5.5 ‘Ideal type cloud’: ideal-typical risk knowledge Dutch paediatricians

Source: own depiction, based on ideal type scores (see appendix G, page 323). For the methodical approach to the use of ‘ideal type clouds’ see chapter 3, page 72).

Hence, Dutch CHC professionals framed the risk responsibility ascribed to them in CHC as ‘risky’ in itself, because which children were ‘at risk’ was experienced as more dynamic and harder to grasp at the individual level.
Some Dutch nurses expressed similar concerns. They experienced a stronger tension however between risk responsibility and the idea of conveying expert knowledge on the one hand versus such information causing parents’ insecurity on the other hand, as we have also seen in ideal-typical risk knowledge of the Polish midwives.

**Figure 5.6 ‘Ideal type cloud’: ideal-typical risk knowledge Dutch nurses**

Source: own depiction, based on ideal type scores (see appendix G, page 323). For the methodical approach to the use of ‘ideal type clouds’ see chapter 3, page 72).

“Parents are quite vulnerable, I think, because well, [...] I think the well-being of someone’s child is very important. And when you give advice, this can be much harder on parents than we think. [...] It can feel as a form of criticism. [...] And I don’t want to overload parents with massive information and only make them more frightened or insecure.” [Jonita, Dutch nurse, Q-12]

Dutch CHC professionals were thus shown to perceive parents as ‘at risk’ from being overwhelmed by employing a risk framework. Moreover, whether children were ‘at risk’ was perceived as debatable in professionals’ every day work. The Dutch CHC professionals also struggled with ideal types of developmental guidelines on the one hand and more relaxed and common-sense ideal types of how to be useful to parents on the other hand.

“For instance, a boy who had to come back due to issues regarding growth, and he continuously heard: worrisome, short child, what to do? And then I see the mother and the father and they are both 1.60, 1.61 m or something. Then I’m like: ok. You know what I mean? That’s very annoying to parents. [...] They don’t like this. [...]
"This is often mentioned [by parents], that a lot of fuss has been made about nothing."
[Ireen, Dutch nurse, Q-13]

These competing risk knowledges on the individual level were found to be relatively strong for the Dutch professionals in CHC, and the nurses in particular. The specific ideal types were found to relate to parents and children in general terms. Different than what we have seen for midwives and postpartum care assistants, these ideal types thus did not result in, or intertwine with, gendered categories of mothers rather than fathers being perceived as ‘at risk’ from medical and psychosocial risk frameworks, or from medical and psychosocial risks. In this sense, a clear distinction was found between ideal-typical gendered categories related to the medical risk framework in OC compared to CHC.

As was observed in the participant observations, the German paediatricians appeared to play a more medical role than the Dutch paediatricians (and nurses), while working as independent family doctors also performing the tasks which a general practitioner performs in the Dutch context. Yet, as German CHC policy documents suggested (see chapter 4, page 103), the ideal types in the interviews with German paediatricians were tailored towards children’s psychosocial well-being rather than to their physical development, infections and illnesses. Although treating illnesses was central to their everyday work, these medical tasks were not translated into what the paediatricians prioritized in what they mentioned in the interviews.

Interviewer: “What are the aspects you like about your job?”
Marianne: “[…] Sometimes these relatively banal acute diseases are a large part [of the job]. This is not so interesting. […] What I like a lot is to be in contact with children, with the families, who are in the opportunity to accompany them. Because I work here for so long, I have guided many from birth until the end of high school. And the ones who were older –when I took over this practice – are now attending again with their children. So, this aspect, guiding families, to observe children growing up, to see them slowly going through life. This is very interesting. An emotionally very, very beautiful aspect of the job. “[Marianne, German paediatrician, Q-14]

Alongside presenting a broader and longer-term perspective on children and families, German paediatricians reflected more autonomy than Dutch paediatricians and nurses in how they framed their different tasks in consultations and in their approach to children’s psychosocial well-being and parents’ needs. One of the German paediatricians explained that prioritising children’s well-being and parents’ needs in
fact followed from being already so familiar with children’s physical development as their family doctor.

"It makes little sense to look at physical characteristic in the prevention. [...] Much more important is, so to speak, what people’s needs are. What problems do they face? Usually, I have known people since forever and I’ve accompanied them. So, I usually don’t detect any physically exciting findings. What I can find, of course, is that a child is not really thriving well. This can be due to different things.” [Torben, German paediatrician, Q-15]

The focus was therefore less strongly on children, or parents, being ‘at risk’, but rather on understanding changes and ‘problems’ in how a child was doing over time, which therefore shows a paediatrician who ‘knows’ children and parents. The same paediatrician also expressed awareness of parents possibly leaving his practice when their (sometimes hidden) needs and concerns were not addressed, assuming that he did not know the child and parents as well as he should have. Parents, as patients, were in that sense also perceived as customers, expecting the paediatrician’s full attention for their child’s well-being.

Interviewer: "Does it also happen that a parent says: ‘Ok, then we go to someone else’?"
Torben: "Yes. Of course. [...] This is relatively common. [...] When it comes to things that don’t need to be talked about for long. [...] Some patients would like to talk about a cold for a long time, because perhaps something else should come up, and when I just don’t have the antenna that there is actually something else behind the runny nose [...], then after the second time they say, ‘He doesn’t have time for me.’ Or ‘he doesn’t take the time I need.’ This happens so fast.” [Torben, German paediatrician, Q-16]

As this excerpt indicates, risk knowledge included paediatricians’ concerns about parents’ (sometimes hidden) questions and needs, especially when parents could potentially choose between various alternatives in primary care. Such pragmatic considerations could therefore also have contributed to an increasing focus of the German paediatricians on children’s broader psychosocial well-being, as a response to parents’ demands (De Graaff 2016; Lupton 1997b). In any case, the German paediatricians were found to negotiate their medical professional role on the one hand, and parents’ autonomy to choose a paediatrician who needed to meet up to their expectations on the other hand. In the absence of a strong overarching medical or governmental framework – as was found for midwives and Dutch CHC
professionals – the independently working German paediatricians did not frame the negotiation of their role in assessing risks, illnesses or children’s psycho-social well-being as their strongest concerns, but they rather emphasised diverse parenting challenges they encountered in their everyday practice. German paediatricians, together with Dutch postpartum care assistants, therefore proved to be exceptional in this respect when compared to the other professionals in this study.

Figure 5.7 ‘Ideal type cloud’: ideal-typical risk knowledge German paediatricians

![Figure 5.7 ‘Ideal type cloud’: ideal-typical risk knowledge German paediatricians](image)

Source: own depiction, based on ideal type scores (see appendix G, page 323). For the methodical approach to the use of ‘ideal type clouds’ see chapter 3, page 72).

The Polish paediatricians on the other hand did express a more medical approach to risks in children’s development, while relating more clearly to the medical context in which they worked. When asked about insecurities of the job, one of the Polish paediatricians replied:

"I think that the strongest insecurity occurs during the care of an infant who is potentially healthy, due to the fact that while examining children who are with their mothers and theoretically should be healthy, well, you have to remain increasingly... indeed increasingly alert and there is this kind of- this kind of insecurity because we don’t expect any pathology, however it may certainly occur and the whole thing is to detect everything and keep our senses at the same time and not scan every child from head to toe and don’t perform a million of tests. Because that’s not the point."

[Klaudia, Polish paediatrician, Q-17]
Similar to the challenges mentioned by the Polish midwives\(^\text{34}\), tensions could be found between a strong sense of potential pathology and professional responsibility to detect and treat these pathologies, while at the same time not wanting to burden children with large amounts of tests. It should be taken into consideration that most of the interviewed Polish paediatricians (7 out of 9) worked in the hospital on the premature and/or neonatology ward, which accounts for a large part of the medical focus within the Polish data. Nevertheless, a medical focus was found in the accounts of all the Polish professionals. Both the paediatricians who worked in preventive CHC particularly did emphasize their role in prevention.\(^\text{35}\) One of these paediatricians said:

\begin{quote}
“I mean the aim is to help children. I’m putting a strong emphasis on preventive healthcare. And I’ve got a really idealistic vision on my job, that I also perform an educative function. I would rather treat less and teach more and put even more emphasis on prevention.”
\end{quote}

[Stefana, Polish paediatrician, Q-18]

\(^{34}\) And to a lesser extent the Dutch midwives, in the above-mentioned case of children being considered as ‘healthy’, whereas it was up to the professional to detect whether they should come to be considered pathological

\(^{35}\) The score for this ideal type (‘prevention’) is based on the two CHC paediatricians in the Polish sample, as reflected in the size in the cloud in figure 5.7. CHC paediatricians were singled out of the total of paediatricians only in relation to ‘prevention’, because this is a central feature to CHC.
Polish CHC, including prevention and educating parents, is in itself relatively new in Poland, which is reflected in how the paediatricians working in Polish CHC emphasized the educational aspect within their job, as ‘idealistic’ and ‘visionary’. Contrary to what was found in the accounts of Dutch and German paediatricians and nurses, the interviews with these two Polish paediatricians did not display a focus on psychosocial risks; preventive education was rather related to physical, medical and health concerns. Moreover, as was especially common in all the Polish interviews, expert knowledge in CHC was in this sense stressed as most legitimate, implying a framing of parents being potentially ‘risky’ when not properly educated. Stefana [Polish paediatrician] continues:

“I think that I have to support [parents] with, for instance, some advice about food or vaccination. Even if they don’t ask about it, I think it’s my role to educate them, and if they won’t hear it from the doctor, I’m positive they will ask somewhere on a playground and may hear something contrary to generally accepted recommendations.” [Stefana, Polish paediatrician, Q-19]

In the accounts of the Polish professionals, a strong emphasis on medical expertise was thus found, whereas in practice this had to be negotiated with competing, and more informal, sources of knowledge. Although psychosocial risks were not as structurally addressed as in the accounts of Dutch and German paediatricians and nurses, risk knowledge of the Polish paediatricians who worked in the hospital wards for premature babies and neonatology were found to include more pragmatic risks such as stress, social problems and parent(s)’ mental health problems.

5.2.1.3 Conclusion

The conclusion that can be drawn is first that cross-national and cross-professional patterns could be detected in how professionals negotiated different risk knowledges in relation to their medical contexts. Hence, the ‘risk objects’ and ‘objects at risk’ in healthcare policy contexts described in chapter 4 were on the one hand clearly reflected in what professionals framed as ‘risk objects’ and ‘objects at risk’, and in that sense potential events came to be constructed as ‘real’ (Brown and Olofsson 2014). On the other hand, however, processes of ‘medicalization’ (especially for the Dutch, German and Polish midwives and Polish
paediatricians) and of professionals’ increased responsibilities in ‘risk detection’ (for the Dutch CHC professionals) were at the same time, although to varying degrees, perceived as ‘risk objects’ in itself, potentially resulting into ‘mothers’ or ‘parents’ anxiety, insecurity or lack of cooperation. The ways in which professionals negotiated these contradicting risk knowledges were found to be related to the specific institutional context.

In contexts with stronger medical (or psychosocial) risk policy frameworks, such as in OC and Dutch CHC, professionals’ tensions in working with – and contrasting – these risks in everyday practice appeared to be stronger. This shows that even within (clinical) healthcare settings, processes of ‘medicalization’ and intensifying perceptions of risk (Rothstein 2006) are not determining professionals’ risk knowledge, but professionals who work in these settings need to negotiate different forms of knowledge (Bröer and Besseling 2017; Lupton 1997b). In the relative absence of strong encompassing healthcare frameworks – which was found to be more strongly the case for Dutch postpartum care assistants and German paediatricians – the pragmatic challenges in parenting which these professionals experienced in their everyday practice came to the fore as more central in their ideal-types of risk than medically or psychosocially informed risks.

Furthermore, in the ideal-typical knowledge detected in the professionals’ accounts in this study, medical risk frameworks were shown to be intertwined with categories of gender. This was especially the case for the professionals working in OC, where professionals consistently depicted mothers and children as the vulnerable ‘objects at risk’ on whom their tasks were focused. Variation was found between OC professionals working in contexts where either ‘pathology’ or ‘normality’ was mainly related to pregnancy, childbirth and early childcare. When ‘objects at risk’ were related to health and addressing pathology, it was mothers and children who were perceived as vulnerable, however when ‘objects at risk’ were related to broader issues such as ‘having influence on decision-making in childbirth’ and ‘getting used to a baby’, as a demanding and unfamiliar situation, fathers were by the Dutch professionals (not by the German midwives) more easily included in perceptions of being vulnerable as well.
Professionals working in CHC on the other hand were focused on children and parents more generally, and the threats that either medical or psychosocial complications, or processes of medicalization could pose to them. The medical frameworks were in these cases therefore not intertwined with clear categories of gender. In this sense, it was also shown that risk concepts were related to where in the process professionals came to be involved with parents: already during pregnancy where mothers’ physical presence in consultations was evident, or after childbirth, where mothers’ centrality was not as clearly assumed and demarcated.

5.2.2 Individualization and categories of gender and social class

5.2.2.1 Parenting under pressure or children being at risk through parenting

In many occasions in the data, concerns were mentioned about broader societal developments perceived as causing challenges to parents and parenting on the one hand and therefore to the professionals’ practices on the other hand. The societal processes which were brought to the fore resembled the “crisis of trust” (Brown 2013, p.17) which according to Beck (1992) and Giddens (1991) result from individualization, a decline of traditional structures and individuals’ related feelings of vulnerability in the face of increasing risk awareness. As is highlighted in figure 5.1 (page 140) and 5.6 (page 150), German paediatricians and midwives stood out in emphasising such processes in relation to parenting risks. All German paediatricians mentioned trends of grandparents not being around, parents and children no longer living in extended families, population changes in the sense of multicultural backgrounds and failing community structures. The change in community structures was perceived as specific for Germany, and in particular for the [Rhein-Main] area in which the interviewed professionals worked, where many people settled because of employment reasons, thereby often ending up ‘isolated’.

“So, it’s an enormous uncertainty and parents always want confirmation. They always want to be assured that everything is good and that they do everything right. [...] And I have the feeling that this is like a generational thing. You no longer have the mother in the house, or the grandmother.” [Sonja German paediatrician, Q-20]

“And the trend that can increasingly be recognized is that the child, the parents are increasingly incapable to assess how the child is doing. Also because of this information overload, I believe parents are lacking intuition in dealing with the child.
The grandmother is missing, who says: ‘be careful, first give a suppository, then wrap the calf, or wrap the waist. And you attend the paediatrician tomorrow.’ What can rather be observed is that parents are increasingly helpless and seek medical professionals with the first signs of illness. They call emergency services and [go] directly to medical centres.” [Johan, German paediatrician, Q-21]

This trend was also mentioned by some of the Polish professionals, but it was emphasized more in the German accounts, and more clearly connected to a lack of grandmothers (and their knowledge) as well as broader community structures. Within this perceived trend, the German professionals depicted mothers as particularly uncertain, which several of the German midwives related to a ‘mother cult’ in the German society, resulting into difficulties for mothers to find their way in terms of being a mother and performing other roles, such as employment.

Interviewer: “Do women discuss with you: ‘I would like to return to work, but this doesn’t pay off with Elterngeld?’”

Isabella: “I believe... based on that there is an incredible mother cult in Germany which is so overwhelming, you know. So, it's such a super-hyper-hyper-mother. It's sometimes difficult for women to find their way: What kind of mother am I? There is no orientation. It’s easy for the Scandinavian countries in my eyes. They have a royal family and can orientate on them. But our Chancellor is childless. So, we have few idols - except the Klum perhaps, who looked as if she had never been pregnant after 6 weeks, or 8 days. This puts women under great pressure.” [Isabella, German midwife, Q-22]

Responsibility for parenting risks was in this sense mainly placed on parents’ being ‘at risk’ of failing societal structures and societal norms, and much less on (individual) parents themselves. A first explanation for this can be found in the historically strong focus on societal processes detected in German child development literature (Bermaoui et al. 2012), which is – despite of a more recent ‘turn to parenting’ – still reflected in the current framing of German CHC by prominent German paediatricians (Ehrich et al. 2016, see chapter 4, page 106).

A second explanation for this societal emphasis in the German parenting risk ideal types can be that the interview topic asking about risk was not in the German item list. This dissimilarity in how professionals were probed would assume that inquiring about (children’s) risks would encourage respondents to focus on individual parenting risks. While this might have had an influence on the risk ideal types that occurred in the interview data, a similar emphasis on the changing
society posing challenges to parenting was not found in the Dutch and Polish observations, follow-up interviews and other interview topics, while expressions of individual parenting risks in the Dutch and Polish accounts were not limited to the interview topic asking about risk.

Moreover, the German professionals in this study generally talked about parents in less problematizing and responsibilizing and in more pragmatic ways, also when they mentioned differences and challenges.

“In [name city], the clientele, so the patients, are different than in the rest of the country. So, there are also large differences, and I think they are also an enrichment. That’s also often the case with foreigners: the family forms are often quite different, which can be good, and which can also – as I have experienced – be very burdening. [...] Many women are speaking in other languages as well, so not German-speaking. This may be a problem, sometimes, in the care. So, I cannot speak Turkish, but I can speak English quite well, which is very, very often requested lately: [...] I can also speak French, there is also a large demand, I have noticed. [Women] from Morocco, that is increasing.” [Gerda, German midwife, Q-23]

Hence, although this midwife faced serious challenges with families, when they came from other countries, in the sense of language barriers and that she had to relate to family situations which she experienced as stressful, she highlighted positive and negative sides, and responded rather practically in summing up which languages she did and did not speak and how she tried to overcome these barriers. One of the German paediatricians depicted his clientele as a ‘normal distribution’, which was also brought up by one of the Dutch paediatricians (see page 149). However, where the Dutch paediatrician argued that assessing risks is not that clear-cut because ‘at risk’ categories are dynamic, Torben (German paediatrician) did not relate to scientific or medical definitions but used more common-sense terms of some parents being ‘unreasonable’ which he in the end did not evaluate negatively.

“For 90 per cent of the day, you encounter reasonable people. Then only 10 per cent are unreasonable people. This is simply a normal distribution. [...] The 10 per cent of difficult [people]... can sometimes also be the salt in the soup. It can also give the kick [laughs]. I find difficult patients not necessarily bad.” [Torben, German paediatrician, Q-24]
The accounts of most of the German paediatricians thus resembled weaker risk ‘lenses’, assuming higher levels of parental autonomy than Dutch and Polish paediatricians and nurses in how they depicted parents. The German midwives generally emphasized their supportive and, in that sense, protective role towards women, especially in a society in which community ties had become weaker.

“I believe [...] that [midwives] take over the... what the social environment used to do back in the days, and where one was simply supported, where one was told: that’s ok, that’s normal, this will pass, this is what happens to many others as well’. And I believe this is neglected, while the women... especially in [this city]; how many women are here only for professional reasons? Perhaps even only for their partner’s professional reasons? Who are completely isolated here, and perhaps due to parenthood have even fewer people who they can talk to about what happened and what’s relevant to them. And when one then talks to people who are not in the same situation, it’s perhaps, it makes it even more difficult. And I believe midwives are in a good intermediate position to really say: ‘yes, this is an insane development you’re going through. Tell me more about it.’” [Carla, German midwife, Q-25]

It was thus shown that midwives framed mothers as ‘objects at risk’ beyond the medical context, and that midwives themselves often saw their role as relevant to mother’s social functioning. Such a focus on mothers at the same time resulted in a gendered category of (social) risk, in which fathers appeared to be less central.

Societal notions of risk and threats expressed by the Dutch professionals – mainly in those of the Dutch paediatricians, nurses and to a lesser extent midwives – were on the other hand tailored towards scientifically established ‘at risk’ groups, such as teenage parents, divorced parents, single parents, parents with financial problems and depths, parents living in poor neighbourhoods, parents with a ‘low socioeconomic status’, ‘migrant background’, isolated parents, parents with addictions and parents (or children) with mental health problems, chronic illnesses or traumatic childhood memories (see Postma 2008). With slight variations, this list was commonly recited by several of the Dutch CHC professionals, as something that was a part of their ideal-typical risk knowledge provided through CHC policies. However, this was often mentioned without much emphasis, while adding that not all members of such groups were necessarily ‘at risk’ (see also chapter 7 and the previous section).
At the same time, individual parenting risks of ‘improper’, ‘negative’, ‘unsafe’ and ‘insensitive’ parenting were stressed much more strongly and these risks were in turn in many cases connected to the ‘at risk’ categories, or even more so to the cumulating of such risk factors. Social categories were thus made individual in the sense that specifically ‘burdened’ parents were considered more ‘risky’ to their children and their development, and less ‘capable’ of and more ‘powerless’ in parenting.

“You also see many of those snarling parents, who are only snapping at the child the whole time and stressing everything that’s not going well again and again, and this provides a very loaded atmosphere, in my view. [...] There are many [...] damaged parents, also in this area, who have experienced a lot in their childhood and in the past, or with a lot of family problems. Or just other problems: financial problems, housing problems. And I think, well, you see that when people are very occupied with other things demanding their attention, yes, that this has its effect on those children.” [Christine, Dutch nurse, Q-26]

The entanglement between ‘at risk’ categories and parenting behaviour framed as unfavourable also implied that parents were assumed responsible and that professionals suggested these parents in particular to adapt their behaviour (when perceived as ‘negative’), as is shown in the next quote where the behaviour of parents who faced struggles, such as having financial problems or being a single parent, became a topic of discussion in relation to their parenting:

“I find it more difficult to see parents who have it a bit harder, and where you see this has an effect on the child. And that you need to have that talk of: yes, I understand you are worried, for instance because you have financial problems, or you are a single parent, but I see this reflected in... in your child, so to speak, and that, well, the way you deal with your child is very negative.” [Ellen, Dutch paediatrician, Q-27]

Hence, the depiction of societal risks in terms of risk factors and ‘at risk groups’ in Dutch CHC professionals’ ideal-typical knowledge easily came to be intertwined with categories of social class (see also Møller and Harrits 2013), and with ascribing responsibility especially to the parents who faced more challenges, because they could potentially have a negative impact on the development of their child. Some of the Dutch midwives and postpartum care assistants also mentioned risk ideal types in which social categories and individual factors were entangled, namely poverty, the absence of a social network and childhood trauma (see figure 5.3 on page 145 and 5.4 on page 147).
Especially the Dutch postpartum care assistants and to a lesser extent the Dutch midwives were concerned about societal changes in terms of people having more stress and less time and attention for their child nowadays, which they saw reflected in the post-partum week. All the postpartum care assistants mentioned several times that mothers were often (breast)feeding, while sending messages and checking Facebook on their phones at the same time.

“The love is different. [...] Taking time for the children changes. [...] Nowadays so many other things also need to be done. [...] The phone, or ordering something on the Internet, or... Yes, unimportant things in my view.” [Leen, Dutch postpartum care assistant, Q-28]

“Back in the days, it was all very natural. And now we have to pay more attention. [...] Like such a bottle: ‘convenient’, you know. I’ve had it in the first week, first, second day I came in, and then I see the baby lying in the baby bouncer [by itself], teddy bear underneath, with a bottle, like this [shows with arms]. It was two, three days old. I said: ‘what are you doing?’ ‘Yes’, she said, ‘my friend works in a day care centre, [...]’, so handy’. [Laughs] You see, then you have to go back to the start, to say, also with the bottle, right. Because with the bottle, we also try the skin-to-skin contact, you know. And to also take that moment, to put the phone away.” [Evelien, Dutch postpartum care assistant, Q-29]

These professionals focused more on societal changes they saw reflected in changed mother-child relationships and caring practices which were believed to be potentially harmful for children, rather than on perceived external societal changes making parents vulnerable. Similar approaches were found in the ideal types of the Polish midwives (see figure 5.2 page 143), where parenting risks of not taking time for children were understood within a broader societal perspective, in which parents were however framed as responsible.

“I expect from parents that they are as parents are supposed to be. [...] So that they don’t focus on all these gadgets; this very materialistic approach to maternity. [...] I want them to remember that interpersonal relations are the most important and we experience deficiency of them, lack of time devoted to other people, including a lack of time we devote to our own kids. So, if we just hope that we will put our little munchkin between glittering and rattling toys, so we can have some time to check out Facebook or blab on the phone endlessly, it’s not really what it’s all about here.” [Olene, Polish midwife, Q-30]

It was thus shown that family relationships were framed as in need of protection, predominantly through mothers’ devotion of time and attention, which was
resembled in the above-mentioned quote and in several other occasions in the Polish midwives’ and Dutch postpartum care assistants’ interviews. Although expressions about ‘materialistic parenting’ as conflicting with ‘family relationships’ were also found in the Dutch and German professionals’ ideal types, they were most strongly stressed among the Polish professionals, reflecting stronger indignation about these changes within family life, accompanied by an emphasis on the centrality of the family and a rejection of material possessions (Ryndyk and Johannessen 2015) being important in maternity. It should be taken into account that the expressions of the Polish professionals about individual parenting risks in general resembled comparatively high levels of being displeased with perceived parental ‘irresponsibility’, which could also be due to a comparatively strong style of expression. Nevertheless, ideal-typical categories of ‘risky parents’ as detected in Polish and Dutch midwives’ and Dutch postpartum care assistants’ accounts were found to be intertwined with categories of gender, in the sense of young children’s need for parents, but in particular mothers’, attention and devotion.

A clearer reflection on broader societal risks was found in the ideal types of Polish paediatricians (see figure 5.8, page 154). Although not stressed as much as in the German data, some Polish paediatricians also argued that motherhood was idealized in Polish society, resulting into high expectations of mothers and stigma when they would not do what was considered best for the baby in society. A premature baby was according to a Polish paediatrician depicted in the wider culture as hard to combine with the image of the ‘Polish mother’ who could manage everything (Hardt et al. 2011; Reimann 2016). According to this paediatrician, such expectations would arise from the grandmother, mother-in-law, neighbour or wider community.

“I mean [when the grandmother’s or mother-in-law’s attitude isn’t always appropriate], stigmatising those premature babies, that they’re not as they should be. [...] There is this problem of one’s community [...] because it’s expected of a pregnant woman that she’ll be back home after three days with a healthy baby and when she comes back on her own or when something is happening, then, well, it’s not always... I mean, this ideal of the Polish mother still persists somehow, doesn’t it?” [Janek, Polish paediatrician, Q-31]
In contrast to lacking grandmothers and communities resulting into parents’ – and in particular cases mothers’ – problems and insecurities, this paediatrician and other Polish professionals perceived grandmothers and communities on the other hand as potential sources of parents’ – and in particular cases mothers’ – insecurities. At the same time, another Polish paediatrician, mentioned that in her view socioeconomic factors contributed more to parents’ problems and insecurities than their gender.

Interviewer: “What are the problems and insecurities parents face, are these insecurities, problems, different for mothers and fathers?”
Beata: “I'm not sure if it depends on being a father or a mother or rather on different factors: place of living, city, village, level of education, also self-reflexivity. […] But I guess it doesn't really depend on if you're a father or a mother.” [Urszula, Polish paediatrician, Q-32]

Other ideal types about societal risks that were recurring in the paediatricians’ accounts in relation to socioeconomic factors concerned the lack of government support, especially in case of ill children, and not everyone being able to afford private healthcare, while public healthcare was not always (timely) accessible.

“We know that health is connected to economic structures. If parents have money, they can do anything [for a baby with an illness].” [Janek, Polish paediatrician in Polish fieldwork notes; part 3]

Interviewer: “To what extent do you experience support for a specific role for fathers and mothers in legal institutions?”
Agnieszka: “Well, in this case I can be pretty clear because practically parents,..., when the child is healthy, then generally parents don’t need any special support and can manage on their own. However, I firmly believe that in the case of children who require more care further on, exactly our preterms who require [special care], there, parents are completely left to their own devices. I mean, obviously there are physical therapists, but usually parents, especially those not so well-off, they receive absolutely no support.” [Agnieszka, Polish paediatrician, Q-33]

One of the Polish CHC paediatricians made a distinction between categories of social class in relation to parenting risks, which she perceived as being visible in parents using public or private healthcare. When asked about ‘threats’ for children, Stefana – working as a CHC paediatrician in a private clinic, and previously in a public hospital – responded:

“Surely in a private facility it happens less often. It's not violence, but there is neglecting […], such as, I don't know, not fulfilling some emotional needs, babies are often with some people… […] And that’s really horrifying here in private healthcare. And in the [public] hospital there are notoriously children that have been beaten,
harassed, persecuted in some other way and you don’t even need to pay much attention, because some parents are capable of hitting the child during the conversation, because something is going wrong, because they have a dubious lifestyle, don’t treat them the way they should, or you can see a hit mark, or you can see children that are very withdrawn even during a short conversation.” [Stefana, Polish paediatrician, Q-34]

Different than in the accounts of Dutch CHC professionals, an intersection of parents being perceived as ‘risky’ in one way (‘neglect’) or the other (‘physical abuse’) and categories of social class was however not structurally found in the Polish data, neither were ‘at risk’ categories expressed or assessed on a structural base by the Polish professionals. Moreover, more heterogeneity in the approach to relations between societal, socioeconomic and individual risks, as well as how this related to categories of gender and social class, was detected in the Polish accounts, compared to the accounts of the German and Dutch professionals, which suggests weaker or less coherent (policy) institutions in terms of aiming to detect risks in relation to families’ socioeconomic backgrounds.

5.2.2.2 Conclusion

In this analysis, I have shown that the professionals’ ideal-typical risk knowledge in my data set varied in how professionals linked the perceived parenting risks to their framing of broader categories and changes in society. Such reflections typically came to the fore in interviews rather than in participant observations, confirming that interviews are especially appropriate to illuminate the meanings individuals ascribe to phenomena, how they frame their anticipation of undesired consequences (Lamont and Swindler 2014), and how they relate this to their direct experiences and their experiences over time (Schutz 1972). In our case, this shed particular light on the professionals’ framing of causal linkages between ‘risk objects’ and ‘objects at risk’ and how these framings were situated (Boholm and Corvellec 2011; Douglas 1992).

In the accounts of the German professionals, the most clear and coherent emphasis was placed on changing community and family structures, resulting into parents, and often mothers, being perceived as ‘helpless’ and ‘isolated’, which was however also suggested to relate to the [Rhein-Main] area in particular. According to several
of the German midwives, societal expectations of mothers’ caregiving roles were at the same time high. Hence, Beck’s (1992) theory about risks in ‘reflexive modernity’, where individualization and changing traditional resources result in increasing levels of uncertainty, resonated to a stronger degree in the German professionals’ ideal-typical risk knowledge. While parents’ crises of trust’ were brought to the fore by most of the German professionals, a professional problematization and distrusting of parents was in turn hardly detected in the accounts of the German professionals in this study. Several of the German paediatricians stated that they facilitated parents’ access to healthcare, with parents’ increasing demands in their view being related to parents’ uncertainty. The German midwives in this study saw a role for themselves to support mothers, especially when social structures were absent. The protective approach towards parents, and especially mothers, in German OC, CHC and family policies (see chapter 4) was therefore reflected in the German professionals’ ideal-typical risk knowledge, in which they framed parents rather as ‘at risk’ than as ‘risky’.

In contrast, a stronger depiction of societal changes as seen in parenting, which supposedly made parenting more’ risky’ for children, came to the fore in the accounts of Dutch and Polish professionals. To some extent, the Polish paediatricians remained closer to the German paediatricians in approaching societal changes as external, and rather outside of parents’ control. Generally, Polish professionals stated that the government provided parents with (too) little financial and social support. Some of the Polish paediatricians mentioned how socioeconomic structures affected parents’ access to public or private healthcare and their means to support their child’s health, while one of the Polish paediatricians reflected on societal demands of ‘Polish’ mothers, in which mothers’ hardships (and premature babies) were not socially acceptable. Among the Dutch CHC professionals, societal demands were perceived in which mothers were expected to be able to perform on all (professional, family and social) domains at the same time, however the focus easily shifted to how mothers played a role here by internalizing such expectations.

The Dutch and Polish professionals in this study placed a stronger emphasis on parents’ individual responsibility. The Dutch postpartum care assistants and the
Polish (and Dutch) midwives perceived societal changes in terms of a declining ‘devotion’ of mothers in taking time for, paying attention to and having physical contact with their young children. These professionals saw a role in educating mothers on how important these types of care were for their children, thereby reflecting ‘intensive mothering ideology’ (Hays 1996; Knaak 2010; Faircloth 2014a), which is discussed further in the next chapter. Some of the Polish midwives related this more clearly to family relationships being crucial for society at large.

The Dutch CHC professionals most clearly and coherently focused on socioeconomic inequality and how this translated in problematic behaviour of parents who faced an accumulation of problems (Postma 2008). In these accounts, categories in parents along lines of social class were detected, in which particular concerns were formulated in ‘risk factors’. Some of the Polish professionals also related parents’ socioeconomic class positions (as intertwined with public or private healthcare) to particular forms of ‘risky’ parenting, but this was not structurally found in the Polish data, and neither pointed to professionals structurally addressing parents in such categories. Hence, the professionals’ ideal types about parenting risks showed cross-national differences in focusing on parents ‘at risk’ of failing societal structures and/ or parents being ‘risky’ to their children due to socioeconomic positions within a changing society, who were therefore expected to adapt their behaviour.

5.3 Conclusion and discussion

This cross-national examination of healthcare professionals’ ideal-typical risk knowledges shows patterns in how children and parents were framed as ‘at risk’, or as (potentially) ‘risky’ for their children. During pregnancy and childbirth, it was mothers and children who were perceived as ‘at risk’, both of medicalization and of medical complications. The later shows that the professionals worked with contradictory risks objects in relation to their medical context much more pragmatically than has been assumed in medicalization theories (see Broër and Besseling 2017). The German midwives strongly emphasized the risk of medicalization in the interviews, while the Polish midwives on the other hand
emphasized medical risks. The Dutch midwives acknowledged both, but mainly emphasized the salience of risk selection, and mothers/parents being ‘at risk’ from not having influence on the decisions regarding their childbirth.

It was shown that when institutional medical and risk detection frameworks were experienced as more central to the professionals’ tasks (in case of the midwives in all three countries, and the Polish and Dutch paediatricians and nurses), potential risks to mothers and children suggested by this framework and potential risks stemming from this framework in itself, as well as how to negotiate these, were also more prominent in the ideal-typical knowledge of risk that professionals presented in the data. Hence, this study suggests that context matters in two ways: first in how policy level ‘risk objects’ and ‘objects at risk’ resonate in professionals’ accounts, and second in how professionals are both pragmatic and reflexive about the diverse, and sometimes perceived undesirable, effects of the medical risk approaches they work with (see Lupton 1997a). When such institutional frameworks were experienced as less central and overarching to the professionals’ tasks (for the Dutch postpartum care assistants and the German paediatricians), the ideal-typical risks professionals presented mainly reflected the professionals’ direct everyday experiences of families. My data thus suggests that healthcare policies influence the central types of risks that professionals experience with and are worried about in relation to families.

After childbirth, the German professionals coherently still framed parents, and mothers in particular, as being ‘at risk’ of societal processes such as individualization and an idealizing of motherhood, thereby using expressions that fit well with Beck’s theory (1992) of reflexive modernity and individualization. In using a comparative perspective, we can thus say that the risk constructions in this theory either are very much connected to particular German cultural values and representations of risk (Brown 2015a), and/or that this theory has had a stronger impact on the knowledge of the German professionals in this study. In the German accounts, a stronger protection of parents, and mostly mothers, was detected. At the same time, a more ‘unproblematizing’ approach to parents was found among the German professionals, in which German paediatricians granted parents higher levels of autonomy and were not shown to rely much on social categories of
parents, neither of targeting them for interventions. The Polish professionals were much more comprehensive in framing parents as potentially ‘risky’ to their child, and they also expressed stronger rejection of parental irresponsibility, which was mainly addressed in professional-family relationships. The Dutch professionals related ‘risky’ parents more clearly to ‘at-risk groups’ of burdened and incapable parents, as defined at the policy level, who needed help to better understand and anticipate their children’s needs.

It has been argued that categorizations of ‘at risk’ groups largely draw on social and taken for granted categories. Moreover, such stereotypes are used to target ‘at risk’ families for preventive interventions at the moment that families are still seen as ‘normal’, which implies that possible anticipated risks are treated as ‘real’ (Møller and Harrits 2013). While this is applicable to the findings for the Dutch professionals, the cross-national perspective in my study shows that how responsibilities are perceived in relation to the state, societal processes or individual parents within cultural risk ideal types underlie different types of social categorizations. Categories of ‘vulnerable families’ were present in German OC and CHC policies, but they did not resonate in the accounts of German midwives and paediatricians. Policies that framed and targeted particular categories of parents were not found in Polish OC and CHC policies. Accordingly, they were not reflected in ideal-typical risks knowledge of the Polish paediatricians, and the social categories of socioeconomic inequality that were presented were much more heterogeneous. It was thus found that apart from reflecting on processes of medicalization and medical risks, wider cultural assumptions about the types of social categories of parents that were used, the degree to which this was seen as pertinent, and the related assumptions about responsibilities of the state, society and of individual parents were also important in ideal-typical risk knowledge of the professionals in this study.

It should be taken into account that these findings could have been partly impacted by the interview setting, in which less emphasis was placed on individual risks for children in the German interviews compared to the Dutch and Polish interviews. Moreover, this study (with a small sample size) has not been designed to generalize from these professionals to professionals in the larger population, or to the entire
country. The examination of professionals’ meaning-making does show however that cross-nationally (and to some extent cross-professionally) different patterns were found in depicting the relationships between ‘risks objects’ and ‘objects at risk’ (Boholm and Corvellec 2011).

When we compare professionals’ ideal-typical risk knowledge as discussed so far with the risk presentations found in healthcare and family policies (see chapter 4, table 4.4 on page 127) we can see that many, but not all, risk constructions, were reflected in the professionals’ accounts, as depicted in table 5.1 in bold text. The main ‘risk objects’ that resonated in professionals’ ideal-typical knowledge of the Dutch professionals concerned risk selection in itself, parenting and ‘at risk’ groups, with the main ‘objects at risk’ being child health and child development. In encouraging ‘disadvantaged’ families to better understand and respond to children’s developmental needs, an anticipation on social equality between groups of children could also be found. Underlying cultural assumptions reflected models of collaboration, negotiation and individual responsibility.

In ideal-typical knowledge of the German midwives in this study, the main ‘risk objects’ concerned to a limited degree pregnancy and childbirth in itself, and to a stronger degree the medicalization of pregnancy and childbirth, potentially causing fear. Accordingly, the health of mother and child, but also the well-being and socially functioning of mothers, were constructed as important ‘objects at risk’. Societal processes of individualization were brought to the fore, mainly by the German paediatricians, and to a lesser extent by the German midwives, as a ‘risk object’ potentially threatening parents’ and mothers’ confidence in assessing their child’s health, while child development was an important aim of the paediatricians, addressed in one-on-one relationships that in which parents’ autonomy was assumed. At the same time, a relatively protected approach towards parents could be detected in ideal-typical knowledge of many of the German professionals.
Table 5.1 Cultural risk constructions within ideal-typical knowledge (in bold) of Dutch, German and Polish professionals

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<tr>
<th>The Netherlands</th>
<th>Risk selection</th>
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The patterns found in ideal-typical knowledge of the Polish professionals strongly reflected the construction of pregnancy and childbirth as a ‘risk object’, and the
health and physical development of children as ‘objects at risk. Furthermore, two opposites could be detected, in which medical expertise and (the lack of) state support was emphasized on the one hand, and individual parenting risks as well as family relationships on the other hand. Responsibilities were framed and conveyed in one-on-one professional-family relationships.

So far, employment and labour market risks and potential aims of gender equality between parents have not been very much reflected in the themes discussed in this chapter. Accordingly, cultural contradictions that were found in and between healthcare and family policy domains neither came to the fore, assuming that these tensions are particularly related to contrasts between parents’ caregiving roles and their working roles. While the present chapter shows that the professionals in this study were mainly occupied with the healthcare, parenting and caregiving side, professionals were at the same time involved with parents when they performed caregiving and working roles. The next chapter therefore examines professionals’ risk ideal types that centred around the risks and individual responsibilities the professionals framed in relation to mothers’ and fathers’ (gendered) roles in care and work, and the division of these tasks.
6 Risk and responsibilities for mothers and fathers in ideal-typical knowledge of Dutch, German and Polish professionals. A qualitative cross-national comparison
6.1 Introduction

In the previous chapter, I have shown that context-specific healthcare institutions and wider cultural values influence healthcare professionals’ risk knowledge and the degree to which professionals rely on gendered and social categories to suggest which particular parents and children are at risk and from what, and how this should be approached. Contradictory cultural values between parents’ caregiving and working roles, and values about gender equality and gender responsibilities remained much more out of sight in the analysis thus far, while it has been argued that not only categories of being ‘at risk’, but also those of being potentially ‘risky’ when acting in certain ways and not in others, and the responsibilities that come to be related to that, are gendered and may function as a gendering strategy (Hannah-Moffat 2004). In this chapter, I investigate the linkages and interactions between healthcare and family policies, cultural gender norms and economic structures within professionals’ ideal typical knowledge about parenting risks and responsibilities in particular contexts, to improve our understanding of how gendered parenting roles are reproduced and shaped in professionals’ knowledge.

In her cultural theory about risk, Douglas (1992; Douglas and Wildavsky 1982) has argued that particular constructions of risk are intertwined with particular constructions of responsibility and blame, and that pointing the finger at someone in the face of risk is not an arbitrary process, because it reveals the social order of a particular context (see also Brown 2013). More than ascribing responsibilities in terms of blame, I argue in this chapter that in the face of risk, efforts are aimed at the prevention of anticipated dangers (Giddens 1991; Alaszewski and Burgess 2007) for families and specifically for ‘vulnerable’ children. Hence, the question how and which parents are made responsible for children’s futures rather than for their pasts, as a form of ‘governance at a distance’ (Rose and Miller 1992), is even more suitable for an investigation of the social order in distinctive societies, because it shows attempts to anticipate and affect certain consequences. Healthcare professionals’ knowledge is salient in this respect, because as ‘street-level’ bureaucrats, they connect institutions and parents (Lipsky 1980; Rose and Miller 1998), thereby drawing on social categories (Harrits and Møller 2011). I focus in
this respect on professionals’ gendered ideal-typical knowledge about mothers’ and fathers’ roles, and on how parents’ caregiving and working roles are depicted.

Several scholars have detected changes in parenting (see Furedi 2002; Hays 1996; Lee at al. 2010), in which parents, and predominantly mothers, are currently perceived as doing ‘much more’ than providing physical care to their young children. Rather, a standard has emerged which assumes that parents should invest hugely in their children, who are now “seen as more ‘vulnerable’ to risks” (Faircloth 2014a, p.26; see also Zalizer 1994). According to Hays (1996), who was among the first to conceptualize an ‘intensive motherhood ideology’, the proper approach to parenting is nowadays constructed as “child-centred, expert-guided, emotionally absorbing, labour intensive, and financially expensive” (Hays 1996, p.8; see also Faircloth 2014a, p.27). It has been claimed that professionals have an important role in depicting ‘intensive parenting’ as a standard and in advising parents accordingly, while at the same time assuming that expert advice to parents is crucial for children’s development and that parenting is in that sense potentially ‘risky’ (Lee 2014; Knaak 2010; Furedi 2002). However, such claims are not often accompanied by an examination of the views of (situated and diverse) ‘professionals’ on parenting, on what they actually perceive and value as risks, and how they translate this into responsibilities for mothers and/ or fathers.

It is therefore of interest to examine whether and to what extent particular gender ideologies, including feasible practices and routines (Tonkens 2012), resonate in professionals’ ideal types, since they could potentially connect cultural gender norms and healthcare and family policy institutions within professionals’ ‘ideal-typical’ (Schutz 1972), and experience-based, knowledge. In the first part of this chapter, I outline the main parenting risks that were depicted by professionals – in rather coherent ways across countries – and examine whether, when and to what degree ‘intensive parenting’ and ‘intensive mothering’ ideologies, which have been claimed to dominate expert knowledge and the contemporary gendered approach to parenting (see Furedi 2002; Hays 1996; Knaak 2010; Faircloth 2014a), were reflected in the ideal-typical risk knowledge of professionals in this study.
In the second part of the chapter, I investigate the *(caring and working)* responsibilities and roles that professionals ascribed to parents, and to mothers and fathers more specifically, for each of the countries. In this part of the chapter my focus is on whether ‘shared parenting’ norms (Kremer 2010), notions of “romanticized maternalism” (Michel 2012, p.24, cited by Lutz 2015, p.343), in which mothers’ primary and unparalleled roles are emphasized; and masculinities depicting fathers as breadwinners and/or as ‘nurturing’ (Hofmeister and Baur 2015; Featherstone 2009; Shirani et al 2012; Coltart and Henwood 2012; Connell and Messerschmidt 2005) were reflected in professionals’ accounts; how they interacted with professionals’ knowledge about healthcare and family policies and what tensions and contradictions could be found in relation to distinctive institutions and cultural values. For this study, I employed a cross-nationally comparative qualitative approach, in which I used interview (n=53) and observational data (n=116). My methods and data for this chapter are discussed further in chapter 3, page 70.

6.2 Results

6.2.1 Risks in caring for a baby: between a lack of protection and overprotection

In the data of this study, it was not straightforwardly confirmed that intensive parenting ideology, and intensive mothering ideology, was perceived and promoted as the main standard to parenting, neither were other – less intensive – approaches to parenting inherently perceived as ‘risky’. On the contrary: two rather coherent poles came to the fore in how the professionals considered parents to be ‘risky’ for their children; the first being that parents could put their child in danger and/or they could not protect their child properly against danger, which reflected but was not limited to notions of ‘intensive parenting’, and the second being that parents could be so overly involved in protection and caring for their child that they would neither grant their child enough space for a healthy, safe and autonomous development, nor ensure their own lasting involvement by keeping oneself stable and healthy as a parent. These distinct parenting ‘risks’ were often presented in tandem, suggesting that extremes should be avoided. Hence, a more nuanced
picture of parenting standards came to the fore in the professionals’ accounts, than suggested by some scholars (see for example Furedi 2002; Lee 2014). Although these depictions of risks in parenting were relatively comprehensive across the data set, meaningful cross-national and cross-professional variances and nuances were also found.

6.2.1.1 A Lack of protection

An important perceived threat that parents could pose to their children according to the professionals in this data was an ‘improper’ performance of caring. In this chapter, I do not focus on ‘violence’ and ‘abuse’, nor on mothers/ parents use of ‘alcohol, cigarettes and/ or drugs’ in the direct environment of the child during pregnancy or after birth. The former category of threats was rather structurally mentioned by professionals in all countries, but this was not so much focused upon, because ‘violence’ and ‘abuse’ were generally framed as the more severe and also more extreme cases of improper care. Parents usage of alcohol, cigarettes and/ or drugs was structurally mentioned by the Dutch and Polish professionals as a response to the question: ‘what are the main threats to a child?’, a question that was not posed to the German professionals. It was however not shown to be an important part of the professionals’ everyday work per se (although it appeared to be more pertinent to some of the Polish midwives).

In this section, the focus is therefore on professionals’ ideal types of improper parental care which the professionals said to encounter in their everyday work. The ideal types of improper care were rather coherent within the data set, and the main distinction that could be made was between risk knowledge about improper care for babies on the one hand and improper child raising on the other hand. I focus in this section particularly on the degree to which ‘intensive parenting’ ideology was reflected in the parenting risks the professionals depicted for babies and younger children, as a part of their everyday work.

*(Im)proper physical care for babies*

What stood out first was that the central aims of midwives, postpartum care assistants and to a lesser extent paediatricians and nurses who worked with parents
and babies were very much related to the (im)proper physical care, in which ‘improper’ meant that parents were perceived as: not competent, not holding the baby in the right way, not guaranteeing the right temperature (of the baby’s body and of the bath water), not ensuring safety in the environment and in physical care, not acting in line with expert knowledge and not being sensitive to the baby’s needs.

In the interviews with German midwives, more general reflections on parents’ uncertainty and (in)competence were brought to the fore, while the German midwives were observed demonstrating to parents how to be cautious and take safety measures and how babies should be handled and cared for. An example can be found in the field notes written about participant observations with midwife Isabella.

The mother now asks about the baby room and whether the pillow and blanket can be put into the baby bed. Isabella advises to take a sleeping bag or a thin blanket in the first 12 months to prevent sudden infant death. [German field notes - observation 9; Isabella, German midwife]

In these occasions, German midwives predominantly minded mothers to do the same, for instance in bathing the baby, and fathers as well in case they were present during the midwife’s visit of the family home.

In the ideal types of the Polish midwives, improper care was more strongly framed as ‘irresponsibility’, and there was a specific rejection of the anti-vaccine movement, parents ignoring symptoms of diseases, not acting in line with expert knowledge, and displaying a lack of devotion. Risks of improper caring were in one occasion related to fathers’ recklessness, and mostly to parents in general and to mothers in particular.

“Ignorance is a threat, bad behaviour. [...] When someone heard something here and there, and isn’t really sure, and they act contrary to what they should do. [...] One mom, you know what? She wanted to carry her baby only in a sling. And it was taking her like half an hour to put it on, it was summer so we were all sweating, she put her baby in it... and the baby fell down on the tiles and bumped his head. The diagnosis was broken cranial bone. And what can I do, it was a threat for the baby. This kind of lack of knowledge and skills, striving for something specific sometimes is just not meant to be.” [Tekli, Polish midwife, Q-35]
As this quote demonstrates, ‘improper care’ was in the accounts of the Polish professionals in many occasions characterized as diverging from medical expert knowledge.

The ideal types of the Dutch midwives regarding improper care were not as outspoken and concrete; they were mainly focused on insensitivity, while relating to parents in general. One of the midwives who had previously been employed as a postpartum assistant compared her current role as a midwife to her previous role as a postpartum care assistant and argued that as a midwife, she was much less capable to assess how parents cared for their child, due to the Dutch task division between midwives and postpartum care assistants in the postpartum period.

Interviewer: “How do you see fathers and mothers in their role of caregivers, and how does this differ?”

Hester: “Well, what I see concretely, is actually very little, [laughs], I think. […] You don’t just see someone bathing the child, or how someone deals with the baby when it starts to cry, how they are in the morning when they’ve had a bad night and you come in. And these are of course important issues by which you see how people deal with their child, and also deal with the stress that comes along. And how they do this together, how they solve problems together.” [Hester, Dutch midwife, Q-36]

This Dutch midwife suggested that the kind of caregiving she would pay attention to, was intertwined with family interactions in everyday life. Hence, according to her, the Dutch midwives were less in the position to assess how this was done, and the Dutch midwives indeed did not reflect on physical care for a baby very much in the interviews. The Dutch post-partum care assistants on the other hand expressed a strong focus on unsafe conditions, temperature, feeding and parents’ lack of attention, in line with the focus seen by the Polish and German midwives (mainly reflected in the observations of the latter). The Dutch postpartum care assistants related risks of ‘improper care’ in some occasions to mothers and in other cases to parents in general.

“You mainly teach parents […] that a child should not sleep in hot rooms. Foreign mothers are fond of tucking in and the heater on 30 degrees and the baby must be in the crib and it must have a hat and three blankets and preferably a cloth. And then we say […] ‘you know, you shouldn’t do that, it’s not good for your baby’. You know, these kind of threats, you tell them all about it. […] And also with carrying and bathing; basis affirmative carrying you know […] they are currently very keen on that
you shouldn’t lift them under their arm pits, but always on two sides. And also when you walk down the stairs you know, the head over here, hold the leg and only then walk down the stairs.” (Annet, Dutch postpartum care assistant, Q-37)

Professionals’ ideal types about safety and (im)proper caring could become especially apparent when they were confronted with people that applied different forms of knowledge and practice. As shown in the excerpt, this was often the case with ‘foreign’ parents, but also with parents following trends that did not comply to medical standards and immunization programs, as was reflected in the Polish professionals’ ideal types, and to a lesser degree also in those of the German and Dutch professionals. In these instances, cultural knowledge and values as well as perceptions of risk and blame (Douglas 1984; 1992) thus came to the fore, even in the more technical and practical facets of physical care.

The ideal-typical risk knowledge of many of the Polish paediatricians was in line with the ideal types that were found for the midwives and postpartum care assistants, in displaying a focus on inadequate physical care, which can be explained by most of these paediatricians exclusively working with new-born babies. As seen in the participant observations, German and Dutch paediatricians and nurses also demonstrated to work with babies, but they emphasized caring for babies to a lesser degree when reflecting on caring practices in the interviews. This resembled that the CHC paediatricians had a broader age group and children’s longer-lasting development in mind, when compared to paediatricians working with premature babies at the intensive care and neonatology wards.

“I think that, well, every mother has maternal instinct so it’s hard to maybe talk here about some kind of a complete carelessness but well, some kind of lack of proper care that is well overheating, or exposure to cold temperatures, improper technique of breastfeeding which may lead to dehydration of a child, improper positions of a child which may lead to breathing difficulties or some kind of choking, something like that, however these are things which are kind of explained even here during mother’s stay at the maternity ward, so such basics to every mother, I think every mother is discharged with this kind of basic knowledge.” (Klaudia, Polish paediatrician, Q-38)

As shown in this excerpt, the Polish professionals related risks of improper care in most of the cases to ‘mothers’ not providing adequate care, thereby demarcating mothers’ roles in (a lack of) protection of children as more central than those of fathers (or other caregivers). It was therefore confirmed in my data that risks in
physical caring for babies in the earliest stages were more often related to mothers than to fathers, and sometimes to ‘parents’ in general. However, while ‘intensive parenting’ ideology assumes that parents’, and in fact mostly mothers’, investments that go beyond physical care are emphasized (Hays 1996; Faircloth 2014a), thereby turning parenting tasks into more encompassing endeavours, it is important to note that by the midwives, postpartum care assistants and paediatricians in neonatology wards in this study, safety in physical care for babies was very much presented as salient in itself.

(Not) spending time in close contact with babies
We have also seen in the previous chapter (see page 163) however, that parents’, but particularly mothers’, lack of time, devotion and attention in care practices – prioritizing their phone instead – directly in the weeks after birth, was emphasized as a major concern by the Dutch postpartum care assistants and Polish midwives. In a similar sense, one of the German midwives expressed surprise about a mother who presented a caring ideal type that opposed prioritizing children’s needs above those of mothers.

“A woman came to me, second generation of immigrants [...] Has a very good job, highly educated, [...] is a lawyer, I believe. [...] Yes, if I could tell her where you can have a caesarean. A planned caesarean. [...] She said: [...] ‘why should I still give birth and things like that? This is nonsense; no one does it anymore today. [...] So, I definitely want my caesarean. Yes, and breastfeeding: no. This twaddle, we’re not going to do that in any case; I don’t want that as well’ [Laughs]. ‘I want a bottle, or... because then I can also return to work quickly and then one has to find a place quickly, a child minder, somehow’ [...]. I was [...] a little flabbergasted.” [Gerda, German midwife, Q-39]

Although this midwife provided this example to express ideal-typical knowledge about (planned) caesareans, she connected this to an entirely alternative framing of risks in caring practices, in which bottle feeding and returning to work quickly was anticipated, rather than (at least intended) breastfeeding and being with the child. Within this interview, as in the other interviews with German midwives, such alternative framings of caring were incidental and met with surprise and estrangement. The ideal types of the professionals within OC in the Netherlands, Germany and Poland thus reflected disapproval of and concerns about parents in general, but mothers in particular, not being with their children in the early stages,
and/or not prioritizing children and providing care and attention at important moments, while focusing on all the things that needed to continue instead, such as social interactions, social media and work.

On the one hand, these elements of professionals’ ideal-typical risk knowledge therefore clearly reflect ‘intensive mothering’ and ‘intensive parenting’ ideologies, promoting that parents – predominantly mothers – should sacrifice their other roles to the needs of the child (Hays 1996; Faircloth 2014a; Knaak 2010). On the other hand, it was found that especially the Polish and Dutch professionals who where in their fifties and sixties expressed concerns about parents’, and in particular mothers’, declining attention, changed affections, and increasingly competing interests in their view, when compared to earlier generations. Likewise, some of the German professionals argued that parents were nowadays less experienced and competent in caregiving because of smaller families and less practice.

“We have fewer children and that means many parents […] have never had a baby in their arms. […] [50 years ago] it was different. There was still more casualness. Today is being considered: "Should I take the diaper, or […] do I wrap like this? Or like this?" Hello? I mean…pfff [sighs].” [Jana, German midwife, Q-40]

This means that in the perspective of these professionals, especially when they had been doing this work for a longer period of time, it was not their norms of being with your child more intensively that had changed, but these norms were increasingly seen as challenged in contemporary societies, amongst other due to new media forms and mothers’ employment. Proper childcare was in this risk knowledge framed as a practice learned by experience and investment, while it was not learned properly when such experience and investment was lacking. Many of the professionals therefore stimulated parents to practice close contact and physical caregiving from the earliest stages.

“As long as they’re here in the ward with the baby they should practice as much as possible, take care of the baby because when they go home, they will feel more confident.” [Sylwia, Polish midwife, Q-41]
Annet, a Dutch postpartum care assistant in her fifties, argued in this sense that many parents she encountered were not used to being with their children for longer periods of time anymore.

“...And you see this more regularly nowadays you know, that children are a bit ‘neglected’... and I don’t mean... they have food and drinks, but... when it comes to love. [...] Nowadays most parents work, and you see that these children are attending a day care centre for entire days. And then [mothers] gave birth and think it’s nice and say: ‘oh, we don’t bring the children to day care then, we leave them at home.’ But my god that they don’t know how to handle those kids. So, after an hour, you already hear: ‘well, when you are this annoying, you had better gone to day [care]’, you know. Then you can just tell from people that they are not used to it anymore, caring for their own child for a whole day. And that they get very easily agitated. And I find that... I always find that so remarkable.” [Annet, postpartum care assistant, Q-42]

The ideal types of improper caring found within this data thus raises the question whether it was the lack of ‘intensive parenting’ that was perceived as risky by the healthcare professionals, or that it was the perceived limited opportunities and parents’ related choices to become engaged and experienced in acquiring skills of learning to understand and respond to their children. It was thus found that ‘attachment parenting’ norms (Faircloth 2014b) were more straightforwardly reflected in the professionals’ accounts and applied in a much more taken for granted way. The construction of risk in relation to parents not becoming experienced and not learning how to understand and respond to their child was in many cases related to ‘mothers’ or more generally to ‘parents’, but it also opened up space for ‘fathers’ seen as (not) becoming a competent and central figure in caregiving following his lack of investment.

"In a way, I find that the fathers, do not really have this competence. [...] So, when the children cry, they are more passive and compassionate. And mothers are a bit more resolute, in a way, and capable with the children ... But I think that’s a matter of practice. I think that if a man would always be doing..., [...] would also hear from us: ‘You have to hold him like this, so he feels safe’ and so on. Because I believe a lack of exercise, that’s also the uncertainty, you know.” [Sonja, German paediatrician, Q-43]

As this quote reflects, the German professionals in this study had stronger assumptions about mothers being with their young children, and thus becoming competent, while concerns about mothers’ absence and distraction from the child were more often expressed by Dutch and Polish professionals, which could be
related to Dutch family policies and Polish economic structures implying mothers’ quicker return to work. When we look at the main difference between how the majority of the professionals in this study approached mothers and fathers in developing competence through practicing and being with their child, it was found that although several professionals supported fathers to engage and become competent in caregiving tasks, fathers’ lack of engagement was not often perceived as ‘risky’, while this was much more clearly and strongly the case for mothers’ lack of engagement in caregiving tasks, especially in caring for babies. These findings for the professionals in my study therefore confirm Vuori’s (2009) claim that in expert knowledge, mothering is predominantly perceived as a duty and fathering as a choice.

6.2.1.2 Overprotection

Coherent and strong ideal types about parents (potentially) posing risks to their children through a lack of proper protection were counterbalanced by opposite coherent and strong ideal types among professionals within all three countries of parents standing in the way of their children’s development through overprotecting them. Ideal-typical knowledge of parents’ overprotection was interrelated with ideal-typical knowledge of parents’ anxiety, uncertainty, lack of confidence, high expectations from themselves and their children, parents being overburdened, stressed, not taking good care of themselves and mothers taking the exclusive caring role while ‘throwing themselves on their child’. Hence, these ideal types clearly contradicted ‘intensive parenting’ and ‘intensive mothering’ ideologies, and in many occasions such intensive parenting practices were framed as actually ‘risky’.

Ideal types stressing the risk of overprotection were particularly strong among the Polish midwives and paediatricians, the Dutch postpartum care assistants and nurses and the German paediatricians. None of the Dutch and German midwives expressed concerns about parents’ overprotection, suggesting that this was not a clear issue to them. Overprotection was in the majority of cases related to parents in general or to mothers, and in a few cases to fathers. The concerns were framed in relatively similar ways across countries and professions. An important element that
was found in the data in relation to overprotection was parents not allowing their children the space they needed to learn from their own experiences.

"Let’s just say, when there is a very overprotective mother-child relationship, or father-child relationship, the child is wrapped in cotton wool and can’t do anything and should be protected as much as possible [...] I try to explain how difficult it is for the child to develop autonomy. Yes, the parents themselves have achieved some autonomy, but also only because they were let go. Otherwise autonomy does not work. And, I’m also trying to explain when that begins, yes [...] autonomy already begins with three months of age. With pauses and steps forwards, at different levels. But the blockade of a child’s autonomy development will be a disaster later in life.” [Torben, German paediatrician, Q-44]

“‘In the last 10, 15 years, we can strongly observe a phenomenon, above all things I would say, we can observe that the children are in some respects perceived as an extension of the parents, especially the mothers. Fathers less, but mothers - that is, that is to say, the pain children experience has a direct and immediate effect on the parents; the parents cannot see any distance; they intervene for instance massively in examinations. [...] I have to point out to the parents more and more often: ‘please keep back, this is an examination for your child!’” [Marianne, German paediatrician, Q-45]

“This morning, I had a child; mother was continuously on it. [...] Normally I would discuss this, like: leave her be for a moment, or: allow her to discover things by herself, that’s always good for the development. [...] To leave them a bit, a bit more free. And to experience a bit more by herself.” [Yara, Dutch paediatrician, Q-46]

"In our times of one-child families, we don’t know how to step back out of the area of being their mother hen. And I think it’s [...] really bad; people theoretically know that we need brave, open children, who can discover the world and easily develop new friendships, but at the same time they bring up a cowardly fondler.” [Olene, Polish midwife, Q-47]

It was thus mainly mothers’ overprotection and being ‘overly’ sensitive that was framed as a ‘risk object’, which was perceived as posing threats to children ending up as properly raised individuals.

“Sometimes a child listens to father, but not to mother. You actually hear this very often. [...] And that’s because mothers often show their feelings a bit, that they care, or that they, that they... A child often knows as well that this is a weak spot of mother, this motherly feeling so to speak. And a child senses this, so it can make use of it.” [Esma, Dutch nurse, Q-48]

"Or post-’68 ideas about child raising. And so forth. That’s now on it’s return. And who knows whether this experimental appetite is good for children. This needs to be problematized one day. And well, I also see this as an important task for a paediatrician.” [Gerhard, German paediatrician, Q-49]
These lines of argumentation reoccurring in the data resembled an ideal type about the risk of parents’ overprotection that was counterbalancing and putting a limit to ‘intensive parenting’ and specifically to ‘intensive mothering’ norms. What was stressed here is that parenting should neither deprive children of learning to deal with limitations in their desires and their opportunities in the world, nor of space to have experiences of and on their own, and as a consequence, deprive them of proper socialization and development. Overprotection was related closely to the perception of parents’ anxiety and insecurity, a theme that was stressed by the majority of all the professionals in my study, except for the Dutch midwives. Furthermore, several of the professionals expressed risks for mothers increasingly confronted with high burdens, while not taking good care of themselves, which was most clearly emphasized by the Dutch professionals.

“When you never think about yourself and sleep three hours a day, just to exaggerate, because the child needs all the attention, yes, you’re going to meet yourself somewhere. And that’s also a risk, because when the mother is worn out, the child can neither depend on the mother. Or the father.” [Esma, Dutch nurse, Q-50]

“I say: ‘No, we are not going to have a quick shower. You are going to have a relaxed shower. The baby is nicely asleep […] you’re taking some time for yourself.’ […] Because when a mother doesn’t take good care of herself, she can’t take care of her children. […] You’re not going to endure.” [Leen, Dutch post-partum care assistant, Q-51]

The focus in not taking care of oneself was therefore clearly on mothers, and the importance of fathers came in as an opportunity to share the burden.

"It’s important to convey to people that they don’t have to do it perfect from the beginning, you know. They should also… take relief; they shouldn’t carry the baby around all the time. My wife did this well. We’ve also had a cry-baby. She did it well. She gave it to me in the evening and that was good. Then it continued crying with me. Then she could take relief, [she] went away, did things. And yes, that’s how I also did this.” [Torben, German paediatrician, Q-52]

“I guess I see some psychological threats, if, well, the mother goes through some kind of… stressful time connected with a tough family situation for example. […] I encourage mutual support between spouses.” [Wiktor, Polish paediatrician, Q-53]

The perception of mothers’ overprotection being ‘risky’ was also informed by the concern that a mother’s intensive investment in her child would come at the cost of her investment in her spouse relationship, and in the limited space left for a father to be engaged with his child. The latter was reflected to a strong degree in the
account of several of the Dutch and Polish professionals, and not as much in the accounts of the German professionals.

“We’re often scared of such situations that mom gives birth to a baby and this baby becomes number one, right. [...] If we’re not in a good relation with the father [...] the child will always sense it, right?“ [Danuta, Polish paediatrician, Q-55]

“I very much point out that..., they often find it funny when I say this, but I say it in almost all families, that you should not put your child first, but your husband or wife comes first and the baby comes second. Because when your relationship is going well, your baby is well. And when your relationship is not going well anymore, you can’t hide it for your baby. [...] And they have mostly never thought about this. They throw themselves, especially those mothers, they throw themselves on the baby. And you can already see this father shrinking back.” [Idelette, Dutch postpartum care assistant, Q-56]

As we have seen in the previous section, mothers’ not prioritizing their children above other things, and especially their babies, was thus on the one hand framed as a risk by the majority of the professionals in this study, while it was found at the same time that placing their babies above their own needs, above their spouse relationships and above fathers’ roles was also framed as a risk, mainly by Dutch and to a lesser extent Polish, professionals.

In a broader sense, it was found across the data set that the professionals’ often presented mothers’ and fathers’ roles as supplementing one another.

“The mother should be this person who provides warmth and care, and the father is more for concrete things, for setting limits, and this should of course be adequately balanced, meaning the mother should restrain the father’s efforts to set limits and the father should restrain this overprotective care.” [Janek, Polish paediatrician, Q-56]

Hence, perceived gender-specific risks could be balanced out within the family unit, and thereby came to be related to gender-specific responsibilities for parents.

6.2.1.3 Conclusion

Ideal types about risky parenting were often coherent across the countries in this study, suggesting that these generalized forms of knowledge were overall not largely dependent on cross-nationally different institutions and/ or cultural values.
The main distinction that could be made was between improper care as presented by midwives and postpartum care assistants, focused on physical care for a baby, and improper care as presented by paediatricians and nurses, focused on child raising (on which I have not focused in this chapter). My findings indicate that the perception of improper care for babies was mostly related to mothers and/or to parents in general, and in some occasions to fathers not being competent. The focus on mothers rather than parents was strongest in the accounts of the Polish professionals. According to Douglas and Wildavsky (1982; see also Douglas 1992), risk and responsibility are connected because they follow from the same cultural constructions. We could therefore see that framing risks for babies in terms of physical care and in terms of spending time with the baby easily translated in parents’, and often mothers’, responsibilities to invest in becoming competent.

While this partly reflected ‘intensive parenting’, and more specifically ‘intensive mothering’ ideology, it also diverged because professionals emphasized (in)safety in technical aspects of physical care, and because it was not so much an increased intensity that professionals promoted and were concerned about, but it was rather their perception of an increasing amount of distractions in contemporary societies they were concerned about. Especially Dutch and Polish professionals felt that mothers’, and families’, caregiving roles in the early stages of a child’s life were under strain. ‘Intensive parenting’ and ‘intensive mothering’ ideologies were most strongly contested by a majority of the professionals (apart from Dutch and German midwives) through the framing of overprotection as a clear risk to children’s autonomy, mothers’ health and well-being and fathers’ involvement. Here, a (potentially) more problematic relationship was suggested between mothers and caregiving or child raising.

These findings have therefore shed light on professionals’ reflexivity and experienced-based knowledge, as we have also seen in the previous chapter. Rather than simply incorporating and conveying specific parenting ideologies, the professionals appeared to be knowledgeable about the diverse (and sometimes adverse) effects of intensive approaches to parenting and to mothering, and we could thus see that healthcare policies (stimulating attachment relationships) and parenting ideologies came to be intertwined with on the one hand professionals’
taken for granted gender norms about mothers’ primary roles, and on the other hand with their more nuanced everyday experiences. In the next section, I examine the context-specific framing of parents’, mothers’ and fathers’ diverse and sometimes competing roles and responsibilities with further scrutiny.

6.2.2 Gendered responsibilities: mothers’ and fathers’ caring and working roles and divisions of tasks

In this data set, cross-national similarities and differences were found in how professionals saw mothers and fathers fitting into their ideal-typical knowledge regarding ‘safe parenting’. With this term, I refer to the responsibilities that professionals ascribed to parents and what in their view constituted important, necessary, ‘good enough’ and/or potentially fruitful practices of parenting, hence what children needed from their parents and what parents did well and/or ideally should (learn to) do or come close to doing. In these ideal types, cultural gender norms were found to interact strongly with healthcare policies in context-specific ways, as is shown in this section.

The data in this study also reflects ideal-typical knowledge about ‘safe sharing’ of care in relation to paid work, in the sense of professionals making more explicit what a mother, a father and/or a family should or could do in (combining) work and care. These perceptions appeared to be less central to professionals’ tasks conceptions, less structured and more implicitly present in their everyday work. Accordingly, more heterogeneity and conflict in ideal types between professionals and within interviews was found, in which different models could easily compete and exist parallel to each other for individual professionals. This can be demonstrated by a Dutch nurse who presented rather conflicting models of dividing work and care between fathers and mothers, while describing them all as ideal:

“I like it a lot when a mother for example wants to pursue an education or something, when she has never studied before. That’s just that I’m thinking: wow, I would, I like that, when she, well wants to develop herself further. And I always like to ask: ‘ok, what do you want to do, what are you thinking of? Just to chat about this for a while.’”

“[...] You see, for me it would be ideal when a father and a mother both, so to speak, would be at home and would work for example. But for someone else it’s very ideal
when a mother is always there for the children alone and the father takes care of the income. So that’s just not up to me... to say something about that.”

[...]

“I sometimes also have mothers of course who are just at home, who are housewives. Well, I personally don’t find this a problem at all. That’s also my personal norm, that I’m like: wonderful for the child, it gets all the attention. And mother is satisfied with it. [...] I only find it positive I must say, when a child can get complete attention at home. Yes.” [Marloes, Dutch nurse, Q-57]

The above excerpts, provided within one interview, thus show depictions of stimulating mothers’ professional development; gender equality and the ideal of fathers and mothers sharing working and caring tasks; and intensive mothering ideology. It has been argued that when ideologies that include noticeable practices and routines change, individuals are affected by several of such ideologies and contradictions, translated into conflicting emotional norms (Tonkens 2012). The parallel support for and acceptance of different models and parenting roles at the same time provided latitude for individual parents (as well as professionals) to navigate different choices and opportunities, which could for example leave space for fathers’ potential involvement in caregiving, but also for the opposite in the sense of mothers providing the main caring tasks.

Accordingly, several professionals in all three countries claimed there was no protocol for safe ways of sharing and distributing work and care and the professionals varied in whether they framed this as a theme falling within the reach of their work. As visible in the excerpts above, many professionals distinguished between what they personally found important and favourable and what they expected or stimulated mothers and fathers to do, as a way to deal with conflicting emotional norms. At the same time, this meant that family policy-related institutional opportunities and constraints were taken into account, while professionals on the other hand granting parents a higher level of autonomy compared to when it came to risk and ‘safe parenting’ ideal types. In this section, I show for the professionals in each country-context how these perceptions of parents’ responsibilities were reflected and intertwined.
6.2.2.1 Dutch professionals’ ideal types: inclusive parenting roles and mothers’ taken for granted responsibilities in reconciling work and care

**Safe parenting: inclusive parenting roles**

The majority of the professionals used general expressions of ‘parents’ or ‘a parent’, implicitly or explicitly assuming that this role and these tasks could apply to mothers as well as fathers, or other caregivers. In such a frame, the child’s needs were put central in relation to a caregiver – be it a man or a woman, or left blank which caregiver – who was to provide the child with what it needed. As was shown in chapter 4 however, ‘gender neutral’ approaches to parenting can also be perceived as assuming and reproducing taken for granted gendered parenting norms and practices (Daly 2013) or exist parallel to gendered role depictions. In this study, the professional respondents were in many cases prompted to make taken for granted perceptions of parents, mothers and fathers explicit.

The Dutch professionals most often and consistently used inclusive terms in representing a set of basic characteristics that would ensure ‘safe’ parenting practices and they mainly referred to ‘parents’ when they stressed the importance of providing children with: love, safety, attention, sensitivity, and protection. Hence, the Dutch professionals most clearly reflected a ‘shared parenting’ narrative (see Kremer 2010).

*Interviewer:* “Can you give an example of good parenting in practice?”
*Ellen:* “A good one? Well, I think it’s good parenting when parents are sensitive, so adapting to their child’s need. Warmth and love in fact. And you can come up with many things related to this; safety, well, basic needs. But I think that when there is warmth and love, and attention, [the other things] automatically follow so to speak”

[Ellen, Dutch paediatrician – Q-58]

Several of the Dutch nurses used the word ‘nest’ as a metaphor in which notions of safety and domesticity were combined. Interestingly, they remained consistent in including both mothers and fathers when they illustrated the centrality of the home.

*Interviewer:* “Can you give an example of good parenting in practice?”
*Ireen:* “Yes. […] I think it’s good when the child is in a safe, warm... yes, grows up in a safe nest; then it’s already good. And safe; I don’t just mean that it can’t hurt itself, but also that a child does get the space to develop and can climb now and then, and when it bumps itself, that it runs to father or mother, or another caregiver, that’s
also possible of course, to seek comfort. You know, safety is a very open concept.”
[Ireen, Dutch nurse, Q-59]

This image of domesticity thus reflected a more open perception of providing children with shelter and was in most cases not exclusively related to mothers in contrast to what has previously been argued about Dutch cultural values of domesticity (Kloek 2010, Van den Berg and Duyvendak 2012), but rather to safety in the sense of attachment to a central caregiver.

Interviewer: “What are the main aims in your job?”
Esma: “I think the well-being of the children. That they are thriving well, that they’re doing well, feel comfortable in their skin, and especially that they are lovingly raised, I think. [...] I think such a child [...] is in a... yes, in a good nest so to speak. [...] And I think attachment is important, that they do have at least one person they are well attached to and whom they can depend on. You sometimes have families where one parent for example is not mentally well, or... one parent who is absent or... one parent who has problems, like alcohol or whatever it is. That’s of course troublesome, but when the other parent takes over, I think a child can also grow up fine.” [Esma, Dutch nurse, Q-60]

Alongside more inclusive ideal types of ‘safe’ parenting, the professionals in this study also ascribed more exclusive roles to mothers and fathers. This was however less strong and coherent for the Dutch professionals, also when it came to caring for babies. Some of the Dutch midwives, although not coherently, expressed a clearer task division between mothers and fathers. Mia did this for instance while using the previously mentioned metaphor of the ‘nest’ in a more gendered way.

Interviewer: “How do you see mothers and fathers in their role as caregiver? How does this differ?
Mia: “Mothers and fathers? Well, in general, mothers have naturally the nurturing role, because things are also happening with them bodily. And fathers don’t have this as much, bodily informed. So that’s a big difference in general. And apart from this, it’s also innate to a man and woman how you take on the caring role, right [...] mothers – this also relates to the bodily [aspect] – are much more for direct nurturing, in general, and the fathers much more for... taking care of a good environment right, so for the nest.” [Mia, Dutch midwife, Q-61]

This depiction of mothers’ and fathers’ roles does reflect a biophysical focus that was more central to the midwifery profession when compared to the other professions. Other Dutch professionals’ depictions of mothers’ and fathers’ roles appeared to be not as distinctive.
Interviewer: “How do you see mothers and fathers in their role as caregiver, and does this differ?”
Els: “What’s only important to me is: are you involved with your child, do you deal with it in a loving way, do you respect it? And whether you are a father or a mother doesn’t matter that much.” [Els, Dutch nurse, Q-62]

Interviewer: “Do you, as a postpartum care assistant, have expectations of parents?”
Idelette: “Yes, I expect them to take good care of their baby.”
Interviewer: “And what does this mean; and what does it mean for fathers and what for mothers?”
Idelette: “It means the same for both.” [Idelette, Dutch postpartum care assistant, Q-63]

In caring for babies after childbirth, the main emphasis in Dutch professionals’ ideal-typical knowledge was on mutuality between parents as well. The perceived stronger physical ties between mother and child that were brought to the fore did in these cases not exclude fathers’ involvement.

“When the people are like: “do I have enough things in the house?’, I say: when you have two breasts and four loving hands, there is enough.” [Leen, Dutch postpartum care assistant, Q-64]

“It’s [...] good to get used to one another as a family and to see like, well what’s the rhythm we have together [...] for people to think about this at least. So it’s not about the woman who alone finds her rhythm with the child, but that the man is also important in this, you know. That you, so to speak, need to get used to one another as a family. [...] A child just needs shelter, and well, this is not necessarily through a bottle from daddy, but that’s just lying with daddy, you know. [...] I always say: well, for a child it’s much nicer to just lie with daddy on his naked chest, you know, when you want to do something that’s really good, it’s that. And these are of course all things... things that stimulate a piece of attachment; this way you try to pay attention to that.” [Joan, Dutch midwife, Q-65]

As shown in the last excerpt, some of the Dutch midwives and postpartum care assistants argued against parents who wanted to introduce formula feeding to enhance the father’s attachment relationship to the baby, while using their expert knowledge to provide families with the alternative of skin-to-skin contact. In this way, they were able to support both breastfeeding and fathers’ (physical) attachment to their child. Hence, although the Dutch professionals were generally reflexive about perceived (biophysical) differences between mothers and fathers, they either used inclusive responsibilities in caregiving that applied to both parents, or they tried to make sense of perceived differences and ascribed specific tasks to both mothers and fathers, in line with was perceived as salient in Dutch healthcare policies.
Gendered responsibilities in balancing caregiving and work quickly after birth

Interestingly, the Dutch professionals assumed a much stronger role for mothers when it came to how parents combined working and caring tasks than was apparent in the rather inclusive parenting frames. For the Dutch professionals in this study, taking mothers’ exclusive responsibilities in care for granted thus especially came to the fore in relation to parents’ work- and care divisions. Many of the Dutch professionals perceived tensions between a family policy focus on dual-working with limited paid leave opportunities (10-12 weeks after birth for mothers and two days for fathers) on the one hand, and children’s needs as well as parents’, mothers’ and fathers’ difficulties to provide (enough) care and to balance different tasks on the other hand. These tensions therefore very much reflected the tensions between Dutch family policy and healthcare institutions as analysed in chapter 4 (see page 129).

“I think many parents think they need to do many things at the same time. [...] I think the challenge is for everyone [...] that you keep finding a balance: that you take sufficient care of yourself, take sufficient care of your relationship, and take sufficient care of your child or children. And I’m not sure whether all parents manage to find this balance, and that the emphasis is perhaps very much on work, career and things outside of the house.” [Thea, Dutch paediatrician, Q-66]

For most of the midwives and postpartum care assistants, mothers’ limited options to recover after birth and provide care after the first months were presented as most urgent, although professionals also showed awareness of fathers’ limited opportunities to take leave or to work less.

“You see, what we have is just too short, is really too short. Mother and child really need to be together for the first year. [...] Employers also don’t cooperate, right. Because when women do choose [to work] for two days [per week] for example, there is also no opportunity for that. [...] Most employers then say: you don’t have enough connection to the company, so three days minimal, not less. [...] And also for a man; it used to be only two days, and now they have [...] now it’s going to four days, right? And how long have we been talking about this? [...] Sometimes the man does want to [work less], but the employer doesn’t want it, is making it difficult, you know. So yes, in this time of [economic] crisis, you don’t have such a big mouth.” [Evelien, Dutch postpartum care assistant, Q-67]

In many occasions, professionals reflected on parents’ practical challenges in dividing and distributing work and care in relation to family policies and economic and labour market conditions, thereby depicting a collaborative and negotiating model of care
they had experiences with. When prompted further however, as shown in the above quote, they often placed a much stronger emphasis on one-on-one parental care, as being under strain. In these instances, gender norms of mother-child relationships came to the fore much more clearly, complemented with ‘shared parenting’ norms.

“Those first two years are actually a blueprint for the rest of your life. And when you see that parental leave is so short that… most mothers stop breastfeeding the moment they return to work; there are many burnouts afterwards; I think the government is absolutely not supportive. [...] I always say: when you think it’s too short, you should report yourself as ill. It’s a great pity, but that’s the way it is in the Netherlands. [...] So there should be much more, much longer leave. In any case for mothers, but also for fathers. Because when fathers have much longer leave, they also immediately feel involved with child raising, without the financial pressure that everything will go wrong.” [Mia, Dutch midwife, Q-68]

Hence, these one-on-one parental responsibilities (rather than collaborative distributions of care with external childcare forms) especially came to the fore in the construction of children’s first years as ‘vulnerable’ and salient to their later life (see Giddens 1991; Macvarish et al 2014). Whereas some of the Dutch professionals at first related to the parents’ pragmatic challenges and the perceived opportunities in the Dutch context, they more clearly envisioned models that allowed for a longer period of leave for both parents as much more ideal, when the international research design of this study was outlined by the end of the interview,

Well, the leave policies that can be improved in the Netherlands are that a man has only got two days and a woman does have the 16 weeks leave, which is of course bizarre. And it would perhaps be nicer to move in the direction of a German or Scandinavian model, in which there are just so many days leave that can be divided between men and women. This would produce a fairer division, and I also think a more equal bond with your child.” [Marijke, Dutch paediatrician, Q-69]

What this shows is that gender norms about parents’ responsibilities came to be intertwined with and attuned towards the family policy, labour market and economic context in professionals’ ideal-typical knowledge. However, gender norms about mothers’ more central roles were at the same time translated in supporting mothers much more than fathers to deal with the perceived pressure to work from a few months after birth onwards and the need to provide and arrange care on the other hand. Hence, in many occasions during pregnancy, in the postpartum period, in the first months (more structurally) and in the first years (when concerns would arise),
many of the Dutch professionals mentioned to talk with mothers about pragmatic problems in the early-on combination of work and care.

“‘How many hours do you work and is this going to work out with breastfeeding when you return to work, how will you do that?’ These sorts of things I ask. And: ‘are you going to make it, how will it be?’ And when they’ve started working: ‘how is it going, is it all going well?’” [Esma, Dutch nurse, Q-70]

We can see here that family policies and healthcare structures – with a consult around the time that mothers’ leave ends – coincided.

"As paediatricians, we have a ‘3 months consultation’, and three months is of course often such a period in which mothers’ leave ends a bit. And sometimes when there is time, and the conversation is going well, I’m inclined to ask: ‘gee, are you returning to work soon? And how are you going to do it? Do you dread to bring your child... is your child going to day care and do you dread to bring him away?’ In order to chat a bit about: how are you going to fill it in, and to get a bit of a picture of how the care division will be when you’re working again.” [Marijke, Dutch paediatrician, Q-71]

However, while the majority of the Dutch professionals expressed they were not as active in discussing work- and care constraints and opportunities with fathers, it was common knowledge in their accounts that since the last decade an increasing part of the Dutch fathers stayed one ‘daddy day’ at home to care for their child, either through working four days of nine or eight hours, or through parental leave. Fathers’ weekly involvement in care was in this sense very much appreciated and perceived as an important means – for those who could arrange this – to overcome the tensions between working and caring arrangements within families, as well as to limit the amount of days that children attended day care over the week.

“In general, [parents] can work it out in good agreement. But it is compromising, how they solve it; it’s always compromising. [...] [They] adjust parental leaves with the days right, in order to need as little day care as possible, so that not four days, but only two days of day care are left. They’re working towards their child needing to attend there as little as possible. But that’s when they both have the opportunity to take parental leave. When you don’t have this, you really are going to need to bring your child four or five days to day care. And already from 10 weeks after the delivery onwards.” [Els, Dutch nurse, Q-72]

“And sometimes [men] can arrange it and they do indeed take this extra day off, they take this [...] daddy day, right [for the child to] attend day care less often, right. Then they really have it planned: on Monday grandpa and grandma, Tuesday daddy day, Wednesday mummy, and so it alternates a bit.” [Evelien, Dutch postpartum care assistant, Q-73]
Notions of ‘safe sharing’ of work and care according to the Dutch professionals were thus strongly informed by the Dutch family policy context, while cultural values about mothers’ and fathers’ roles and professional knowledge about children’s health and well-being were applied when assessing ‘the child care puzzle’ (Knijn 2004; Verweij and Reimann 2016) that followed from limited paid leave and a focus on dual working. Most of the professionals were receptive to this puzzle and the related struggles when it came to mothers, and much less when it came to fathers. Yet, fathers were at the same time increasingly perceived as having a function in solving the puzzle.

“I shall perhaps in a specific situation, when a child is very restless and has difficulties, discuss with parents: ‘but well, but how much are you working and is it an idea maybe to arrange different childcare? Or a paid individual childcare instead of day care, which is more of a one-on-one relationship, or a bit less busy, or perhaps a family member. Or could mother maybe work a day less, or could father maybe work a day less? Or can parental leave be taken up?’” [Jonita, Dutch nurse, Q-74]

The integration of fathers’ roles in parents’ distribution of care was especially apparent in (but not limited to) the accounts of a few of the younger Dutch professionals, such as the Dutch nurse in the quote above.

6.2.2.2 German professionals’ ideal types: exclusive mothering roles and mothers’ difficulties to be employed

Inclusive parenting frames and mothers’ unparalleled roles

As was found for the Dutch professionals, many of the German professionals, especially the paediatricians, also ascribed central tasks to mothers as well as fathers, which mainly centred around: responding to a child’s needs and raising it well.

Interviewer: “What is a good mother to you, and what is a good father?”
Sonja: [...] Mh. So a good mother is on the one hand caring for the child: psychologically, in nursing, and in nourishment as well, yes. So that everything... that the NEEDS of the CHILD are addressed, so to speak. But a good mother also needs to set certain limits, which is also very important, to be capable of raising a child. [...] Principally, this is exactly the same for the father [laughs].” [Sonja, German paediatrician, respondent’s emphasis, Q-75]

Interviewer: "What do you think is a good mother and what is a good father?"
Gerhard: [...] A good father or a good mother is the one who responds rightly in most cases, who brings a certain intuition with which nature has endowed him, and
perhaps also his own socialization, as the case may be. That he can adequately deal with the child. Then he is a good father or a good mother. And when he succeeds in giving the child a framework in which it can orient itself [...] this big wide world: we will now see what suits you best. What are all these swift images and shrill colours? We will look for what you appreciate. That’s I think the EDUCATIONAL TASK that is behind it ... good father good mother, yes, then it’s well done.” [Gerhard, German paediatrician, respondent’s emphasis, Q-76]

These two excerpts show an interesting contrast in which Sonja, as a female paediatrician who in other occasions in the interview referred to her own experiences as a mother, started with a ‘good mother’ and emphasized the child’s needs, and in which Gerhard, as a male paediatrician who close to this part of the interview referred to his own experiences as a father, started with a ‘good father’ and emphasizes educating the child. This contrast in emphasis, as was also found in other instances in the data, reflects relations between these professionals’ perception of parenting and their own gendered experiences. What was shared in these and in several of the German interviews however was an underlying general frame of what was believed to be important for children and what this required from a parent, both a father and a mother, in which on the one hand sensitivity and closeness and on the other hand socialization and guidance was stressed.

Several of the German professionals at the same time expressed more exclusive notions of mothers’ unparalleled roles, that have been framed as “romanticized maternalism” (Michel 2012, p.24, cited by Lutz 2015, p.343), while such notions were much less reflected in the accounts of the Dutch professionals. The German midwives emphasized in this sense a special ‘mother-child bond’, as intertwined with breastfeeding.

“But when a woman is breastfeeding, she already has a lot of contact with the child. [...] So I really consider [breastfeeding] now as work, a new job, a new work field. [...] Also in what a child’s needs are; communication, this nonverbal communication. This is also very important, to recognize when a child cries and how the child cries. And this upbringing, as is now classically seen, happens in the first months and in the first year, actually unconscious, through the interaction between mother and child.” [Isabella, German midwife, Q-77]

Interviewer: “And after birth, do women have entirely different tasks than men? Is it then also divided that much [as during the delivery]?”
Gerda: “Well, do you mean that now, out of [laughs]?”
Interviewer: “Yes.”
Gerda: “So the women normally breastfeed the children. This is a very, very close relationship with the children, as before. So, I think the child is no longer in the belly,
it’s indeed out, but through breastfeeding it’s a very, very close relationship between the mother and the child.” [Gerda, German midwife, Q-78]

Josefine, a German midwife who recently finished her midwifery education suggested that the centrality of mothers in the first stages of parenting was reflected in how midwives were trained.

“[Midwifery education] was always primarily only about the women. [...] Men, families were never really thematised that much. It was actually really about the women and the child.” [Josefine, German midwife, Q-79]

Cultural values in the German context about a strong role for mothers (Vinken 2001; Dechant and Rinklage 2016) could also be found in how some of the German professionals claimed to support mothers in dealing with the high expectations regarding their roles.

“It is important to know that there is not a perfect, a perfect mother. It’s always important to downsize this claim” [Gerhard, German paediatrician, Q-80]

“And I am learning for myself just as a mother, and that is what I try to convey, to all the others, all women I care for: we are the mother we can be, in the situation where we are. And we are good enough.” [Isabella, German midwife, Q-81]

The more exclusive focus on mothers’ roles, especially in the early stages, suggested less space for fathers’ roles and responsibilities in ideal-typical knowledge of the German professionals. One of the younger German midwives, who also said to aim for sharing caregiving tasks with her partner herself, challenged the strong exclusive mother-child bond narrative and did stress the salience of a father-child bond.

“It’s just as important to me that fathers develop an emotional bond [...] There is no mother instinct or natural intuition, but a capacity to see someone, and wanting to do this. Of course, when I’m often home with the child, I know it a little better.” [Clara, German midwife, Q-82]

While this was a more exceptional stand within the German data, at other instances some of the German professionals combined a biophysical and natural focus on gender differences with a less strict and more pragmatic approach, allowing for a degree of exchange between mothers and fathers.
Interviewer: “Do you think that there are certain tasks for the mother and certain tasks the father can only do?”
Johan: “Not necessarily, no. So that can certainly be divided. So, whoever stays at home in the beginning, I think it’s more natural when - there are also fathers who stay at home from the beginning and the woman goes back to work immediately - this is of course not necessarily according to nature. The mother, in the normal situation, is breastfeeding the child. Then, of course, it makes sense the mother is with the child the first months. But otherwise, I believe, this can all be distributed as desired. [...] Nowadays, there is little gender separation. So, I think the transitions are fluid.”
[Gerhard, German paediatrician, Q-83].

However, ascribing responsibility to fathers and depicting an active fathering role directly after birth was much less pronounced in the German professionals’ accounts than in the Dutch and Polish professionals’ accounts, while the framing of a natural and exclusive mothering role was stronger in the German interviews than in the Dutch interviews. Especially among the German midwives, it was more clearly suggested that mothers’ exclusive roles left little space for fathers’ active involvement in childcare.

“My husband [...] said at some point: ‘you know, as a man, you actually have no chance. [The child] won’t be calmed down.’ [...] With children who are exclusively breastfed, that’s often the case. Fathers sometimes don’t have a chance to calm the children, because it is the breast that calms them” [Isabella, German midwife, Q-84]

Acceptance of mothers’ work and perceived difficulties to combine this with care
Others have shown that this image of mothers is consistent with cultural values in Germany about mothers’ work, in which working mothers are easily disapproved of, as ‘raven mothers’ abandoning their children (Dechant and Rinklage 2016). The German professionals in this study however appeared to be much more open to and supportive of mothers’ decisions in terms of work and career, in line with a focus brought to the fore by the majority of the German professionals on supporting and reinforcing mothers’ aspirations.

"My first principle is the strengthening – and I even believe the empowerment aspect – of the woman above all, so also a certain feminist claim. Yes, that women in their womanhood, in their motherhood are strengthened by me, but above all in their own individuality. " [Clara, German midwife, Q-85]

The positive approach to strengthening mothers provided space for supporting mothers’ choices in work and career development.
Interviewer: “Do you personally have a certain idea of what is a good mother and a good father?”

Gerda: “No, [...] I think you cannot say what is good now and what is bad. Since everyone comes with their own beliefs ... what she imagines, what she likes to do. Of course, roles you know from childhood play a role. But also demands in the job, yes, and your own demands. Many women are nowadays also very ambitious, and not only ambitious, they also enjoy their job, and also don’t just want to be a mother, and I think that’s completely ok. But some say: ‘no, I have really been looking forward to this, and I want to dedicate myself to this child, and spend a lot of time with him, or spend a lot of time with her.’ And that’s also ok. Yes.” [Gerda, German midwife, Q-86]

One of the German paediatricians, who also expressed concerns about mothers’ part-time rather than full-time jobs, was most outspoken about mothers’ work not being in conflict with caring for children.

“It’s one thing to strengthen families and to give them the opportunity to provide children with a good home. This does not mean however that the mothers should not work, so that does not contradict itself at all, and it is very much presented as a contradiction.” [Marianne, German paediatrician, Q-87]

Similar to what was expressed by the Dutch professionals, a dominant pattern was found in the German accounts in which the professionals focused on mothers rather than fathers in combining roles, thus supporting mothers in positioning themselves between their working and caring roles. While German midwives talked more often about whether a mother wanted to return to work or not, supporting that decision, German paediatricians on the other hand – similar to Dutch paediatricians and nurses – focused more strongly on mothers combining working and caring tasks after parental leave had ended.

“It’s very clear that when it comes to returning to work, one should express everything in a very positive way to the parents. I would never say to any parent: "Go ... rather take care of your child." You have to frame it more positively, in the end: ‘look for help’, so to speak. Also show parents the various opportunities; displaying for example how childcare provision goes; how to follow a workday routine, in combination with coming back peacefully [laughs]; with ... with the job and the everyday life and the children. So, to convey this rather positively, because most of them have to [work]. But also, the other way around, right; there are also women who quit, and that’s also all right. Yes. So, strengthening positively what the mothers want. [...] Times have changed. You simply have to see that as well.” [Sonja, German paediatrician, Q-88]
Negotiating how much mothers worked, let alone fathers, was not a theme that was presented in ideal-typical knowledge of the German professionals, pointing to the relevance of the institutional context in how professionals perceived and dealt with sharing of working and caring tasks. This was also reflected by the fact that for the German professionals, dual working and dividing and arranging care was found to be less pressing in the first year after birth for the majority of parents, in line with German family policies that provide parents with a year of paid parental leave. Some of the German midwives suggested that since paid parental leave was brought back to one year instead of three years after policy reforms, returning to work itself was less of a choice for women and therefore less of a negotiation.

“In my view, we as women do not really have freedom of choice. [...] The pressure on women is first to stay at home […], so the pressure to stop working, because you get Elterngeld, and then, after a year, to work again, because then the money is missing […]. So, no, I think women don’t have real freedom anymore at the moment. […] They seldom look at: What do I really want? What will do the child good?” [Isabella, German midwife, Q-89]

While mothers returning to work a year after birth was perceived as common practice and the German professionals were generally found to be supportive of mothers’ work, there were rather few instances in the German data set in which fathers’ decreasing working hours were discussed, as part of the professionals’ ideal-typical knowledge of parents’ opportunities, or as a topic they discussed with fathers. Hence, parental leave, in principle equally accessible to mothers and fathers, was generally perceived and used by the professionals as leave for mothers, as an extension of maternity leave.

Interviewer: “I can imagine that when they get pregnant, every woman asks the question: Ok, what will it be: am I now going to spend more time with the child, or am I going back to work. Is this discussed with you?”
Gerda: “Yes, I believe this is discussed. Most have already made some decision, but one talks a lot of course also in birth preparation, so there are several couples with whom this is discussed, or in a conversation of course. So, most of them decide to stay home for about a year, so parental leave for a year maximum; I think that’s the majority. And a few really take this period of 8 weeks after the birth and return to work then, return immediately.” [Gerda, German midwife, Q-90]

This midwife confirmed the interviewer’s suggestion that mothers made a decision between spending time with their child and returning to work, and continues by automatically relating this decision to mothers taking parental leave for the fully
paid period of one year. As was also seen in the other interviews and observations, she did this without referring to fathers taking up (a part of) parental leave. A small part of the German professionals expressed very different experiences and reported that many fathers did take up a part of parental leave:

Interviewer: "And what about the men after birth; do you experience that many men say: ‘Yes, I’m taking parental leave’?"
Jana: “Yes, increasingly. So [there are] in any case more and more very sweet and passionate daddies, proud daddies, daddies in love. So parental leave is really a step forward. There are also many impossible and crappy moments during parental leave [laughs], but it is basically a very, very important time, for the men to simply also experience this bonding, right. I think that for the relationship and for parenthood, this is a great benefit, what’s possible nowadays.”
Interviewer: “Can you say: such and such is the average time that is taken up?”
Jana: “So I have the impression [that] some take three months, or two months and one month. So that’s this model, to be honest I don’t know this so well, [but] many do this. And there are also a few who say: ‘I’m taking half a year’. Only a few, but ... these two, three months, quite a lot of them do this.”
Interviewer: “And how long do women stay at home on average?”
Jana: “One year.” [Jana, German midwife, Q-91]

It is interesting to note that this midwife, who was much more aware of and explicit about fathers’ opportunities to take parental leave early-on than others, also expressed that she did not know exactly what ‘model’ was involved. Considering that she referred to a model of ‘one, two or three months’, it can be assumed that she talked about the two months that only fathers are entitled to in the German parental leave policy, especially because she also stated that in her experience, mothers usually took up one year, which reflects the period that can be used by either of the parents. Other midwives suggested that fathers were most often only at home for the first weeks.

“This new world citizen simply demands full attention, and that’s the challenge. And if the partner then ... He possibly has three weeks’ vacation, and it all works in this period. He does the shopping, wraps the child, ensures the mother is supplied. But this all collapses after the three weeks.” [Isabella, German midwife, Q-92]

In any case, we can see here that when the German professionals did discuss fathers’ involvement in care at the cost of his work, this was focused on the period directly after birth when mothers were also on leave, either in terms of fathers’ bonding or in terms of fathers’ helping out after the child was born. In contrast to what was found to some degree in how the Dutch professionals perceived a ‘daddy
day’, the German professionals hardly perceived parental leave for fathers as a means to bridge tensions between work and care, or as a solution in finding a work-family balance after mothers’ return to work. This is interesting, because the analysis of family policy and healthcare institutions in chapter 4 suggests that tensions between healthcare knowledge and cultural values concerning child development and gender equality in the German context can especially be expected for the period after mothers’ leave ends.

While the latest reforms of German parental leave in 2017 (see chapter 4, page 109) actually do address a longer period and aim for fathers to use and spread out leave, the data in this study gathered before that reform suggests that although mothers’ employment was supported by the majority of the German professionals, it was at the same time perceived as difficult to realize in practice. The first perceived barrier to mother’s employment concerned the fact that fathers were seen as occupied with work and career.

“[…] I have the impression [...] that it’s still the case that more men pursue their professional career, also with children, than women. So, women pursue this as well, but less so when it comes to spending time; they certainly make less of a career because of child-related reasons. [...] If you want to make a career and want to have children, you need a man at home who takes care of everything. And who gives up on his career. That’s what it takes, but that’s the exception.” [Jana, German midwife, Q-93]

Many of the paediatricians and midwives pointed out that men were especially focused on and expected to be breadwinners in the city in Germany in which these professionals worked.

"If a man works a lot, what most men in [name city] do here..., then in fact I often also don’t see where it ends. [...] If I take my husband: he wants to be there for his children, but he also has the pressure to be a breadwinner. And I believe, I believe he simply, he simply wants to be there. But that’s also difficult." [Isabella, German midwife, Q-94]

The breadwinner norm for fathers appeared to be especially strong in the German professionals’ accounts, compared to the Dutch and Polish professionals’ accounts. As suggested in the above quote, and by other German professionals, the German city (as an important financial district) where this study was performed appeared to be perceived as a-typical, with a particularly strong emphasis on men as
breadwinners. Dominant depictions of ‘masculinities’ (Connell and Messerschmidt 2005) could therefore be different in this city compared to in other areas in Germany. At the same time, some of the German professionals referred to a strong breadwinner practice in relation to Germany more broadly.

"It's just the first year after birth, I think it's very tensed ... [...] So how will it be for the women after birth? [...] It’s not always the case, but I still think in Germany, worlds are separating a bit, the man's world and the woman’s world. In my impression, that’s really very strong in Germany. I have experienced this differently in other countries, such as England, the Netherlands or France. I think it’s very – it sometimes still surprises me - but very traditional. " [Gerda, German midwife, Q-95]

Hence, many of the German professionals, in particular the midwives, highlighted how a breadwinner norm complicated fathers’ involvement in care as well as mothers’ employment. The second barrier that the German professionals, especially the German paediatricians who also saw parents in the years after parental leave, reflected on concerned day care not providing a suitable alternative to parental care. Perceived risks of infections and a lack of attention due to the staff-child ratio were framed as barriers to mothers’, and not fathers’, employment.

“Johan: "One knows that children have basic needs, which can certainly not be satisfied to that extent, when three educators are for instance available for twenty... or four educators for twenty-one-year-olds. [...] And it’s also a lot of stress for a child in day care. [...] Paediatricians, child neurologists and developmental neurologists also say that this is definitely not all good. And... one must really look specifically and see what the staff ratio for the children is in day care." Interviewer: "Probably only a few children have that perfect day care condition." Johan: "I think so, yes. These are often the private ones and they're really expensive. [...] And for a mother who doesn’t earn that much, or only works for 60 per cent; two thirds of the income is then gone. [...] So there are certainly some mothers who have to consider whether they are going to be working at all, because child care is expensive. “ [Johan, German paediatrician, Q-96]

‘How well are the caregivers emotionally attuned to these children, so they can recognize their needs at all – to also notice when the children are stressed, are overburdened, when they need attention, when they can be left to themselves and so on. These environmental factors are really decisive, really decisive in relation to the question whether it harms children or not. [...] [The quality of the care], that is really the big problem. We have relatively few settings where one can say that one can be really satisfied with the care. [...] This is a very serious ambivalence for parents, which is a very bad case for the women [...]” [Marianne, German paediatrician, Q-97]

The expected tensions for professionals and parents in the German context following contradictory cultural values and policies for the period after parental leave were thus indeed found to be relevant to the German professionals in this
study. We can see here how professionals’ support for mothers’ employment, and to some extent gender equality (which was strongly the case for Marianne, German paediatrician, who was also not negative about day care per se) contradicts with their valuing of exclusive (and often gendered) caregiving relationships, their knowledge of healthcare and scientific care standards which were perceived as barely reflected in the current childcare facilities, and their view on economic and labour market conditions. Whereas in the accounts of the Dutch paediatricians and nurses mothers’ working hours could easily be questioned, it was found that in the accounts of the German professionals mothers’ employment, or when/whether to return to employment, could easily be (implicitly) questioned.

"One often doesn’t have the time, and then of course always the employer in your neck as well. The child actually cannot be ill. That has already become difficult as well. And I’m a mother myself, I have two children, so I also say sometimes: ‘Oh, if only I wouldn’t have had the desire to work, it would have been much easier’ [laughs]. Everything is simply not optimally dissolved yet; day care is not optimally solved. Also in the case of illness, I think children want to have their mother, or their father, when they are ill. They don’t want to be cared for by someone else.” [Sonja, German paediatrician, Q-98]

“Increasingly, both parents are employed. From the point of view of the paediatrician, this is not always an advantage. In the period of early parenthood, also of early childhood, children are most often ill. When they attend day care early on, they are often ill. [...] This often leads to a lot of stress. Mothers usually start working again after one year. [In other countries even after half a year or three months.] I think that’s just too early. In everyday practice, the children who are most frequently ill are the day care children. [...] Every four or six weeks a child is ill. This causes stress. A mother said: ‘I’m reported ill for the third time in a row because of the child. My employer is getting nervous’. [Laughs] They are getting pressure from all sides. [When I would be asked for advice], I would first ask whether they need to earn the money. If so, you don’t need to go into it, because you only give parents a guilty conscience. If you honestly ask me for human advice, not necessarily as a doctor, I also have two children myself; my wife is at home, we practice the old model. A mother at home, it’s not so socially desirable, but it relaxes the entire situation. When a child is ill, there is no immediate vacuum.” [Johan, German paediatrician, Q-99]

What can be shown from the German data, as demonstrated above, is how cultural values and professionals’ knowledge about children’s development and mothers’ and fathers’ roles not only intersect with family policies, but also with healthcare structures. The fact that German paediatricians were also very much involved with treating children’s illnesses – as opposed to the Dutch paediatricians and nurses who only performed preventive examinations –, strongly informed their framing of parents finding a work-family balance in relation to children’s illnesses, and in that
sense, with parents that needed the paediatrician to write out forms in order to
claim leave from their employer, as is specific for the German context. While this
on the one hand informed paediatricians to question parents’ dual employment and
day care in relation to children’s health and associated stress within the family, they
dealt with this much more pragmatically in practice, as was reflected in the
interviews as well as in the observations. The same paediatrician who said earlier
that “a mother at home relaxes the entire situation” mentioned at the same time:

“When both parents work, each parent then gets ten days [sickness leave]. And then
they look for themselves how it fits. And often the father stays at home. So, I write out
forms, which can be split: for each day an extra sick report, so the parents can decide
who stays at home. Those who are employed often indeed share this, it’s not the case
that only the mother stays at home.” [Johan, German paediatrician, Q-100]

Hence, in everyday healthcare practices when it came to dealing with employment
and caring for ill children, parents were approached more pragmatically and fathers
did have a function in finding a work-family balance. This also shows that although
it was mothers’ employment in general that was (implicitly) questioned by some of
the professionals when children were often ill, this did not prevent them in concrete
cases from helping both parents to deal with everyday challenges in relation to
balance work and care in case of children’s illnesses.

6.2.2.3 Polish professionals: parallel perceptions of exclusive mothering roles and
fathers’ involvement in care

Negotiating mothers’ exclusive roles and fathers’ involvement in care

Many of the Polish professionals depicted the main parenting responsibilities,
emphasized for both mothers and fathers, in a similar way as was found in the
German professionals’ accounts, with a focus on being sensitive on the one hand
and properly raising and socializing children on the other hand.

Interviewer: “If you were to say, who is a good father and a good mother?”
Urszula: “A good father and a good mother. Hm. Loving parents, I guess that's what
it takes [...], a loving parent, but responsibly and critically, which means doesn't
allow for everything, doesn't give it all like this, but rather sets some boundaries in the
name of well understood well-being of the kid.” [Urszula, Polish paediatrician, Q-101]

Interviewer: [...] “What's important for a baby in your personal opinion?”
Urszula: [...] “Well, so they feel that they are loved, that parents devote time to them, explain them how the world works, they are close together, that's about it.” [Urszula, Polish paediatrician, Q-102]

As is shown in these excerpts, many of the Polish professionals stressed elements of devotion and priority, in relation to their experiences of stronger constraints to parents to spend time with their children, which can be understood from a stronger necessity for Polish parents to work full-time, for relatively many hours (Hobson and Fahlén 2009; see also chapter 4).

In the Polish accounts’ an essentialist and ‘romanticized’ displaying of mothers was found to be strongest, with professionals pointing to the mother-child bond, the role of the mother, maternal intuition and a matriarchal model stressing women’s roles in the broader (family) context.

“I guess mother is always good, she’s always the mother, if she’s good or if she’s bad, she’ll always be better or worse.” [Janina, Polish midwife, Q-103]

“I always believe that it's impossible that mother hurts her baby. It’s such a bond.” [Felcia, Polish paediatrician, Q-104]

“Every mother has the maternal instinct.” [Klaudia, Polish paediatrician, Q-105]

“To give women faith and power that they can give birth [...], they can be mothers; everything that happens in their lives is practically a thing inscribed into their nature.” [Zuzanna, Polish midwife, Q-106]

“Mothers talk with each other and are more intuitive and more flexible in taking information [...]. They used to have an aunt, a grandma, a cousin; it’s still a profit of these big families” [Stefana, Polish paediatricians, Q-107]

These depictions expressed by midwives and paediatricians reflected Polish cultural gender norms in which mothers were framed as being natural and central figures in the family (Hardt et al. 2011; see also chapter 4), potentially leaving less space for fathers’ parenting roles since equally strong depictions of fathers as essential figures were not found. Moreover, directly related to ‘safe parenting’ and children’s needs, the Polish professionals expressed the strongest focus on breastfeeding and nutrition, exclusively bound to mothers.

Interviewer: “Do you have examples of (future) parents’ behaviour that you would encourage”?
Janek: “Hmmm, well in the case of mothers it’s expressing milk above all from the first days, which we’ve been strongly promoting here from... basically from the very beginning the patient is here” [Janek, Polish paediatrician, Q-108]

Interviewer: “If you were to tell me what role do fathers and mothers play in childcare, do these roles differ according to your observations?”

Wiktory: “Well certainly when it comes to our patients because we very, very strongly promote exclusive breastfeeding and so the mother’s role is surely stronger, even if fathers feed their children with a bottle, because for the lactation to be effective this mother has to be close to her child. [...] The food is always the food of a mother.” [Wiktory, Polish paediatrician, Q-109]

“Mother is expected, even required, to breastfeed. [...] And here, hands down, the priority for a baby is food, so it has to be there.”[Tekli, Polish midwife, Q-110]

The strong emphasis on mothers breastfeeding could have been especially apparent because a large part of the Polish professionals worked in the hospital with premature babies, who can be seen as particularly vulnerable in terms of health.

Interestingly however, parallel to mothers’ roles the assertion of responsibilities to fathers was also strong and explicit in the Polish data, in terms of fathers supporting mothers emotionally and practically, but also in fathers’ own roles in providing care for their child.

“I think that one of the major fathering roles should- should be, against all appearances, supporting mothers, because it is mother with her dose of hormones and maternity instinct who does excellent with this child, is probably in the majority of cases able to handle the situation, however often has so many emotions and even more physical restrictions after birth in which support is simply necessary, and I think it’s here where the father is mostly needed. Of course, the creation of a father-child bond is also very important. That’s why we want fathers to be present for example during baths, or during some other activities like that, so that they can take part in them, so that they feel needed, so that they feel like they are not only needed to read a goodnight-story and that’s it. ” [Klaudia, Polish paediatrician, Q-111]

More essentialist and biophysical perceptions of mothers’ roles were thus accompanied by depicting fathers as supporters, but also by activating fathers from the beginning in childcare. As others have pointed out (Evertsson and Grunow 2016), bathing babies appeared to be a task that the midwives and postpartum care assistants in all three countries often related to fathers’ care, stressed most strongly by the Dutch postpartum care assistants and the Polish midwives and paediatricians. The recurring emphasis among Polish paediatricians and midwives on ‘attachment relationships’ in which mothers and fathers needed to be responsive
to their child and have close physical contact with their babies was according to one of the midwives related to parenting ideals developed in Western countries.

Interviewer: “What do you yourself find important for a child?”
Krystyna: “Direct contact with the father and the mother, because that has an impact on the child’s future. If for example the child feels loved already, let’s say, since the time like after birth. The parents will know how to proceed and all. They will be with this child all the time and they will understand this child, so the child cries, because something is happening and not only that it cries because it wants to cry, right? […] What is a very important thing […] skin-to-skin contact. […] This is very popular in Western countries and in our country, truth be told, less, but already in some clinics the father holds the baby close to his chest directly after birth. […] Of course the father should have the same role as the mother in childcare […], both parents should simply take such responsibility and take care of such a new-borne, for it to feel the skin of both father and mother.” [Krystyna, Polish midwife, Q-112]

Hence, fathers’ involvement was thematised as a new standard, informed by standards in Western countries. In some instances of the Polish data, it became clear that professionals, as well as parents, needed to negotiate mothers’ biophysical exclusiveness and the promotion of both parents’ physical involvement, as was to a more modest degree also reflected in the Dutch data.

“Fathers have it a bit harder because this creation of a parenting bond, well it has to happen without this sort of- without this lactation, without this element.” [Wiktor, Polish paediatrician, Q-113]

“The dad is more and more often engaged. Here [at the intensive care ward] it’s perhaps unfortunately a bit, a bit limited because, because of biological reasons we can here kind of allow the mother to participate, I mean, be with the child for 24 hours a day. Dad no, not necessarily, not always. But, but we do try to at least to make them take turns.” [Agnieszka, Polish paediatrician, Q-114]

“But [dads] are expected to take care of their babies […] to participate, sometimes maybe even to go too much into women’s intimate sphere, but women expect it. […] Sometimes dads say they wish they had breasts to feed. So, dads participate more and more in this caring, loving life on a level mom-baby.” [Tekli, Polish midwife, Q-115]

The Polish data in this study shows therefore that ‘romanticized’ and essentialist cultural values about mothers’ exclusive roles (Lutz 2015) did not necessarily mean that fathers’ were not made responsible for nurturing and caregiving, because these values were accompanied by cultural gender norms and healthcare practices that were much more inclusive and activating towards fathers. What is particular here, is that a large share of the Polish paediatricians worked at an intensive care ward in the hospital were fathers’ physical involvement in care was specifically stressed.
Yet, similar dualistic notions of stressing both mothers and fathers’ involvement in caregiving were expressed by Polish midwives and Polish paediatricians working more widely in OC and CHC practices.

**Mothers’ central and fathers’ additional roles in reconciling work and care**

The two parallel narratives found in the interviews with the Polish professionals – namely a strong, exclusive and natural role ascribed to mothers as well as a relatively strong focus on fathers’ partaking in care and parents exchanging tasks – were found to be rather straightforwardly reflected in how the Polish professionals depicted mothers’ and fathers’ performing and sharing working and caring tasks. The perceived best scenario was when mothers would stay at home, and out of the labour market, in the first year and in that sense, mothers’ care was prioritized above fathers’ care.

**Interviewer:** “What would be reasons for you to trust that a preterm baby will be ok […] when a baby goes home, when would you trust that they would be ok?”

**Janek:** “[…] If parents have money, the mother can stay at home, she doesn’t have to work.”

**Interviewer:** “Do you think that’s better for the baby?”

**Janek:** “Yes, I think that’s better. Certainly, for the first year. But some can’t.” [Polish field notes – section 3; Janek, Polish paediatrician]

We can see here how many of the Polish professionals were perceptive to parents’ income and labour market situation, thereby suggesting an intersection between gender and social class in parents’ opportunities to stay at home.

“**Men, fathers, they have better salaries or a more stable situation on the labour market, or they have their own company, so when the baby appears they are kind of more effective […] so yeah, it’s more often a mum who stays at home with kids. But often, it's like in my case […] because I had a more stable situation and higher salary, but I wanted to stay at home with my first and second child, and with the second one I wanted to stay the whole year knowing that I won't have such an opportunity again ever in my life and what you work out with the baby at the early stages it- it's an investment into the future. Maybe it all sounds really I don't know calculated, but I love my kids and I want to devote to them and that’s why I left the job at the university, because I would need to spend a lot of time afterwards on other different activities than at home, so I prefer to work at a kind of less prestigious place but have much more time for kids.” [Urszula, Polish paediatrician, Q-116]

We can see here that different opportunities between fathers and mothers, but also between jobs, to combine work and caregiving were influenced through labour
market institutions. Yet, this Polish paediatrician is also reflexive about gender norms, interacting with healthcare policies, assuming that especially mothers’ devotion will be beneficial to children’s futures, whereas she takes her own choice as an example of mothers rather than fathers sacrificing their careers, even when financial motivations would suggest otherwise. Comparable to what was found for the German professionals, many of the Polish professionals primarily perceived parental leave, which can legally be shared between mothers and fathers, as leave for mothers and not fathers.

“Right now the only option for mom is a year leave. And it is some support for the parents indeed, for the mom I mean. So that she can have this baby a whole year.” [Tekli, Polish midwife, Q-117]

“I don’t really… sure, there are all these maternal leaves [...] it’s just like a general norm that moms just sit at home, if I may say so, and fathers go to work and these roles don’t really change. It’s my opinion- but also it’s how the state works, so it’s provoked by the situation, and moms have a maternal leave and what do dads have, two weeks of paternal leave, so how is he supposed to...” [Danuta, Polish paediatrician, Q-118]

Comparable to what was found for the Dutch professionals however, a strong awareness of mothers’ work, also in the period shortly after birth, was displayed.

“When women have a good position and get a good salary, they care a lot about this job, so in some cases they try to come back to work as soon as they possibly can. People have some loans, commissions, sometimes it breaks their heart, but they just have to do it. [...] Generally [...] they have to come back to work. I think that for comfort of both mother and child, such parental leave should take three years. [...] Then it’s just mother’s will if she provides the greatest care for their little sweetie, either a loving granny or a professional babysitter will hug the baby, but she herself wants to pursue her career, I surely respect it, but most women come back to work out of necessity and in tears.” [Olene, Polish midwife, Q-119]

“Well, here I think it’s still mainly moms that stay at home, yes, but most of them, I think more often than before, there are more women who want to return to work as soon as possible, but there’s the question whether they really want to or have to. Because the job might not wait long for them, right? [Sylwia, Polish midwife, Q-120]

Many of the Polish professionals thus experienced that mothers were eager to return to work, while they also experienced their necessity to work for financial reasons, and because they had limited bargaining power at the labour market. Polish professionals generally outlined a situation in which the financial necessity for (both) parents to work (full-time) was particularly strong. One of the Polish
midwives highlighted these necessities by suggesting a conscious focus on the present when a baby was born, and not on concerns about the situation that would follow later.

“…These moms who have their own business are in a better situation, because they have a lot of options here, they can both come back to work and do other stuff, but for other full-time employed women it’s a big uncertainty. They are looking for a babysitter, they both try to work, because you know, most people have some loans and other stuff. But moms have it harder in life, I mean at work.”

Interviewer: “How is it approached during the consultation?”
Tekli: “No. Everyone knows, what’s here and now it’s here and now, and the future is the future. Nobody cares about it when the baby is born. They are happy with their little sweetheart and they leave the rest aside.” [Tekli, Polish midwife, Q-121]

Interestingly, such a dualistic presentation of caring and working roles was increasingly also applied to fathers. They were on the one hand strongly depicted as breadwinners:

“…Fathers, [...] they only sacrifice themselves in very particular situations. And financial well-being is super, super important. Not the most important, but sometimes a lack of money makes the atmosphere at home really heavy, and it leads to conflicts, which consequently also has some negative impact on the baby and their relations. So, I really do understand it, I think it’s something natural. I’m sure no-one says that it’s not like this, because fathers focus more on their careers.” [Olene, Polish midwife, Q-122]

Since the new parental leave policies however – introduced a few years prior to the interviews (see chapter 4, page 121) –, many of the Polish professionals reported experiences with fathers taking up parental leave.

“Now it varies: mums go back to work fast, daddies [take] leaves.” [Ewa, Polish midwife, Q-123]

“I think that in the majority, mother stays with the baby for most of the time. However, it happens more and more that fathers also declare during conversations that they want to take some part of that paternal leave.” [Klaudia, Polish paediatrician, Q-124]

Interviewer: “What forms of childcare do parents plan and use? How is it approached during the consultation?”
Stefana: “Oh, they plan it, absolutely, they call to ask one or the other grandma, a babysitter, sometimes when they’re going on a leave they exchange: two days a mom, two days a dad. And it surely changes, for the better, slowly, step by step, but it does and you can tell. [...] A lot of fathers go on these paternal leaves and they share it, more and more. It’s still a very small share, but something is getting better there.” [Stefana, Polish paediatrician, Q-125]
As the above quote shows, fathers were thus also displayed by some of the Polish professionals as having a role in balancing working and caring tasks over the week, comparable to what was found in the Dutch data. It was thus found that several of the Polish professionals depicted fathers’ increasingly important roles, facilitated by recent parental leave policies, in finding a work-care balance within the family. In tandem, within the Polish ideal types, concerns were expressed about unknown and unreliable nannies; insufficient day care opportunities and children growing up alone, with their parents being employed elsewhere.

“The baby sitter that comes to our home is generally an untested person, she can’t be asked for a lung X-ray to test for tuberculosis without even talking about swab on Streptococcus or Staphylococcus. Yet, she touches the baby. Moreover, the personality of the baby-sitter is unknown and there is huge fear if the baby sitter is an unfamiliar person.” [Zyta, Polish midwife, Q-126]

“There are lots of euro-orphans, so children left with grandma or someone, a cousin or an older sister, and their parents go abroad to seek employment. [...] There is a lot more violence in a form of neglect, than strict beating or tormenting. And these neglected children are left completely alone and they have to deal with everything on their own and it’s terrifying.” [Stefana, Polish paediatrician, Q-127]

Hence, parental leave policies encouraging mothers and fathers to share leave were found to fit well with (medical) distrust of external childcare and an emphasis on family relationships and parents’ roles. The interplay between cultural values concerning mothers’ and fathers’ dual (working and caring) roles, parental leave policies and an economic necessity for full-time dual working was reflected in an often pragmatic approach regarding parents’ exchangeability and task division.

“It’s just that they were with their kid, especially for these early years. They can exchange, but they should be the ones to raise their baby, not the group of other people.” [Stefana, Polish paediatrician, Q-128]

“I think that the decision who takes leave is a matter of money. [...] If a father has a poorly-paid job, and at the same time he’s that kind of a man who can fit into the role of a household caregiver, cause then it’s not only the baby, but he has to take care of the whole household for these couple of months.” [Olene, Polish midwife, Q-129]

When looking at healthcare institutions, it stood out that the Polish midwives provided parents with information about parental leave much more structurally than the Dutch and German paediatricians, a task that was often delegated to and managed by well-informed medical assistants.
Interviewer: “How is this discussed in your consults; [...] do parents ask about leaves, the amount of time [...] is such information discussed with midwives?”

Zuzanna: “Yes. To be honest, men and mums are quite knowledgeable, but there are also some who want more specific details and for sure we can help with advice. Besides, the rest of the personnel too, because our medical secretaries do well in these things. Sometimes they have broader knowledge than us who work directly with patients.” [Zuzanna, Polish midwife, Q-130]

Variance was found in whether this information was focused on mothers, fathers or both parents, reflecting parallel cultural gender norms being present in healthcare institutions, and in professionals’ ideal-typical knowledge.

“When ladies go home [...] they complete all the formalities with our secretary; she is very well informed and passes information [about leave] on to them immediately just before they leave for home; what [forms] need to be completed, and what it looks like.” [Ewa, Polish midwife, Q-131]

Krystyna: “Also the support of the father, most certainly yes. He should also take some time off and [they] should simply be together in some activities, support her, because it’s also a very difficult period for her [...] so he should be...”

Interviewer: “Is it actually discussed during consultations with the parents?”

Krystyna: “Well, we give various tips, of course, but it also varies. It depends on the individual families. So sometimes they take time off, sometimes it’s impossible, but of course I give tips, most certainly [...] they set up themselves what [happens] after maternity leave, so we tell them what this maternity leave looks like, how much they can take: before, after. How much can a man take for this care.” [Krystyna, Polish midwife, Q-132]

Similar to the German paediatricians and different than the Dutch paediatricians and nurses, a stronger medical focus in Polish healthcare institutions was found, in which Polish paediatricians worked in the hospital, or offered children treatment alongside preventive examinations in CHC services. Accordingly, the Polish professionals most frequently discussed parents’ work and care divisions in case of children’s health problems.

Interviewer: “How is [women returning to work] discussed in your consults?”

Sylwia: “That’s very rarely, really. It’s only when, when there are children who are somehow, who require care, constant care, that’s where this keeps coming back but in general not really.” [Sylwia, Polish midwife, Q-133]

It was thus found that healthcare policies intersected with professionals’ experiences with and knowledge about the ways in which parents performed and divided their working and caring roles.
6.2.2.4 Conclusion

In this section, interesting variation has come to the fore in the degree to which mothers’ roles were essentialized (more strongly in the Polish and German cases, and in midwifery) and the degree to which parallel expectations of fathers’ active and nurturing roles were presented (more strongly in the Dutch and Polish cases). The healthcare professionals in this study turned out to be hesitant and heterogeneous in how they perceived their role in mothers’ and fathers’ work and care divisions, and mothers’ choices and employments were in all contexts acknowledged and supported. At the same time, we have also seen in the previous section that children could in the views of the majority of professionals very well be ‘at risk’ through mothers’ absence and external childcare.

Both professionals’ particular concerns about external childcare, and the ways in which professionals perceived constraints in work-family balances were strongly informed by family policies, and by how this became relevant in specific healthcare contexts and professional interactions. It was found that especially mothers’ pragmatic challenges were placed centrally, and fathers’ roles in obtaining a work-family balance within the family were only to a modest degree perceived as relevant, mainly in the Dutch and Polish cases. Gendered task divisions were therefore importantly reproduced in professionals’ pragmatic solutions in which constraints following from the institutional context were hardly challenged but rather confirmed (Waitskin 1989), although a minority of younger professionals formed an exception to this. Such pragmatic solutions on the other hand also provided the openings in which professionals facilitated parents’ task divisions and fathers’ caregiving roles, as was shown for instance by German paediatricians who handed both mothers and fathers forms for their employers that allowed them to stay at home with their ill children.

When summing up the findings of professionals’ knowledge and gendered perceptions in all three countries about parenting risks as discussed in the previous section, and their knowledge and gendered perceptions about parenting responsibilities in this section, we can see linkages between the knowledge derived in relation to the different institutions (see table 6.1).
Table 6.1 Context-specific interactions within professionals’ ideal-typical knowledge between gender norms, healthcare policies and family policies, as related to gendered ideal types of risk and responsibility

<table>
<thead>
<tr>
<th>Gender norms</th>
<th>Healthcare Policies – babies</th>
<th>Family policies</th>
<th>Economic and labour market conditions</th>
<th>Risk</th>
<th>Responsibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dutch prof.</td>
<td>Attachment Safety Learning skills Breastfeeding One-on-one care</td>
<td>Short leave Day care Daddy day</td>
<td>Necessity to work (part-time) in first year</td>
<td>Mothers’/parents improper care Overprotection Not taking care of yourself Mothers’ lack of investment Too much day care and too busy weeks</td>
<td>Mothers and fathers to care Mothers to reconcile work and care Fathers to help reconcile work and care, when possible</td>
</tr>
<tr>
<td>German prof.</td>
<td>Attachment Safety Learning skills Breastfeeding One-on-one care Treatment</td>
<td>Parental leave mothers, to some extent fathers</td>
<td>Necessity to work after first year</td>
<td>Mothers’/parents’ improper care Overprotection / lack of autonomy child Day care infections and staff-child ratio Mothers’ employment</td>
<td>Mothers to care Mothers and fathers to raise a child Mothers to reconcile work and care Working mothers and fathers to care for ill child</td>
</tr>
<tr>
<td>Polish prof.</td>
<td>Attachment Safety Learning skills Breastfeeding One-on-one care Treatment</td>
<td>Parental leave mothers and increasingl y fathers</td>
<td>Strong necessity to work (full-time), in or after first year Relation to social class</td>
<td>Mothers’ improper care Diverging from medical expertise Overprotection Lack of family relationships Mothers’ lack of involvement Untrustworthy external childcare</td>
<td>Mothers and fathers to care Mothers to reconcile work and care Fathers to help reconcile work and care, when possible</td>
</tr>
</tbody>
</table>

Source: own depiction based on the analysis in this chapter
For the Dutch professionals, ‘shared parenting’ norms, combined with a taken for granted assumption that mothers had a more central role in caregiving, were very much reflected in parenting responsibilities perceived for both parents on the one hand, and mothers’ responsibilities to reconcile work and care on the other hand. Some fathers’ weekly involvement in care through a ‘daddy’ day was, when possible, seen as a means to reconcile work and care within the family. The latter responsibilities were perceived against the background of Dutch family policies, focused on facilitating work and collaboration, as well as a financial necessity for mothers and fathers to return to work relatively shortly after birth. In the depicted parenting risks, we could see that contradictions between healthcare-based knowledge privileging attachment and parents’ investment within exclusive relationships contradicted with the opportunities and constraints experienced due to the family policy and economic context. Here, a stronger reflection of mothers’ assumed central roles was detected, translated into professionals ‘helping’ mothers – thereby making them responsible – to deal with these contradictions when they would cause problems.

For the German professionals, gender norms of exclusive and unparalleled roles for mothers, intertwined with healthcare policies emphasising mothers’ caregiving tasks, were predominantly combined with depictions of fathers as breadwinners, which was found to be translated in ascribing caring responsibilities more strongly to mothers, perceived as facilitated by parental leave in the first year after birth. For the period thereafter however, contradictions came to the fore between gender norms of mothers’ unparalleled roles and exclusive relationships with limited opportunities for feasible (family policy) alternatives in terms of day care and fathers’ options to negotiate work and care on the one hand, and acceptance of mothers’ employment and their perceived financial necessity to work on the other hand. Fathers’ involvement in the first stages after birth was mentioned by only a few of the German professionals, and mainly related to fathers’ options to take leave in the first months after birth. Fathers’ breadwinner roles were rather prominent in the overall interaction between knowledge forms, while their involvement was much less part of these forms of knowledge.
For the Polish professionals, gender norms about mothers’ exclusive and unparalleled roles in tandem with norms about fathers’ involvement, and medical knowledge about how to perform care, were reflected in professionals’ depictions of mothers’ main and fathers’ additional responsibilities in care and in reconciling work and care, in the first year facilitated through parental leave. At the same time, mothers’ perceived unparalleled roles were reflected in a focus on mothers when depicting risks for children, and contradictions between high expectations of (medically-informed) caregiving and family relationships, as well as a lack of alternatives in external childcare on the one hand, and a financial necessity to work potentially already in the first year, for some more than for others, on the other hand. Hence, whereas institutional sources of knowledge intersected, tensions between and within mothers’ and fathers’ roles were also brought to the fore.

6.3 Conclusion and discussion

In this chapter, I have shown that professionals’ risk knowledge was in many occasions gendered and gendering, because the professionals ascribed particular risks and responsibilities to parents, mothers and fathers, thereby implying gender-specific caring roles. Other studies have also detected gendering processes in professional frameworks (Hannah-Moffat 2004; Murphy 2003; Vuori 2009; Knaak 2010; Tiitinen and Ruusuvuori 2014), however ideal-typical risk knowledges about parenting have not been systematically investigated cross-nationally. This study provides insights in how professionals’ ideal-typical knowledge connected different forms of knowledge related to 1) often taken for granted gender norms, 2) healthcare policies and professionals’ role perceptions, 3) family policies and 4) parents’ financial necessities to work under varying labour market conditions (see table 6.1). When comparing these forms of knowledge cross-nationally and studying their linkages to professionals’ gendered knowledge about parenting risks and responsibilities, we can draw important conclusions about the (re)production of gendered parenting roles in professionals’ situated ideal-typical knowledge.

First, knowledge relating to healthcare policies appeared to be rather cross-nationally homogeneous when focusing on caring for babies, as I did in this
chapter. Whereas I have shown in the previous chapter that cross-national variation was found in how professionals pragmatically related to their medical context, this variation was much less found when it came to perceived parenting risks and responsibilities in the first stages, with only minor differences that drew on cultural values in relation to the institutional context. This assumes that cross-nationally different depictions of gendered parenting risks and responsibilities relied on the interaction between healthcare policy-based knowledge and other institutional sources of knowledge and values. In a similar sense, it was found that the variation in family policies alone did not straightforwardly translate into professionals’ situated and gendered ideal-typical knowledge about parenting risks and responsibilities. Rather, gendered risk and responsibility depictions were informed by the interaction of different sources of knowledge.

Second, it was found that gendered parenting norms often appeared as sets of sometimes contradictory cultural norms that functioned parallel to each other, and that these gender norms were important in how professionals’ knowledge based on different institutions came to be connected and contradicting. Moreover, while Douglas (1992; see also Douglas and Wildavsky 1982) has argued that risk and responsibilities are based on the same cultural constructions, I found in this study that gender norms played out differently in knowledge constructions of risk – in which mothers’ central positions were emphasized in tandem with medical knowledge – and in knowledge constructions of responsibilities – in which gender norms of shared parenting (in the Dutch case) and fathers’ involvement (in the Polish case) were much more integrated in medical and family policy-based knowledge. My findings therefore argue for a separation between ‘risk’ and ‘responsibility’, both in terms of theoretical and in terms of policy implications.

The distinction between gender norms of ‘shared parenting’ (Kremer 2010), ‘gender-neutral’ parenting (Daly 2013), exclusive and ‘romanticized’ mothering roles (Lutz 2015), and fathers’ depicted as breadwinners and/or as nurturers (Hofmeister and Baur 2015; Featherstone 2009; Shirani et al 2012; Coltart and Henwood 2012; Connell and Messerschmidt 2005) appeared to be especially useful to understand professionals’ gendered knowledge about parenting responsibilities.
‘Intensive parenting’ and ‘intensive mothering’ ideologies (Hays 1996) were to some extent useful in understanding particular (gendered) parenting risks. While ‘intensive parenting’ and ‘intensive mothering’ ideologies were found to be reflected in professional’s risk knowledge in my data, this was not as prominent and straightforward as, and much more pragmatic than, some have suggested (Furedi 2002; Knaak 2010; Faircloth 2014a). Many professionals emphasized the competence in dealing with children (‘s needs) through experience and investment, rather than the supposed intensity of parenting. Indeed, risks of overprotection, not allowing children to develop autonomy, not setting limits to children’s behaviour and desires, and not taking care of oneself as a parent were coherently perceived as risks by many of the professionals in my study.

Limitations of this qualitative cross-national comparison are that the sample of selected professionals is relatively small, and located in particular regions, which could mean that certain aspects in professionals’ gendered knowledge were highlighted in my findings, while they may be less pronounced in other regions of the same country. The professionals in the German area were for example reflexive about the finance sector in their region, which they related to strong(er) breadwinner norms. Moreover, the sample of healthcare professionals was not exactly similar between countries. The high share of Polish paediatricians in my sample that worked in neonatology wards could in this respect have resulted in a stronger emphasis on medical knowledge, which may be less pronounced for Polish paediatricians working in CHC practices. The aim of this study has therefore not been to generalize these findings to professionals in these countries more broadly, but instead to shed light on interrelations of institutional sources of knowledge in professionals’ gendered ideal types about parenting risks and responsibilities. Now that we have seen that several institutions were related to professionals’ ideal-typical risk knowledge, it becomes particularly salient to understand how professionals get to know risks and ascribe responsibilities in case-by-case situations.
The everyday ‘risk work’ of Dutch healthcare professionals: Inferring ‘safe’ and ‘good’ parenting through trust, as mediated by a lens of gender and class.

A phenomenological study

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This chapter is based on an article published as: Veltkamp, G., & Brown, P. (2017). The everyday risk work of Dutch child-healthcare professionals: Inferring ‘safe’ and ‘good’ parenting through trust, as mediated by a lens of gender and class. *Sociology of Health & Illness* 39(8), 1297-1313.
7.1 Introduction

It has been argued earlier in this dissertation that during the twentieth century, the dominant Western framing of childhood generally shifted from one in which children ought to be disciplined and protected from themselves to a belief that children should be happy, able to play and require protecting from the world (Ansell 2005). A related sacralization and increased emotional valuing of childhood (Zelizer 1994), interwoven with shifts in social welfare governance (Donzelot 1979) and paediatric medicine (Halpern 1988), has shaped an intensifying concern with the wellbeing and development of families and children (Reich, 2005:9; Elizabeth and Larner 2009).

Within such social and policy contexts, child rearing is increasingly conceptualized and medicalised in terms of harm prevention and risk. Scholars in child sciences have asserted the importance of problem detection and early intervention in children’s lives (Lee et al. 2010), based on evidence of different probabilities of outcomes across categories/groups, in order to prevent disruptions in childhood and serious psychopathologies in adulthood (Béhague and Lézé 2015, p.251). This extends ‘risk work’ beyond a small number of abusive or neglectful families (c.f. Reich 2005) to include almost all families within the welfare concerns of the state (Donzelot 1979). As I have shown in the previous chapters, healthcare policies differ cross-nationally in the ways and degrees to which a structural detection of risks for all families are implemented.

In the Netherlands, on which I focus in the chapter, risk-management has assumed a central role in the daily work of professionals, reflecting the current policy infrastructure around Child Health Care (from here on CHC). The ongoing development of professional procedures and instruments for risk signalling and interventions via evidence-based programs is prioritized (Hermanns et al 2005; Postma 2008) as is also the case in other European countries such as England (DfES 2004) and Denmark (Møller and Harrits 2013). Such wide-ranging, future-oriented and ‘fateful’ policy conceptualizations of children’s development and education have emerged out of more enduring policy traditions, informed by and informing various constructions of childhood (Donzelot 1979; Hoffman 2010).
In practice, every Dutch municipality provides low threshold CHC walk-in centres for all children between 0 and 19 years. Municipalities implement national protocols for child examinations, whereby fifteen meetings (alternating between paediatricians and specialist CHC nurses) in the first four years follow a pattern of immunizations and developmental checks which are registered in each child’s electronic file. The CHC teams receive newborns’ birth information from the municipality and they call families for a home visit after birth to perform a newborn screening, followed by an intake at home by the CHC nurse. After the intake, the family receives a new appointment with the CHC paediatrician at the CHC centre, where all subsequent visits take place (NCJ 2016). Legally-speaking CHC is not compulsory but in practice it functions as a comprehensive system, working with 92.8 per cent of Dutch children aged 0-4 (99.8 per cent aged 0-2) and their parents (CBS 2010). ‘Families at risk’ are specifically targeted for additional home visits, more intensive programs and/or are referred to specialist healthcare and welfare services (Postma 2008).

Functioning at “access points” to broader systems of scientific-expert knowledge and state intervention (Giddens 1991), CHC professionals stand as key figures in overseeing the interests of vulnerable children (Wubs 2004) via the application of “risk factors” (Postma 2008; Vink and Detmar 2012). Professionals’ risk work requires them to identify, assess and manage negative risk factors and positive protective factors, therefore optimizing children’s development potential (Kuo et al. 2006; IGZ 2009; Postma 2008; Hoffman 2010). The prioritizing of children’s development above the family (Wubs 2004) has entailed the framing of parents both as sources of risk and protection (Lee et al 2010; Hoffman 2010) and as risk managers themselves (Groenendijk and Bakker 2002; Knaak 2010).

Organizational pressures to ward against the “reputational risk” posed towards CHC services have pushed professionals towards increasing preoccupations with assessing risk (Rothstein 2006; Lee et al 2010; Warner 2015). Risk management strategies may, however, result in distancing effects between professionals and service-users (Brown and Calnan 2013). In 2010, an influential Dutch Internet forum advised parents to stop sharing their worries with professionals in CHC
centres because of concerns regarding professionals’ trustworthiness. A mainstream newspaper reporting on these tensions called for empirical research and a public debate in order to “chase away the ghost of distrust from the [CHC] consultation rooms” (Trouw 2010).

Risk assessment of parental behavior, as an emerging feature of CHC services in the Netherlands and elsewhere in Europe, has received limited investigation from a more critical social science perspective. Hopma and colleagues (2014) point to a “hidden curriculum” within CHC in The Netherlands, comprised of the values and beliefs of policy-makers, focused on particular notions of security, as shaped by broader cultural developments within Dutch society (see also van den Berg and Duyvendak 2012). Studies from Nordic countries have also emphasised the influence of ‘common sense’ categories and reproduction of gender norms within child-oriented risk policy and assessments (Møller and Harrits 2013; Tiitinen and Ruusuvuori 2014). This reflects more specific child protection and historical studies emphasising the inherent normative tendencies of CHC, wherein class, ethno-racial and gender distinctions are reproduced (Donzelot 1979; Reich 2005).

In the previous chapters, I have engaged with and added to recent work that interrogates the categories emerging from policy frameworks (e.g. Møller and Harrits 2013) in a cross-national examination of gender and social class categories in healthcare and family policies, and the degree to which these were reflected in professionals’ situated, generalized knowledge. Professionals’ everyday case-by-case interpretations of ‘risk’ and how professionals come to know risk have however received much less attention (Gale et al. 2016). In this chapter, we therefore analyse practices of risk-assessment within professional-parent(s)-child interactions in Dutch CHC centres with a particular interest in uncertainty (Brown and Oloffson 2014) when professionals work with ‘precautionary risk approaches’ in which possible events are anticipated and intervened (Alaszewski and Burgess 2007).

As the basis of our analysis, we first outline a more constructionist-phenomenological framework for conceptualising risk assessment. Then, we analyse observational (n=61) and interview (n=15) data (see chapter 3, page 72 for
the data and analysis used in this chapter), focusing upon how professionals inferred children’s future prospects and related risks from interactions with children and parents. By inquiring into the phenomenological lifeworlds of professionals’ risk assessment practices, we: a) develop understandings of how inexorable uncertainties around ‘risk’ assessment were overcome through practices of intuition, emotion and trust (White 2002; Zinn 2008); b) analyse how such sense-making practices were shaped by the relative socio-cultural proximity of the parent-other to the professional-self (Schutz 1972; Van Duursen et al 2004); c) explore how these ‘modes of knowing’ were embedded within social structures, not least those of gender and class.

The starting point of the analysis presented below is an unearthing of the underlying sense-making processes by which social actors give meaning to the world around them. Following Husserl’s edict to go ‘back to the things themselves’, Schutz (1972) encourages us to interrogate broader social phenomena in terms of the individual actions and modes of thought through which these are made manifest. This enables a more precise and detailed understanding of individuals’ actions and interactions. Moreover, the approach illuminates how these motivational and interactive processes contribute to, while being shaped by, wider social structures (Schutz 1972; Berger and Luckmann 1967):

“… the meaning of particular social phenomena can be interpreted layer by layer as the subjectively intended meaning of human acts. In this way the structure of the social world can be disclosed as the structure of intelligible intentional meanings” (Schutz 1972:7).

Our Schutzian-phenomenological approach correspondingly forbids us to take ‘risk’ at face value, even though it may be employed unproblematically in many health care settings as an ostensibly effective basis for intervening in uncertain futures. Risk is most neatly defined as “the probability that a particular adverse event occurs during a stated period of time, or results from a particular challenge” (Royal Society 1992:2). When subjected to further scrutiny, however, we see that ‘risks’ involve countless assumptions which must be taken-for-granted in order for risk assessment to function. The general acceptance of particular outcomes as
adverse – as defined by some (powerful) groups, and not others – through the influence of scientific and other systems of knowledge, indicates that risks are never merely neutral and technical, but profoundly political, moral and value-laden (Douglas 1992; Szmukler 2003; Møller and Harrits 2013). Furthermore, probabilistic attributions linking particular adverse outcomes to decisions or behaviors involve the grouping of these outcomes within one relatively homogenous ‘category’, overlooking the variations within (Heyman et al. 2013). While the probabilistic aspects of working with risk receive the most attention within the medical-science literature, the values, categories and time-frames intrinsic to risk remain much more implicit and insidious (Szmukler 2003; Heyman et al. 2013).

The policies, organizations and training in which CHC professionals in The Netherlands are embedded compel them to work with risk; to adopt it as real. Professionals are furthermore required to consider more nebulous risks regarding ‘poor parenting’ more generally, as well as risk of more specific forms of abuse (Postma 2008). This ‘risk work’ is far from a simple task. Alongside implicit valuing, categorizing and time-framing, risks above all comprise “inductive probabilistic reasoning” connecting various “factors” with outcomes (Heyman et al 2013:5). While this approach works well in comprehending patterns of outcomes across larger groups, an ecological problem remains where risk information is much less useful in predicting outcomes in individual cases (Heyman et al 2013:9). Low base-rates of child abuse greatly increase error-rates of risk assessment tools (Szmukler 2003). This problem, coupled with the low tolerance for child-safeguarding accidents or errors amongst the media and general public, leave professionals in a decidedly precarious position (Warner 2015).

Amidst the vulnerability and uncertainty faced by CHC professionals and the limited utility of ‘risk knowledge’ for decisions about individual cases, Zinn (2008) denotes the use of other tools for coping with uncertainty – especially emotion, intuition and trust. These approaches combine aspects of more rational-calculative reasoning with less formal modes of knowing which are indispensable when acting towards the as-yet-unknown future (Möllering 2001; Zinn 2008). These strategies overcome the limitations of probabilistic-induction through gut-feelings, tacit
knowledge and relying on others (see also Anspach 1993; Polanyi 1967), working ‘in-between’ the rational and non-rational (Zinn 2008).

These different logics of action and decision-making amidst uncertainty are not mutually exclusive. Emotions and intuition are very much part of what it means to trust (Barbalet 2009) and in turn become interwoven with more procedural considerations of risk. In contexts where ‘risk assessment’ is partly or more largely shaped by who professionals feel they can(not) trust, the everyday construction (inferring) of knowledge about others – in our case parents – through interactions becomes highly salient. Within this inferential construction of knowledge about others, phenomenological theory points us towards the greater ‘concreteness’ of knowledge derived from face-to-face interactions, in contrast to the relative remoteness of more abstract information (Brown 2009). Schutz (1972, 163-187) delineates different intensities of ‘knowing’ others and understanding their actions and motives. The ‘concreteness’ of this knowing is determined very much by the proximity of the other to the self. Accordingly, “we-relationships” provide the most intense and compelling ways of knowing others, where common lived experiences and correspondingly shared stocks-of-knowledge facilitate familiarity and mutual understanding. In contrast “they-relations” are more remote, abstract and thus ‘flatter’ in terms of depth of knowing (Schutz 1972:8).

7.2 Results

7.2.1 The uncertainty of ‘risk assessment’

As noted already, CHC in the Netherlands is increasingly preoccupied with assessing risk regarding individual children and parents. Probabilistic relationships between categories of people and outcomes are invoked within health and welfare contexts to render uncertainty more calculable (Zinn 2008). However, our findings denoted several limits to risk knowledge in assessing whether a child (‘s development) was at risk: Children’s individual situations were perceived as ambiguous, contacts with parents and children were brief, and professionals were
required to interpret nebulous possible signifiers of difficulties with regard to an unknown future.

7.2.1.1 Ambiguities surrounding parents’ and children’s situations

As an attempt to standardize and support ways of inferring diverse children’s futures, CHC professionals referred to ‘risk groups’ and related factors, as defined at national and organizational levels. Each of these categories has been scientifically related to adverse outcomes for children’s development, especially where multiple factors combine (Hermanns et al 2005; see Møller and Harrits 2013 for a critical assessment). Risk factors included poverty, single parenthood, teenage parenthood, living in a bad neighbourhood and social isolation.

Our professional participants claimed to perform the assessment of individual parents and children by weighting these risk factors against other potential protective/insulating factors. Children deemed ‘at risk’ in relation to risk groups were highlighted in their electronic files, in order to be followed more carefully over time. However, these ‘risks’ were described as difficult to standardize. It was particularly the more experienced professionals who claimed that individual cases needed to be considered on their own merits:

“It’s a heightened risk, but it’s not by definition already a risk. ... That’s what I’ve really learned after all these years; leave them at home, those stereotypes.” [Els, Dutch paediatrician; experience=21 years, Q-134]

Some of the professionals described risks in individual situations as fluctuating over time rather than fixed to category memberships. Case-specific contingencies were emphasised further where parents and children were described as responding differently amidst ostensibly similar risk situations:

“One child can carry a much heavier burden than another.” [Marjan, Dutch paediatrician; experience=29 years, Q-135].

Professional judgments of specific cases also varied. Attempts at standardisation had not overcome the ambiguity and subjectivity in evaluating risk within individual family situations:
“It depends on who [which colleague] you talk to, is my impression; how heavily you weight [a situation], when you act and when you let go or wait and see. That’s very personal and this makes it difficult for me as a beginner. You need to develop your own [risk] boundaries.” [Christine, Dutch nurse; experience=3 years, Q-136]

7.2.1.2 Fleeting contacts with parents and children

Further challenges involved appointment timeslots (10-20 minutes) which were described as very short for making adequate risk assessments. Obtaining sufficient contextual knowledge to evaluate a child’s situation was thus difficult, especially because parents themselves decided what they did and did not say, and to whom, within the limited face-to-face time.

“It’s not always as realistic, to be able to see everything. It’s a snapshot. ... [Take the example of] what we had yesterday, with the mother that had thyroid cancer and told her complete story to the assistant [in reception]. If I wouldn’t have heard it from the assistant and I wouldn’t have asked, I wouldn’t have known about it at all.” [Marijke, Dutch paediatrician; experience=2 years, Q-137]

These limitations were also reflected in the observations:

A mother came in with her son and urged the doctor to hurry with the vaccinations, after which she left to rush to another appointment, leaving the doctor behind with her unasked questions. [Dutch field notes - observation1; Yara, Dutch paediatrician]

These fleeting contacts allowed brief glimpses of family life which were considered neither representative nor a natural reflection of how children and parents functioned more generally. Cases of abuse were perceived as particularly difficult to identify within these brief encounters, because parents would usually be the “perpetrators” themselves and they could easily “hide information” (doctor 3, experience=22 years).

“In a consultation of 15 minutes, you can’t judge whether a child is abused or not...When parents provide desired answers and try to hide something: that’s possible. We can’t look inside one’s head and we see children for 20 minutes. Well then you can’t see what horrible things might happen at home - when the child is calm and cooperative during the consultation, everything is well and parents say it’s all fine.” [Jonita, CHC nurse; experience=1 year, Q-138]
7.2.1.3 Uncertain and ambiguous futures inherent to professional risk work

CHC professionals’ ostensible role was to systematically observe and interpret the physical and social functioning (and associated risks) of a child in its (family) environment and the interaction with its parents in the present, alongside references to the past. Electronic files were read and new ones were completed in order to document and evaluate signs regarding child development. Alongside the use of these more structured approaches, our observations also noted how immediately visible ‘child signs’ were interpreted in more informal ways. In one follow-up interview a nurse was asked to explain why in two earlier cases, involving toddlers displaying rather similar behaviour of head-buttting the floor, she judged one situation as problematic and not the other (Field notes; observations 51; 53):

“Yes, and that’s just my feeling, my experience, like: this mother is a bit messed up with something...I didn’t worry about [her] child at all, for sure. But that doesn’t mean that when there are no worries at the moment, [that] they could not arise. So that’s why the child gets extra attention. Because they slip through so easily, you know.” [Els, Dutch nurse; experience=21 years, Q-139]

The professional decision-making referred to here, as in many cases, was not based upon clinical records or structured assessment tools regarding child development. Instead the impression that the child’s environment (a “messed up” mother) was potentially harmful was inferred far more informally in relation to the mother. Using (gut) feelings (a sense that something might be wrong) and personal experience (comparing a family to previous encounters with other families) appeared essential to this nurse, as to the other professionals, in interpreting signs about a child’s situation with regard to future development.

Emotions and tacit judgments were in this way vital to inferring the potential hampering of the child’s development and these interpretations came to the fore as a crucial mode of decision-making. Yet uncertainty and ‘worries’ endured, despite formal and informal strategies, because professionals were required to infer the (unknowable) future. As the above excerpt indicates, judgments implicitly invoked a future timeframe and involved the fear that certain issues, nebulous as they were now, would grow into bigger problems later on.
7.2.2 Assessing ‘risk’ via trust

As noted thus far, formal-rational risk assessment was of limited utility for professionals while brief encounters with parents left substantial residual uncertainty about a child’s future. CHC professionals were nonetheless required to build inferences about the future, as a means of bridging over lingering unknowns (Möllering 2001). Drawing on experiential knowledge and gut-feelings, the professionals continuously constructed inferences regarding the “subjective meaning-contexts” and “motives for action” (see Schutz 1972:187) of the parents and children during their brief interactions. The more parents appeared willing to share about their and their children’s’ lives, the more concrete professionals considered the knowledge drawn through these inferences.

This inferring of an actor’s likely behavior and reliability in the future, based on interpreted pasts and interactions in the present, is better conceptualized as professionals’ trust in parents, more than formal risk assessment (Zinn 2008). Moreover, the development of a parent’s trust in professionals, in facilitating parents’ talking openly and frankly, was also described as crucial to acquiring more concrete knowledge.

“I find it good parenting when [...] parents [...] dare to tell you they find things difficult.” [Ellen, Dutch paediatrician; experience=4 years, Q-140]

Emerging from these ‘leaps of faith’ (Möllering 2001), the effective exchange of knowledge about the child and parenting and, subsequently, a growing mutual understanding (Schutz 1972) was highly valued and commonly emphasized as important.

“It doesn’t work to just hold things against parents, you know. You need to take care of being on the same page first, before you get them to a point [where] they will follow you.” [Coby, Dutch nurse; experience=11 years, Q-141]

In practice, trust in parents’ motives and capacities was more readily established with parents who were more like the professional(s).
“... Some parents are for some reason just closer to you and live sort of a similar life as I do, and that makes it easier, because it’s easier to sense them.” [Christine, Dutch nurse; experience=3 years, Q-142]

From interview and observational data, it appeared to be easier for professionals to understand, ‘sense’ and trust parents who were, in a taken-for-granted way, more similar; who therefore ‘felt’ closer. We labelled such proximate interactive experiences ‘we-relationships’ (Schutz 1972:164), wherein rich mutual understandings were formed and from which inferences about the future felt more concrete.

Such we-relationships were found in 20 per cent more cases (coded in our interviews and observations) with parents who displayed characteristics similar to the professional (concerning gender, educational level and ethno-cultural background) than with parents who had different characteristics. Nevertheless, professionals still developed close direct relationships with many parents with different characteristics to themselves. Professionals described being eager to understand and get to know parents who were open to them, thereby going beyond class and ethnic differences.

“...You know less richly how things are going exactly; I mean you don’t know each culture so well. But [...] when parents are open to CHC, it doesn’t matter so much which culture they come from, then I feel like I’m having a good conversation and you’re building a nice bond.” [Marijke, Dutch paediatrician; experience=2 years, Q-143]

A condition of effective relation-building appeared to be that these latter parents also shared ideas and awareness of the ‘child’s best interests’, for instance by breastfeeding, appearing sensitive to the child’s needs and/or being ‘open’ to the professional’s expert knowledge and advice. Indeed, common stocks-of-knowledge regarding broadly ‘normal’ parenting norms facilitated exchange with the majority of parents and this characterized the daily work of our professional participants:

“I see many normal children, you know. Very normal, nice parents [laughs]... Even in the in-between cases [you’re going to figure out ‘what can I offer?’ Because it’s not about: here [fisk] boundaries are crossed. At most you think: ‘it would be nicer when [the situation] would be like this’ and: ‘is it useful for this mother when I offer that [advice]?’ That’s actually the normal work.” [Marjan, Dutch paediatrician; experience=29 years, Q-144]
Accordingly, ‘normal’ good (enough) parenting was perceived as encompassing a fairly broad spectrum. So long as particular risk-related ‘boundaries’ were not crossed, professionals were able to adapt knowledge and cooperate with specific parents in face-to-face contact.

In terms of crossing boundaries beyond the normal, not following good practice was inferred most seriously as a problem for parents that had different characteristics on top of this. In only one observed case in which a parent possessed ‘other’ background characteristics *alongside* deviating parenting norms and knowledge was a we-relationship observed as developing:

A father with a ‘lower class’ background made it clear he didn’t value his daughter’s development being measured as it was done in the consultation, neither were there other signs of common ground between him and the nurse. Yet, she developed some kind of rapport with him and later evaluated him as being a ‘loving’ parent [Dutch field notes - observation 38; Jonita, Dutch nurse].

By contrast, in several cases in our data the relationship with parents who were ‘other’ regarding *both* background and parenting approaches resembled a more remote ‘they-relationship’ (Schutz 1972). In such cases (coded in 19 interview excerpts and four observed cases) remote and/or limited contact with a family led the professional to resort to more stereotypical knowledge (“ideal-typical” knowledge in Schutz’s terminology) and related inferences (for example relying on correlations involving membership of ‘risk groups’). In a few more extreme cases, the relationship had become even more remote, with parents rarely or never attending meetings and moving out of sight. In these situations, professionals relied solely on generalised risk group stereotypes. In the absence of deeper insights greatest uncertainty was expressed around these most distant parents:

“It is precisely the risky families who you often see even less, since they don’t show up [and] without leaving a message. Families who are open and express themselves...they form the easy group. But the risk group [parents], who are not open, don’t show up, don’t show disclosure and don’t see everything [like we do], that’s the difficult part. [The government] can say: ‘you are responsible for this case’, but how responsible can you be?” [Tineke, Dutch nurse; experience=12 years, Q-145]
Professionals thus referred to the dilemma of a knowledge vacuum, in which there was no clear basis for action and where they just had to “wait and see”. Despite this remoteness itself being interpreted as a ‘risk’, attempts to proactively manage risks across they-relationships were perceived as potentially problematic for already fragile trust relationships. A trusting relationship with some level of proximity – in order to be “on the same page” and gather concrete knowledge about a particular family – proved to be essential for any meaningful assessment of risk at the individual level.

In the absence of proximity, CHC professionals were merely experiencing uncertainty rather than managing risk. We noted above how this residual uncertainty and social distance was ‘tackled’ using crude knowledge of risk groups which were bound up with marginalized groups. Literature on the construction of these risk groups or categories (Møller and Harrits 2013; Heyman et al. 2013) has emphasized their political-moral dimensions and potential role in reproducing inequality. In the next section, we move to explore how the reproduction of gender and class structures may similarly emerge through the dynamics of professional-family interactions.

7.2.3 A mediating lens of gender and class

7.2.3.1 Gender and a responsibilising focus on mothers

The ostensibly inductive data gathering and categorizing of risk assessment has been seen above as being entangled with more inferential features rooted in trust and emotions and, correspondingly, with social background and related feelings of (un)familiarity. All professional participants in our study were female, reflecting CHC as a highly-gendered sector (Lieburg 2001). Professionals often referred to their own motherhood experiences (or not being a mother yet) and to their own mothers. It appeared easier for them to understand and feel for mothers (c.f. White 2002), for example as being torn between personal needs and those of their families or in feeling responsible for their children. Such empathy accordingly facilitated an experienced deeper knowing of mothers, as also shaped by the relative absence of fathers in encounters.
Fathers were less often present at appointments (16 of 61 observations) and professionals claimed to have much more frequent direct contacts with mothers. Accordingly, although fathers’ increasing involvement was very much welcomed and praised, the professionals still spoke about fathers in more general, remote and thus stereotypical terms (Schutz 1972:181): fathers were assumed to work either fulltime or they had one caring day per week\(^{37}\); they were described as more direct in their communication and wild in playing with their children; and fathers with a higher educational level were assumed to be more “involved”. Father’s qualities as carers were only mentioned in greater detail in a few atypical cases, where fathers took over the caring role when mothers experienced severe mental health or alcohol problems.

Stereotypes about mothers, for example assumptions regarding their considerate behaviour and part-time working arrangements, were also expressed. However, the sense-making, descriptions and evaluations of mothers were far more diverse and precise; they were, for instance, “natural”, “possessive”, “chaotic”, “sensitive”, “career minded”, “unstable”, “cold”, “sweet” or “insecure”. The quantity and quality of face-to-face contacts can therefore be interpreted as enabling greater apparent depth and nuance in their understanding of mothers (Schutz 1972: 166). Even when fathers were present, their presence was less central to the professionals’ experience:

“I have to confess that I’m usually focused on mother…Father is sitting there as well of course and is also a fully-fledged caregiver of his child and he has questions. But somehow, you’re sometimes missing out on signs [of the father].” [Jonita, Dutch nurse; experience=1 year, Q-146]

In everyday practice therefore, the judgment of a child’s future often related to a trust or distrust of mother’s capability and sensitivity. Preceding one consultation, a nurse praised a family that were described as having migrated from India:

“These children are so sweet. Very intelligent, very careful. Parents are very much focused on education. [They] are hyper intelligent. They are so great with the children. The children are triggered exactly in the right way to learn, but are still allowed to be child. Mother finished university with three children. She’s a sweet woman. She is

\(^{37}\) In 2016, 26.6 per cent of Dutch working men worked part-time (Labour Force Survey - EUROSTAT, 2016). One “daddy” day to care for their child is a familiar concept in The Netherlands, as reflected in our data.
now at home until the youngest is one-and-a-half.” [Dutch field notes - observation 12; Ireen, Dutch nurse]

Subsequently it was the father who came to this consultation, with his son behaving in a shy way, who resisted doing the eye test. The nurse reflected afterwards on the difference between her earlier praise and the later consultation that did not go so well in her view:

“Mother is always very sociable. Father works hard. Mother is more like ’come on, just do [the eye test]’. Normally mother comes, I had never met father.” [Dutch field notes - observation 12; Ireen, Dutch nurse]

This example reflects commonalities across the data, where the focus of evaluations of parents and children’s performances appeared to be mostly based on relationships with mothers and, especially, understandings of their sensitivity towards their children. Trust in the mother was sufficient for trust in parents, with assumptions regarding mothers’ central role making fathers' characteristics less relevant.

This focus also meant that when a child was deemed ‘at risk’ the professionals typically ascribed the responsibility to act to the mother. The mother was usually the key point of communication, regardless of her other (employment) roles or duties. Gender norms thus came to structure the interactions upon which risk assessments were based, through feelings of proximity and familiarity, as well as in advice given to parents:

**Interviewer:** "Do you advise on that – number of hours worked?"
**Doctor:** "No. Only when I see for instance a mother working four days who is struggling, has a hard time, then I would discuss it. [...]"
**Interviewer:** "And do you sometimes also advise father to work less?"
**Doctor:** "Not really. No, never. {Laughs.} No." [Yara, CHC doctor; experience=7 years, Q-147]

There was therefore a tendency to responsibilise mothers – and not fathers – to establish a work-family balance and reduce risks to children, as a means to overcome uncertainties about the children’s present and future functioning.
7.2.3.2 Social class and heightened levels of uncertainty

Processes of trust and uncertainty were also mediated by structures relating to and intersecting with ‘class background’. A “lower-social-class background” was the common term regularly referred to as a (‘potential’) risk factor in itself. Professionals’ narratives indicated its (sometimes complex) association with an array of factors including lower educational levels, financial and psychiatric problems, intelligence, housing limitations, ‘problem neighborhoods’ and non-hegemonic ethnic backgrounds.

Starting assumptions regarding such “troubled” parents usually involved them lacking suitable parenting abilities. Parents were often approached by professionals who were drawing on generalized assumptions regarding what information parents could handle, in attempting to connect with them. Professionals referred to, and were observed as, trusting parents from less familiar (non-white-Dutch-middle-class) social and cultural backgrounds when they were: ‘open’ about their parenting practices and the difficulties they faced; and willing to act in line with expert knowledge and professionals’ advice. This enabled some familiarity and a shared (or in some cases imposed) understanding and way of acting on behalf of the child’s ‘best interests’.

In contrast, professionals reported experiencing many instances where low-income parents questioned hegemonic (intensive) parenting ideology and professional advice. Difference was in itself not necessarily seen as inherently unsafe and in interviews it was often stressed that professionals needed to move beyond their personal norms and understandings; regarding hygiene for example. Yet seemingly as a result of this resistance towards mainstream norms, the relationships between professionals and these lower-social-class parents more often resembled distant they-relationships.

As with earlier examples, professionals negotiated social distance via basic information already collected about these families and group-based assumptions, for example those involving class and ethnicity:
“These people can’t buy a baby bed and [my colleague] picked up a bed with her car. Mother said: ‘my husband can pick it up tomorrow’, but he didn’t show up. These people do have another background; they are not so precise with time and maybe it also has to do with the relationship between father and mother, that they don’t cooperate much. But the child just needs a bed. It’s 11 months and it lies on the ground, this is dangerous. [Yet] they don’t see the danger. Mother said: ‘I don’t have space for it’ […] A very different perception than us, you see this with foreign people. You should not lump them together […], but I’m so happy when I can notice the response, then I’m like: just come and get [the bed]. Though maybe we’re happier than they are.” [Dutch field notes - following observation 31; Tineke, Dutch nurse]

Professionals also experienced difficulties building trusting we-relationships with some university-educated parents, who were also (although much less commonly) described as too critical and sceptical of the professionals:

“The people that don’t open up; this varies a lot. …[It’s] often also those highly educated parents, saying ‘Well, I don’t know what it is you’re doing here, playing games with the kids, but it’s actually just nonsense. And everything’s fine, I can see all is fine, right?’ Well, then you’ve also got a different type of relationship.” [Marijke, Dutch paediatrician; experience=2 years, Q-148]

But the use of more basic risk group indicators amid ‘different’ (they-) relationships led to divergent outcomes in terms of class. The uncertainty emerging within these relations appeared to be much less problematic in cases of higher educated parents.

Professionals made plenty of critical remarks about this latter group, but this was not accompanied by a targeting of these parents with extra professional help or (involuntary) supervision. Disapproval regarding either a lack of emotional care (in case of both parents working full-time) or overly emotional care (in case of uncertain/anxious parents with many questions) was expressed. However, professionals were prone to interpreting this behavior as the higher-educated parents’ choice, or as not harmful enough to act upon, thereby granting these parents a level of autonomy. Professionals’ handling of uncertainty about a child’s situation was thus mediated by class: stereotypes about higher educated parents were less pressing in terms of risk attribution compared to stereotypes about lower educated parents.
In general, the CHC professionals distinguished between parents with at least an intermediate vocational training (or higher) and parents that had ‘barely’ or not pursued education after high school. After labeling a mother “a natural” and “knowing where to seek care”, a doctor checked this woman’s educational level and made positive remarks when reading in the electronic file that mother was a project manager (Field notes; observation 5). In this way, inferred characteristics pertaining to educational/professional and gender norms could be seen to intersect:

A younger mother (aged in her teens) expressed that things were not going so well, because her baby cried the whole time. The nurse did not carry out normal developmental tests and explained to the mother that she would leave her to get on with things, stating she had faith in this mother and the wider family. This happened despite service protocols delineated such a context as involving multiple risk factors (due to mother’s age and infant-behavioural factors). [Dutch field notes - observation 28; Esma, Dutch nurse]

In our follow-up interview to this consultation, the nurse explicitly related her trust to the parent being “such a sweet mother” and “incredibly loving” and to her belonging to a “good and warm” family. She added that people with this surname (common in the area) were usually highly educated (Field notes; observation 28). Here specific parent and child ‘risk’ signs were largely disregarded when a trust relationship was established with a mother, ostensibly from a middle-class background, who was perceived as being sensitive to her child.

7.3 Conclusion and discussion

These final examples and our wider findings shed significant light on the interactional-dynamics of risk assessment regarding children’s future safety and well-being. Our Schutzian approach has focused on the underlying meaning-making processes of professionals’ risk work within everyday (as opposed to ‘high risk’) CHC contexts. This illuminates how familiarity and trust, as structured through professionals’ gender and social background, bore importantly upon experiences of uncertainty, inferences regarding parents and thus on ‘risk’ assessment and interventions carried out on behalf of the state. Manifestations of gender, ethnicity and class within understandings of parenting adequacy have been
understood in the past through more institutional and policy-framework dynamics (Donzelot 1979; Daly 2013; Møller and Harrits 2013), with these more directly framing street-level interactions and decisions involving vulnerable families (e.g. Reich 2005). By digging deeper into the inferential and sense-making processes of risk assessment interactions, these most elemental ways in which actors interpret the social themselves become loci for the reproduction of intersecting social structures (Berger and Luckmann 1967; Brown 2009).

The design of the study – small-n within specific municipalities focused only on professionals – was not oriented towards making general claims about Dutch CHC. We focused instead on an in-depth interrogation of the nature and processes of risk-work itself. Our findings denote the limited functionality – and thus use – of formal-rational risk assessment based on ‘risk groups’, as derived from knowledge of correlations between certain factor-categories and outcomes. This population-level knowledge was invoked but found to be of limited utility in overcoming uncertainty when making decisions in specific cases. Where possible, professionals overcame this looser categorical basis for considering future possibilities through a phenomenologically more concrete relational basis of knowing family futures. The manner by which detailed personalized knowledge was used as a basis for drawing inferences about future parenting behaviour and outcomes, in conjunction with emotions and intuitions, is more accurately captured by conceptualizations of relational trust (Zinn 2008; Barbalet 2009). Formal-rational models of risk assessment were of limited relevance. This is an interesting finding, because the cross-national comparison of healthcare policies between the Netherlands, Germany and Poland has shown that risk detection is especially central in Dutch CHC policies.

Relational assessments of family contexts not only involved professionals trusting in parents but also required parents’ trust in professionals, in order for communication to be sufficiently open for concrete knowledge of parents and their practices to be elicited. As Lareau (2003) and Reich (2005) show, parents within poorer and working class families are less inclined to talk to professionals and teach their children how to talk to professionals in the manner that middle-class families tend to do. Accordingly, we-relationships (Schutz 1972) were more likely
to be built with parents who the professionals felt an affinity with, that is to say parents who more fully shared stocks-of-knowledge with the predominantly white-Dutch middle-class female professionals. We-relationships could be built with less familiar parents where these ‘others’ displayed appropriate (intensive-maternal) parental commitment, disclosure about their parenting practices and openness to professional advice. Generally speaking, however, we-relationships were more straightforwardly built with more highly educated (often white-Dutch) mothers.

They-relationships, in contrast, failed to provide the concreteness of knowledge upon which trusting inferences could be made. In these more distant contexts, professionals resorted to stereotypical knowledge based on general assumptions and/or ‘common sense’ shaped risk-group categories (Møller and Harrits 2013). This weaker form of knowing was experienced as leaving large amounts of residual uncertainty which professionals regularly felt anxious about. Both these bases of more remote knowing tended to lead to middle-class parents being given the benefit of the doubt within they-relationships. In contrast, the cultural stereotypes and ‘risk groups’ applied by professionals could lead to some more disadvantaged family contexts being assumed risky until deemed otherwise. The limits of formal risk-based knowledge were rendered most glaring amongst those families who remained most distant; where a breakdown of trust relations had rendered ‘risk assessment’ little more than guesswork amid a knowledge vacuum.

Social structures of gender, class and ethnicity can thus be seen as active both through the differing potential for we-relationships to be formed and via the generalizing and stereotyped knowledge applied in their absence. These lifeworld structures also directed professionals’ attention towards mothers rather than fathers when assessing family contexts, with we-relationships forming more straightforwardly with women who were implicitly assumed and thus encouraged to adopt chief responsibility. The relative neglect of men amidst these interactional processes can be seen as supporting various negative outcomes: the reproduction of gendered norms of intensive mother responsibilisation; the partial disenfranchisement of good fathering; and the relative overlooking of potentially dangerous men, especially in contexts where mothers form we-relationships with professionals.
More broadly, our analyses point to the usefulness of phenomenological and related frameworks for grasping and interrogating the pragmatic and interactive practices by which health and social care professionals handle uncertainty through risk. Triangulating interview data with observations, especially where brief follow-up interviews immediately post-observation are possible, appears to be especially useful in peeling back the ‘layers’ of professionals’ lifeworlds (Schutz, 1972) as they accomplish this ‘risk work’. The formats of lifeworld assumptions (rooted in structures of gender and class) explored above are in some ways particularly bound to wider notions of good parenting. Risk work in other health and social care contexts will be grounded in different structures of assumptions and wider discourses, though Warner and Gabe’s (2004) research in contexts of mental health services suggests that intersections of gender and race are strongly influential across quite different forms of risk work. While the cultural basis and value positions inherent to risk have long been recognized (Douglas 1992; Szmukler 2003), our framework is useful in deconstructing other forms of risk work, in varying institutional contexts, towards a better understanding of how inequality emerges through situated dynamics of interacting and knowing. Such research would be a useful contribution to a critical medical sociology but can also inform a more reflexive practice among professionals.
8 Pre- and postnatal healthcare professionals knowing, trusting and responsibilizing fathers in the Netherlands, Germany and Poland. A comparative and phenomenological study
8.1 Introduction

We have seen in the previous chapter that interactional dynamics of trust and familiarity were central to Dutch CHC professionals when assessing parents’ capacities in safeguarding their children’s potential futures. Building on the work of Schutz, we distinguished between varying degrees of familiarity with and depth of knowing parents (Schutz 1972, p.164) and examined this in relation to how the professionals interpreted parents’ actions and intentions and whether professionals’ expectations about parents’ capacity and children’s futures were “favourable” or “unfavourable” (Möllering 2001, p.413). It was found that concrete knowledge established in more intimate ‘we-relationships’ allowed for mutual understandings and “leaps of trust” in which professionals held more favourable expectations about parents’ capacities and children’s futures and more readily accepted what was unknown (Möllering 2001, p.403). A lack of concrete knowledge in more remote ‘they-relationships’, on the other hand, often forced professionals to use more abstract and ideal-typical ways of knowing, while favourable or unfavourable expectations about parents’ capacities and children’s futures largely depended on available ideal types in relation to ‘categories’ of parents (Schutz 1972, p.164).

Structures of gender and class were found to be reflected in such trust processes; the professionals ascribed caring responsibilities more readily to mothers than to fathers in more intimate interactions and granted middle class parents more autonomy in case they remained distant, while the more remote non-white/ lower educated parents were in such cases easily targeted with interventions. The ‘unknowable’ was therefore perceived as especially problematic when concrete knowledge was lacking, and ideal-typical knowledge suggested unfavourable outcomes for families who were ascribed certain risk characteristics. Accordingly, the Dutch professionals appeared to be eager to establish direct trust relationships with all parents – or at least with one of each child’s parents or caregivers – including those who remained more distant. Yet, this was not so easily achieved in everyday interactions.

In this chapter, I focus therefore on professionals’ interactions and trust relationships with potentially more distant parents, more specifically: on fathers,
and examine the “good reasons” professionals expressed to have favourable expectations (Möllering 2001, p.412) of fathers’ roles and fathers’ influence on their children’s futures. This is salient to get more insight into how more direct or remote (trust) relationships with fathers relate to professionals’ ascribing either autonomy or responsibility to fathers in terms of caregiving. Indeed, as “street-level bureaucrats” (Lipsky 1980), professionals are in the position to ‘make’ policies through their discretionary space that can be used to structure parents’ roles and opportunities. At the same time, Lipsky argues that professionals often use – and need to use – coping mechanisms to deal with tensions between ‘the universal’ and ‘the specific’, by means of applying stereotypes, and thus ideal types.

However, as shown in the previous chapter, they also get to know and trust parents in direct interactions. The question in this chapter is therefore to what extent, how and when professionals envision fathers as caregivers. It is in the envisioning of such roles – central to their profession – that professionals try to understand and affect others’ (in our case fathers’) future-oriented motives and actions. In other words: how and when do professionals trust fathers as if their possible future caregiving roles will occur and as if this is favourable for children’s futures (Lewis and Weiger 1985, p.969, cited by Möllering 2001, p.414; Schutz 1972, p.148), thereby also making the ‘leap of trust’ with fathers. Scholars have argued that professionals approach mothers as primary caregivers, thereby neglecting fathers (Vuori 2009; Tiitinen and Ruusuvuori 2014; Knaak 2010; Murphy 2003) and that “in the West […] the hegemonic norm of masculinity was never attached to bodily practices like changing the diapers of children […]” (Lutz 2015, p.355). In this chapter, I zoom in on professionals’ knowledge of and interactions with fathers in diverse Western countries to examine this claim and to provide a more fragmented picture of how various professionals envisioned and related to fathers.

According to Schutz, understanding and influencing someone requires direct face-to-face contacts: “Every interaction is, therefore, based on an action of affecting another within a social situation. The object of the action is to lead the partner to have conscious experiences of a desired sort. The necessary condition of the action is that the partner be paying attention to the actor” (Schutz, p.159, emphasis in original text). We have seen so far that Dutch CHC professionals developed such
interactions more readily with (middle-class) mothers but will now look closer at professionals’ knowledge of and interactions with fathers.

When investigating interactions with ‘fathers’, an intersectionality approach is appropriate to “look at the different social positioning of [women and] men and to reflect on the different ways in which they participate in the reproduction of these relations […], [in order] to grasp the complex interplay between disadvantage and privilege” (Lutz et al. 2011, p.8). This is especially relevant since working practices have become more flexible over time due to processes of postmodernity and globalization, which has influenced connections between class and masculinities, including persisting masculinities depicting fathers as ‘breadwinners’ – varying along lines of property, occupation and working in public or private sectors – (Morgan 2005, p.176), and emerging masculinities depicting fathers as nurturers (Hofmeister and Baur 2015; Featherstone 2009; Shirani et al 2012; Coltart and Henwood 2012; Connell and Messerschmidt 2005). Moreover, within increasingly plural societies in terms of people’s race and ethnic backgrounds, it is salient to take into account the “simultaneity and mutual co-constitution of different categories of social differentiation and to emphasise the specificity of the experiences shaped by these interactions” (Lutz et al. 2011, p.2), and thus: how different forms of ‘otherness’ build up and play out in relationships between professionals and various fathers.

The phenomenological and comparative design of this study, using 53 interviews with and 116 participant observations of pre- and postnatal healthcare professionals performed in areas in the Netherlands, Germany and Poland (see chapter 3, page 73 for an in-depth discussion of the methods), is especially suitable to dig deeper into taken for granted elements in how professionals get to know ‘fathers’, and to obtain insights into how specific family policy and healthcare institutions and cultural values shape professionals’ knowledge of and interactions with fathers. The present chapter thus brings our Schutzian analysis further by interrogating the role of institutional structures in healthcare professionals’ sense-making processes and it sheds light on the factors enabling and disabling professionals to be successful in moving beyond structures of gender and class in establishing we-relationships and concrete ways of knowing potentially more remote parents, in our case fathers.
Fathers are not treated as isolated in the analysis but approached in their interrelationships with ‘mothers’. It can be argued that rendering mothers invisible when looking at fathers’ involvement in childcare is counterproductive, since fathers themselves “remain preoccupied with mothers and their perceived power”, and it is deemed important that “spaces for dialogue are opened up […] to build genuinely co-operative relationships between men and women” (Featherstone 2010, p.222).

In chapter 6, the focus has been on how healthcare professionals in the Netherlands, Germany and Poland depicted, applied and formed ideal-typical knowledge about fathers’ roles in parenting, in relation to those of mothers, and how much responsibility this ideal-typical knowledge implied for fathers within different contexts in terms of parenting as well as in dividing and combining working and caring tasks. In this chapter, I proceed with a more phenomenological approach by zooming in on how this relates to the concrete interactions that various healthcare professionals had with fathers and how the depth and richness of knowing fathers and affecting them as caregivers was structured.

**8.2 Results**

**8.2.1 Family policies facilitating professionals to know fathers**

The first thing that stood out in this study was the relevance of different forms of leave for when and whether professionals interacted with fathers and in that sense whether they did or did not get to know fathers as caregivers of their child. These forms of leave could be divided between a short period of full-time leave directly after birth and fathers using leave or flexibility in employment over the longer period after birth to be able to attend consultations. In the Dutch case, two patterns came to the fore: postpartum care assistants, and midwives on the background during the postpartum period, interacted with a broader variety of fathers who were at home the first week after birth through two days paternity leave and a few days holiday, and paediatricians and nurses increasingly interacting with a smaller selection of fathers who attended their consultations when they had a weekly
‘daddy day’ – either through unpaid parental leave, a decrease in working hours, or working hours being differently divided over the week. It was thus found that professionals clearly related interacting with fathers to fathers using some form of leave or flexibility in work.

Interviewer: “And do you see fathers and mothers just as frequent?”
Idelette: “Yes, a remarkable number of fathers are at home. Yes. At least for the first couple of days. It depends a bit on how the weekend falls, so to speak. Very rarely you have a father who needs to return to work immediately, but that’s really a minority. Yes, most are at home.” [Idelette, Dutch postpartum care assistant, Q-149]

“I have to say I’m often seeing fathers at the consultations, who come alone with their child, or have a ‘daddy day’. Then it’s often a day, or two days [per week]. [...] You see this more often in my view. Because well, a father should work part-time then, I would say, when you have a daddy day. (Laughs). I even have fathers who always come, so I’m thinking: who is the mother again? I have those as well. Perhaps you wouldn’t have seen this a few years back, it used to be standardly the mother.” [Yara, Dutch paediatrician, Q-150]

“What’s funny is that I’m working on Fridays and this is really such a daddy day, so you’re suddenly having a lot of daddies at your consultation.” [Marijke, Dutch paediatrician, Q-151]

Most of the German midwives in this study mentioned that fathers were in their experience generally at home for the first two or three weeks after birth.

“My impression is that the majority [of men] stays at home shortly, that is two or three weeks, and then returns to work. Sometimes even much, much earlier.” [Gerda, German midwife, Q-152]

The fact that this period is in general longer, as well as less clear-cut, than the ‘week’ mentioned by the Dutch professionals reflects on the one hand that the German midwives are involved with families for a longer period of time, thus able to capture more variety in the duration of fathers staying at home, compared to the Dutch postpartum care assistants and midwives, who end their home visits eight days after birth and reflect on this ‘week’ specifically. Moreover, it reflects German family policies, in which fathers do not have fully paid paternity leave (as is the case in the Netherlands and Poland), but instead an exclusive entitlement to two months of parental leave, with a relatively generous, but not fully paid, financial compensation. In the professionals’ experiences, these two months, let alone the
additional months to which both parents are entitled, were however not strongly represented.

“The partner possibly has three weeks’ vacation. [...] And it’s still the case for my clientele [...] that very few fathers take paternity leave. So this parental leave, which would be possible ... by the state. But it is quite often a financial calculation.”
[Isabella, German midwife, Q-153]

The German professionals’ experiences of seeing fathers who took up parental leave after these first weeks, thus being able to attend consultations, were much more modest and less consistent. Some of the midwives and paediatricians stated that they did not often interact with fathers exactly because they were usually at work and not on leave.

Interviewer: “Who usually attends with the child?”
Torben: “Mother. [...] For 95 per cent [of the cases], the mother attends.”
Interviewer: “And in the other 5 per cent?”
Torben: “Mixed. Sometimes grandparents. Sometimes father. [...] And that’s, well: I work during hours that those who are not at home with the child are also working, you know. So accordingly, they must take up leave for this time slot and that’s not easy. Because the appointments with us are not always planned in line with fathers and mothers’ agenda’s.” [Torben, German paediatrician, Q-154]

Other professionals did report to have an increasing number of fathers over the years who attended consultations.

“There used to be hardly any fathers in the practice. They only came in the weekends [...] fathers were sometimes sitting at the emergency services but other than this, I predominantly only knew the mothers. [...] It was in the first half of the 2000’s, the first decade I must say, that this has changed a lot: we have seen more and more fathers as well. And it’s now the case that fathers come along quite frequently at the U3 [examination], so when the child is five weeks old, and then often at the next examination as well. Or there are also days that we almost exclusively have men coming in the waiting room, that used to be very different.” [Marianne, German paediatrician, Q-155]

“More and more fathers are attending; in case they have parental leave.” [Sonja, German paediatrician, Q-156]

The latter German paediatricians thus suggested they increasingly encountered fathers who were able to realize some form of leave or flexibility in work. The Polish professionals generally related their interactions with fathers to the two weeks of fully paid paternity leave available within Polish leave policies, and to
parents’ specific occupation and the extent to which this allowed for their flexibility in work, rather than to parental leave playing a role in this.

“I mean at the beginning during the first visits; dads stay at home, because they want to stay at home. In some cases they don’t want to be there, so they go to work because work is the most important thing. But generally, they want to be there and really, for these two weeks they take care of their families, they try to participate in everything.”
[Tekli, Polish midwife, Q-157]

“I meet mothers definitely more often, but as I say, there are more and more fathers every year. What’s curious, it’s kind of a phenomenon to me, parents often come together and are both very interested, but it is very much dependent on where they work. If they have their own company, they can do it. Because I assume that a teacher and an office clerk wouldn’t be able to come to the appointment at 1 P.M., right.”
[Stefana, Polish paediatrician, Q-158]

Professionals’ opportunities to get to know fathers in caregiving roles easily challenged ideal-typical knowledge of mothers’ exclusive roles in caregiving and of fathers supposedly being less fit to perform caregiving tasks. This became especially clear in the accounts of many of the Dutch and Polish professionals, in which such ideal types were explicitly contrasted with reference to their interactive experiences with fathers.

Interviewer: “How do you see mothers and fathers in their roles as caregivers? Does this differ?”
Evelien: “Very funny, because I often see that the mother says: ‘gee, I never expected him to be so… caring.’ During pregnancy the man seemed to have been more like: ‘well’, you know, and once the child is out, he is really completely… And the mother is a bit jealous because he can do things she still can’t with the baby. It’s so funny to see, like: ‘I didn’t do a diaper at all and he…’. And [he is] like: ‘No problem, I will bathe [the baby] now’, you know, these sort of things, not an issue [for him] at all.”
[Evelien, Dutch postpartum care assistant, Q-159]

Interviewer: “[…] and can mothers have a protective role in a certain way, and fathers in another way?”
Tineke: “It could be, but that’s not my experience. […] I think they can supplement each other in a good way, or that the one is stronger in this and the other in that. […] You do have mothers of course who are a bit more caring, but this doesn’t mean fathers wouldn’t be. […] Because when [fathers] are here at the office, they also perform fine.”[Tineke, Dutch nurse, Q-160]

“Most fathers who I see coming here have their children very well under control and deal with them in a fun way, make jokes. Yes, relaxed, most of the time.”[Ellen, Dutch paediatrician, Q-161]

Similar experiences were expressed by many of the Polish professionals.
“Very often during some of my first visits when I instruct them how to bathe the newborn baby, it’s not the mom, but the dad who declares willingness to bathe the baby. ‘Look at me, when you explain, cause I’m the one who’s in charge of bathing.’ […] Sometimes they say kind of as a joke, kind of honestly that if only they could breastfeed they would do everything around the baby.” [Olene, Polish midwife, Q-162]

“[…] Men are not ashamed to, are not afraid to take care of children, they take part in bringing up the children, they are actually not observers of family life, they are very active in this life.” [Zuzanna, Polish midwife, Q-163]

“It’s an absolute novelty in recent years, really, but I see that slowly these fathers are getting interested and it changes even more every year.” [Stefana, Polish paediatrician, Q-164]

Hence, we can see that ideal-typical knowledge about fathers as caregivers often coincided in the Dutch and Polish cases with meeting fathers through forms of leave and getting to know them as engaged and capable in these interactions. Interestingly, in the accounts of the German professionals, these descriptions of fathers in caregiving roles were hardly apparent, as something that the professionals encountered in practice. In fact, when many of the German professionals did interact with fathers, ideal-typical knowledge of gender differences was rather confirmed.

“The man is then really more concerned with organizational things, earning money and so on.” [Gerda, German midwife, Q-165]

“Of course, I talk differently with women than with men. With men, you shouldn’t talk so much. One talks more with women (laughs). Most men who are present at the preventive examinations take an observing role. And when everything has worked out well with the child, it takes another 5 [minutes], and then it’s ok.” [Torben, German paediatrician, Q-166]

Accordingly, it can be shown that family policies that facilitated professionals to get to know fathers through opportunities to interact with them, at the same time facilitated a differentiation between specific fathers taking up leave and others who did not, and between fathers taking a nurturing role and fathers who did not. In this sense, interacting with fathers could also partly confirm existing ideal-typical knowledge of mothers as primary caregivers, which was most common among the experiences expressed by the German professionals.
Dutch and Polish professionals more clearly pointed to differences among fathers, whereas some of the fathers did confirm ideal-types of mothers who – in these cases – were primarily responsible for caregiving, despite of fathers’ presence.

“At the delivery; most men are present and are also supportive towards their wives. And in the postpartum bed, it varies a lot. Some men are very clear: ‘well, those babies, that’s not really my cup of tea’ and they are holding back a bit and just return to work. And there are also many men who are very supportive and do a lot with the children, want to learn everything and are very involved. [...] I think most men are at home in the postpartum week, so they are at least bodily present and it varies [laughs] to what extent they feel engaged.” [Hester, Dutch midwife, Q-167]

Interviewer: “Do you give moms and dads different advice; do they react differently? And do you have some examples of such situations?”

Urszula: “It all depends on how everything goes along, how they share their responsibilities when it comes to children, because when it's very traditional and it's a mummy who is responsible for most of these important issues, including medical things, so I talk with fathers using a bit simpler language or just let them write everything down, or I ask to call the mother. But when a father is equally, or even more, responsible for these medical issues, so they kind of get that major message... It depends more on [...] like, I don't know, the perceptual capacity of the one who takes care of the baby.” [Urszula, Polish paediatrician, Q-168]

In relation to experiencing fathers as involved or as not (so much) involved, an intersection between gender, class and ethnicity came to the fore with mainly a selection of the more privileged fathers using particular forms of leave and meeting with professionals during this leave. In the Dutch case, this was predominantly related to educational level, while for parents who were perceived as less privileged, indications of poverty, ‘lower’ educations and ethnicity, in terms of having an immigrant background (indicated as “allochtonen”, “buitenlanders” or “andere culturen”), were often clustered.

“The role of the partner varies greatly. So also when he is present; the one is just much more involved than the other. [...] I’ve had partners who were smoking outside half of the delivery [...] could be for a number of reasons. And there are also those who are overly concerned, super sweet; there are men because of whom we don’t need to do anything because they care so well. [...] And also during pregnancy; some partners you never see at consultations and others... even want to film the whole consultation [laughs]. And this is also very much dependent on the area in which you are [...] where I have worked, with many single households or immigrants, where men are also less involved due to culture, or to be in a neighbourhood were men are overly involved in the whole happening, like ‘we are pregnant’, and [...] well, where it’s all very much planned. [...] And where it needs to fit into the picture, into work. [...] Many young graduated people who keep lingering here after college. [...] You know, that group; often dual earners and... highly educated jobs.” [Sophie, Dutch midwife, Q-169]
Interviewer: “You said: more fathers are attending compared to a few years ago. And does this mean that the role doesn’t differ [between fathers and mothers], or do you see differences?”

Yara: “No, with these families you see that it’s rather similar, that they try to be there together and to do it in a good way.”

Interviewer: “And with the others, how is it with the others?”

Yara: “Less, I think. Do you mean immigrant children for instance, or lower educated?” [Yara, Dutch paediatrician, Q-170]

A minority of the German professionals who did mention experiences with fathers as being more involved in caring pointed to an even more selective group of fathers, who were privileged in the sense of being able to combine work with leave, either due to their older age or due to working in specific (academic) institutions.

“Of course, there are also men who are very, very much looking forward. These are usually [...] older parents, who are at least in their 40’s, who have then also fixed their career well and the men very consciously [...] take this time as well to really be at home for a longer period, also happy to engage in many activities for the child. So apart from breastfeeding, see what they can do in changing diapers, or swaying, or calm the child down when it cries.” [Gerda, German midwife, Q-171]

“It’s very rare in my experience that someone really takes parental leave, in what I encounter. I have also worked in an [academic] institute and this was different there, because these were all scientists. They sometimes did really take a longer time, depending on how far [in their career] they were, of course not when they were in the promotion phase. [...] I also believe that within such institutes, family policies are generally promoted and family friendly, and that it’s somehow compatible, the opportunity to take at least these two months’ parental leave.” [Gerda, German midwife, Q-172]

This did not apply however to the geographic area where most of the German respondents worked, with a highly developed financial district, in which professionals’ experiences with many fathers actually confirmed a strong breadwinner norm.

“Here in [this city], it’s a special case: I often don’t know the men at all in [this city], [...] not at all. I don’t recognize this from [working in] Berlin. This really stood out to me; I always observe this with great amazement. I have actually experienced that the women came to the delivery alone, without a man. Which I find not bad in itself, you know. [...] I think it is quite legal if a man does not attend the delivery. But the couple needs to clarify this.” [Isabella, German midwife, Q-173]

Given the fact that most of the German professionals worked in this geographic area, it is not unlikely that this has affected the outcomes in this study in which fathers were less often experienced as caregivers, when compared to the Dutch and
Polish professionals. Some of the Polish professionals with experiences in the private and the public healthcare sector mentioned how this distinction structured their different experiences with fathers.

“In public healthcare – in these less well-off families, not working in companies and corporations – more responsibilities connected to childcare [are] then [taken up by] mothers for sure. Mothers, they have 100 per cent knowledge about their kid, fathers rarely appear. But in private healthcare there is higher activity. The younger the child, the more their fathers appear. They know how the labour has been, how much the baby weighed, what score on Apgar scale they had, they come with their children on their own for an appointment or even make an appointment without their kid, because they want to talk about some topics.” [Stefana, Polish paediatrician, Q-174]

Here, an overlap was thus suggested between parents having the financial possibility to afford private healthcare and fathers being involved in caregiving and in attending consultations. While there were no references in the Polish data to ethnicity and parents’ immigration and/or cultural backgrounds, this was more common in both the Dutch as well as the German interviews.

“I really see that fathers are much more involved in taking care of their baby. Not to discriminate, but I’m talking about the Dutch fathers. The foreign fathers still do not interfere with their baby at all.” [Annet, Dutch postpartum care assistant, Q-175]

Interviewer: “Who comes here most often with the children?”
Gerhard: “Well, usually it’s of course the mother. With younger children, then it’s the mother. Lately also more fathers, at least for the German clientele.” [Gerhard, German paediatrician, Q-176]

What I have shown in this section is first that experiences that healthcare professionals in this study had with fathers were facilitated and informed by fathers taking up leave or working flexibly, as fitting within the country-specific institutional context. Although the data indicated that healthcare professionals generally formed ‘we-relationships’ with mothers much more readily than with fathers, I found that professionals who interacted with fathers did also form ‘we-relationships’ with fathers, in which mutual understanding resulted into more in-depth and concrete knowledge of these fathers, as well as professionals contesting and adapting ideal types about mothers’ and fathers’ roles and capabilities. This

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38 The paediatrician did not clarify here what he meant with the ‘German clientele’, but when placing this in the broader context of the (German) interview(s), it can be assumed that he referred to native German clients, as opposed to clients with a ‘foreign’, ‘immigrant’ or other cultural/ethnic background.
more strongly reflected in the Dutch and Polish interviews than in the German interviews. On the one hand, the German professionals were less consistent in having experiences with fathers, and generally reported less of these experiences due to only a few fathers taking leave after the initial weeks following birth. On the other hand, it became clear that face-to-face contacts with fathers did not in all occasions contest ideal-typical knowledge of fathers being more distant or taking less responsibility in caregiving. Hence, such relationships could also be more remote due to fathers being experienced as having a more remote role in childcare. Such distinctions between fathers’ roles, as being more involved or more distant in caregiving appeared to intersect largely with fathers’ perceived class and ethnicity positions, with more privileged fathers being experienced as more involved, in terms of caregiving and in terms of engaging with the healthcare professionals.

The variety in fathers’ involvement and the lack of consistency in their presence, which was in many cases perceived as outside of the control of the professionals, also created space to ascribe more autonomy to fathers in how they wanted to participate in caregiving.

“So well, it varies greatly. And with immigrants, you quite often see that fathers are not present at the delivery, out of culture or religion, so well, this is of course always something to respect. But that's always different, because they only arrive once the baby is born. And they can be very involved from a distance, you know, but on the hallway and help out with everything that happens outside (laughs). So a partner... that's so diverse.” [Sophie, Dutch midwife, Q-177]

“Also during postpartum, I leave men relatively free. [...] So when there is a moment in which they can retreat for example. [...] Basically, I let them do how they please. I don't have... I do invite him of course, but when I have the impression he wants to be out somehow, then I think it has its reasons. For the family.” [Imke, German midwife, Q-178]

“And I hope of course that the father doesn’t completely withdraw himself, or that the one who is not staying at home withdraws, but is also there now and then.” [Torben, German paediatrician, Q-179]

“So what’s my point, we may say that most of the fathers actually aspire to be THIS father, who's with the baby from the very beginning and not that father who suddenly appears when they can chat, or play, or exercise with a child. Which doesn’t mean I judge negatively about fathers who keep such distance. What’s most important is that, same as being present during delivery, [...] that all what this father does may not be forced, done against him. So that the couple, the parents, both future ones and the present ones, so that they know that there is nothing worse than forcing the partner to be present during the delivery, forcing him to participate in bathing without any argument, if he declares that instead he will work, take care of the family and do other
things to relieve his partner of her duties. To understand that we are not all the same. Us, women, we know it easy, cause our maternal heartiness is caused by hormones.”
[Olene, Polish midwife, Q-180]

It has been argued that mothering is in expert literature framed as a duty and fathering as a choice (Vuori 2009), which points to a different set of social norms and responsibilities for mothers—who are expected and to some extent required to perform caregiving tasks – and for fathers – who can in a more voluntary way see if this fits them, without much implications in case they do not perform caregiving tasks. Using a phenomenological approach, this study points to the interactional dynamics involved in how professionals ascribed responsibility in caregiving to mothers in face-to-face interactions based on mutual understandings (see chapter 7), but in many cases consciously granted fathers much more autonomy in being involved in caregiving or not, sometimes also when professionals reached mutual understandings in face-to-face interactions with particular fathers. In doing so, professionals acknowledged diversity among fathers’ levels of involvement, building on their frequent experiences with more remote relationships in case of less involved fathers.

8.2.2 Healthcare institutions facilitating professionals to know fathers

The comparative and phenomenological approach (see chapter 3, page 75) in this chapter is useful in shedding further light on how professionals’ relationships with fathers within specific institutional contexts connected to ascribing autonomy or responsibility to fathers in face-to-face interactions. In this section, I therefore investigate how particular healthcare institutions facilitated and informed professionals in knowing or not knowing fathers and in responsibilizing or not responsibilizing fathers. I do this by taking a closer look at the three professions in this study in which the professionals were found to activate and responsibilize fathers most strongly, which were: the Dutch postpartum care assistants in the postpartum week, the German paediatricians in acute illnesses and the Polish paediatricians (and one midwife working) at the intensive care unit for premature babies. Although these cases are rather different from one another, they can be seen as ‘negative cases’ (Katz 2015 [1981]; Tavory and Timmermans 2009), in which alternative patterns were found that were contrary to expectations. I contrast these
cases with midwives, particularly the German midwives, who were generally found to ascribe the strongest autonomy to fathers, and responsibility to mothers.

What the three healthcare professions in which professionals most clearly activated fathers had in common was that their work contained a central element of crisis and heightened levels of (health) risk for the child, and that both mothers’ and fathers’ everyday (gendered) working and caring practices were in that sense disrupted for the period in which the interaction(s) with professionals took place. This was most visible at the intensive care unit were the Polish paediatricians, and one of the interviewed midwives employed at this ward, worked with hospitalized premature babies.

“A baby staying in a hospital, it’s a different type of contact with a doctor than a baby staying, or a visit at a family doctor, or a pediatrician, for example. So, there are quite a lot of these daddies there in a hospital; children experience a trauma there, so parents always try to complement each other in taking care of their child if they can. Very often mums stay overnight, yeah, but fathers also participate in it a lot.”
[Urszula, Polish paediatrician, Q-181]

Accordingly, in interviews with these Polish paediatricians and participant observations at the ward it was shown that the professionals’ knowledge of fathers was vivid and rich, which especially stood out since interviews with these respondents were comparatively short.

“[The roles of mothers and fathers in childcare] are different, but not by default, it depends more on the type of relationship between parents, the approach to this baby, to having a baby in general. There are fathers who care much more than mothers, there are fathers who aren’t really interested, there are marriages or- or parents where neither of them is interested in a baby, there are some, most of the people, actually, that it is more or less equal: it’s not really like that it’s just the mother; I see that fathers are also very engaged. I don’t know about later, what it looks like in later stages, because it surely changes depending on- work, and so on, but in the period we can observe them I think that in most cases, in the majority it’s like equal.” [Danuta, Polish paediatrician, Q-182]

“I’m positively surprised with how many fathers take part in caregiving, and demand longer visits on the ward, because fathers in our hospital were allowed half an hour. So, they themselves say that they feel they’re discriminated against. After all they are parents too and want to stay longer. And a large number of fathers somehow dominate, and you can see that those parents prepare a schedule: who and when, that it’s not only the mom but also the dad and that’s great because it shows that especially in the case of ill children who stay longer, the engagement of both parents, even with such, it would seem, unmanly things. [...] So I think that this role, against
all appearances, I mean they complement each other, right.” [Beata, Polish paediatrician, Q-183]

Closer ‘we-relationships’ with fathers in which ideal types of mothers’ exclusive roles were adjusted also meant that hospital regulations about mothers’ unlimited stays in the hospital and fathers’ limited visiting hours were contested and renegotiated.

“For those who live in the area here, every dad rather craves the baby just like the mom does. [...] [Fathers] were outraged, when not so long ago we still had those rules that allowed only half an hour a day for the dad. All rebelled against it, and now we have unlimited time, so they can just exchange, and they’re happy.” [Sylwia, Polish midwife, Q-184]

Recurring in these professionals’ accounts was that the increased health risk for premature children, as well as the ‘abnormal’ situation in which a child was hospitalized, required commitment of both parents. Fathers were in that sense granted much less leeway than found in alternative settings in which they could choose for themselves whether they would be engaged.

“I expect parents to engage themselves very actively in the process of childcare, especially during hospitalization, so they are fully prepared when we can discharge prematurely born patients [...] I approve mutual support of spouses, especially in this period when these children spend a couple of months at our ward; I definitely approve this full commitment.” [Wiktor, Polish paediatrician, Q-185]

Activating fathers was in these cases furthermore informed by a concern for the continuing future commitment of both parents after discharge of a baby with additional health needs. Several of the paediatricians mentioned that they sometimes found out later that parents separated, while the professionals appeared to regret that the full burden of care was then placed on mothers.

“We often hear afterwards that parents of premature infants can’t handle the stress and split up.” [Wiktor, Polish paediatrician, Q-186]

“Especially in those families where the child has some hereditary risk, a neurological risk or some other diseases; well, unfortunately it quite often turns out that mothers are left on their own.” [Felcia, Polish paediatrician, Q-187]
At the same time, closer relationships with fathers and renegotiations of fathers’ presence also implied new challenges for the healthcare professionals in the hospital context.

Interviewer: “You just said, doctor, that fathers feel discriminated when they can come only at specific hours.”
Danuta: “For sure, but there is no possibility that somebody stayed here all the time, because we would just have a crowd here, not even mentioning that everyone would come to ask about something all the time, so the doctor on duty wouldn’t - what actually happens a lot, unfortunately, when fathers come in the afternoon and the doctor being on call has to take care of everything and not [...] directly of every baby.” [Danuta, Polish paediatrician, Q-188]

A similar pattern of activating and responsibilizing fathers, although in a different setting, was found in the interactions that German paediatricians had with fathers about acute illnesses, when fathers attended consultation hours with their ill child. Especially in participant observations, it was found that these consultations with fathers were different from preventive examinations of German paediatricians, and also from those of Dutch paediatricians and nurses (who only offer preventive examinations). In about 30 per cent of the observed consultations with German paediatricians, a father was present, which was similar to fathers’ attendance rate at the observed Dutch consultations. In about half of these (German) cases, fathers and mothers came together to a preventive examination or an immunization consult. Fathers were then in many occasions both physically and content-wise standing further away from the paediatrician than the mother, on whom the paediatrician was mainly focused.

So far, only the mother talks to Torben. The father is still sitting on his chair and observes the examination. Torben is standing next to the baby and therefore next to the mother. His body is turned towards her. He does not ask any direct questions to the father. The father now asks whether he will receive calcium tablets for the baby. Torben corrects him and says he most certainly means vitamin D tablets. [...] The baby is getting more restless and the mother tries to calm her by talking to the baby. The father gets up from his chair and goes to the baby, takes a brief look and then goes back to his chair. [German field notes – observation 50; Torben, German paediatrician]

Observed attempts of fathers to step closer to their child and the paediatrician, as well as to engage into the conversation, were successful to different degrees, but mothers’ – predominantly closer – roles to the child remained central within the
interactional dynamics in the majority of the consultations. In the other half of the observed cases that fathers attended however, fathers came to consultations alone with their child, and this turned out to concern almost always (in 90 per cent of the cases) situations of acute illness. Here, it was found that in a rather taken for granted way, paediatricians and fathers exchanged vital information about the health condition of the child. The heightened level of urgency, together with fathers coming alone in these cases, was reflected in the paediatricians being both more open and directive towards fathers, in suggesting and confirming fathers’ responsibility in what needed to be done to improve and safeguard the child’s health.

Johan enters the room and greets the father. The father then tells how the child is doing and names the symptoms. Johan investigates the child. During the investigation, the father holds his child in his arms while he sits down. Johan also sits nearby and examines it, while the father has the child on the arm. [...] After the result, Johan comes back into the room and tells the father that his suspicion is confirmed and the child has streptococcus. The father says: ‘oh no.’ Johan prescribes an antibiotic. Johan then asks the father if the child already has had antibiotics prescribed before. The father answers that this was not yet the case and they wanted to delay the prescription of antibiotics for as long as possible. Johan tells the father that the drug is not so strong and names further benefits. The father asks how long the child should stay at home and Johan replies that until Thursday would be good. The father then asks how the drug should be taken. Then the father asks about the maximum use of the drug. Johan advises on preparations and assures him that he will also write it down. Johan asks the father if he needs a sick report. The father says he does not need it. Johan picks up the recipe, signs it, and hands it over to the father. [German field notes – observation 30; Johan, German paediatrician]

References to mothers’ roles, as well to fathers’ supposed choice in caregiving in everyday life were absent and apparently irrelevant in these situations. Moreover, the paediatricians were found to respond in a rather similar way to mothers and fathers when they attended with an ill child, in terms of applying a medical and curative focus, and also in terms of answering parents’ (frequently asked) questions about the amount of days that the child should stay at home. Hence, it appeared to be especially in these occasions that ideal-typical knowledge of the German paediatricians about mothers’ and fathers’ distinct roles were most strongly contested.

Interviewer: “I would also like to ask if you notice that when men and women ask questions, whether these are different questions or similar questions?”
Johan: “Not, no. Not gender specific, no I don’t think so, not about the child. The concerns are the same; the questions are mostly the same. There are also often fathers coming along with an acute ill child, yes.” [Johan, German paediatrician, Q-189]

Apart from the observed difference between parents coming together and fathers coming alone to consultations, acute situations of health risks, in which paediatricians would rely on their curative role, also appeared to stimulate professionals more clearly to move beyond structures of gender, and also of class and ethnicity. One of the Dutch paediatricians, who had previously worked as a general practitioner, confirmed this observation.

“The moment someone enters with a medical problem, he just wants to be helped and it actually doesn’t matter that much what culture you have in front of you. [...] As a general practitioner, I for instance visited a family once where I really didn’t speak the language and they didn’t speak Dutch, and there were ten family members standing around a man who didn’t feel well. And purely based on sight, I thought: I think he’s having a heart attack. And someone could translate a few things, so I ordered an ambulance and let him be taken away, and afterwards they thought the world of me. [...] But in prevention, this is actually a bit different. [...] When you want to gain respect from a culture, you really should know much more about the background, because you can’t prove yourself with [medical interventions].” [Ellen, Dutch paediatrician, Q-190]

Although medical settings do not rule out taken-for-granted assumptions (see for instance Van Duursen et al. 2004), my findings indicate that in preventive examinations, it appeared to be more important for the professionals to obtain and exchange concrete knowledge of children through parents’ backgrounds and everyday caregiving experiences, in order to gain their trust and also to be able to anticipate and trust children’s secure developments over the longer term. Accordingly, specific language and knowledge barriers between professionals and parents, as intertwined with gender, ethnicity and class, frequently appeared to be more of an obstacle in preventive examinations.

Marianne asks the mother to bring someone next time who can translate from Polish to German. Marianne first does not ask any further questions, as was the case in the other examinations. [...] The conversation is slow. Marianne asks if it’s mother’s first child. She briefly confirms. Marianne simplifies her language as much as possible and says phrases such as: "Daytime always on belly." Then she asks about the food of the baby, which the mother cannot answer. [...] Finally, Marianne says, "All well with hips." The mother says nothing. [...] [Marianne] emphasizes again that the mother and Marianne must be able to talk with each other, otherwise ‘it does not work’. [German field notes – observation 57, Marianne; German paediatrician]
Hence, an unexpected finding in this study was that it was exactly in consultation hours for diagnosis and treatment of children’s acute illnesses that the German paediatricians built closer relationships with fathers when they attended such consultations, in which clear responsibilities were ascribed to fathers. In preventive examinations on the other hand, not getting to know parents’ everyday life experiences with their child, due to levels of otherness in terms of incomprehensiveness of language or not being primarily responsible for the child, turned out to be more problematic, because this knowledge was important to relate current practices to children’s favourable (or unfavourable) futures. In chapter 7, it has been argued that mutual understandings between female Dutch CHC professionals and mothers seemed to stem from similarity in gendered experiences. However, when taking alternative cases in the German and Polish data into account with male paediatricians interacting with mothers as well as fathers, it was found that similarity in gender could on the one hand indeed facilitate mutual understandings, but mutuality – for instance between male German paediatricians and mothers – was on the other hand clearly related to how well a parent knew the child by being a primary caregiver.

The third profession that stood out in the degree to which fathers were activated and responsibilized in caregiving concerned the Dutch postpartum care assistants, which was not a matter of children’s illness, but a matter of the timing of postpartum care assistants interactions, in relation to (new) parents learning to deal with the often unexpected ‘crisis’ of caring for a new-born child in the home situation, without medical staff and resources. What was atypical in the work of the Dutch postpartum care assistants during the postpartum period was that they helped and instructed parents in how to care for their baby already from a few hours after birth onwards in the family home. The German and Polish midwives were on the other hand generally involved in postpartum care either in the hospital or in the family home once the baby and mother were discharged from the hospital a few days after birth.

German and Polish midwives and Dutch postpartum care assistants (in collaboration with Dutch midwives) performed very similar tasks, such as monitoring the baby’s health and the mother’s recovery as well as helping and
demonstrating parents in how to feed, bathe, carry and cloth the baby. Yet, the Dutch postpartum care assistants showed a specific focus and dedication to this first week at home, directly after birth, in which parents – according to the professionals – usually experienced the new life change as a disruption of everything they had been familiar with.

“And then they have a baby and it’s, wow, really a baby. Because well, it cries and you can’t go away and you suddenly can’t go out. [...] But I also find that important, that they know after eight days, that it’s not just ‘how do you change a diaper?’ but also ‘how do you deal with a little baby?’” [Annet, Dutch postpartum care assistant, Q-191]

“I [...] see this in these postpartum families; they are just scared stiff, by such a baby. [...] I actually throw them in the deep right away: I’m not doing the first bath alone, no: ‘you are doing the bath, I’m standing next to you.’ I try to provide them with self-confidence very soon, because they usually just find it very scary, such a tiny baby; afraid that it might break, being concerned about all sorts of things. And you do see that when you put them to work immediately – as far as possible, right, it depends on the extent to which they are restricted by... when the postpartum woman can’t do it; I immediately put the postpartum man to work. And you are steering from the background. So that after a few days, they feel like: I dare to do almost everything by myself; I’m not afraid to do it on my own later on. That’s my aim actually.” [Idelette, Dutch postpartum care assistant, Q-192]

Since all interactions that Dutch postpartum care assistants had with the parents and their baby were concentrated in this one week, with both mothers and the majority of fathers staying at home, the Dutch postpartum care assistants in this study were predominantly concerned with both parents for this fixed period; in engaging them in learning how to care as well as in using both parents’ resources to deal with ‘crises’ of caring.

“I want them both to be equally concerned with the child. And I teach them both how to care; I want the father to do it as well. And afterwards they can choose how they’ll be dividing it. I don’t interfere with that. [...] [But] I try to pass on to them of course that it’s convenient when you keep doing it both.” [Idelette, Dutch maternity assistant, Q-193]

“My latest family [...] chose not to give a pacifier, that’s fine, it’s their good right. But the mother was full with milk and the baby had its belly full, but she wasn’t satisfied. [...] So, you can’t solve that. [...] The mother needs to sleep. So, who should do it? The father. [...] I say: ‘the little one has a major need to suck and your breasts are so full that she is full with three big swallows, but she does want to suck.’ So, I explained to the father: ‘you need to wash your hands thoroughly and you need to go sit with your child’. And he was like: ok, so I have to do that? I say: ‘yes, you have to do that’. And then it’s fine and eventually he is doing it, and he actually likes
“It’s not the case that I think the mother should do everything; the father should do it just as well.” [Sandra, Dutch postpartum care assistant, Q-194]

“When a father says: ‘I’m not going to do that’, I say: ‘but it is also your baby, right?’ Or when a mother says: ‘it needs to wear this today’, I say: ‘today it’s daddy’s day, so daddy can choose which clothes the baby will wear.’” [Leen, Dutch maternity care assistant, Q-195]

Hence, what also turned out to be atypical in the work of Dutch postpartum care assistants in comparison to the midwives was that they did not have a history of guiding women during pregnancy, neither with having had more interactions with women than with men within couples.

This was especially in contrast to the German midwives, who reported to develop strong relationships with mothers, which potentially continued for up to a year after birth and could be continued for subsequent births. Such trust relationships with mothers were found to have an impact on how midwives related to parents in the post-partum week, and to the relationships that these midwives could develop with fathers.

Imke: “Because women get to know me better, they also often report problems. [...] My impression is that the earlier you get to know the people in their pregnancy, the longer the contact remains afterwards.”

Interviewer: “Does this mean that a very close trust relationship develops?”

Imke: “Frequently, yes.”

“...It’s of course the case that I’m working here for a couple of years already. At least half – if not more – of the women who already have children also gave birth to them with me, I have guided them. I know the men. And then they are honestly not interested in a first consultation in pregnancy. So, they are [...] then going to work and so on and that’s also what the women find primarily important.” [Imke, German midwife, Q-196]

The majority of the German midwives nevertheless tried to engage fathers in the postpartum week, especially in encouraging them to bathe and talk to their baby, but their interactions with fathers generally appeared to be more remote and their knowledge of fathers less direct and concrete. The Dutch postpartum care assistants in this study on the other hand mentioned numerous examples of their diverse interactions with fathers and accordingly displayed a frequent adapting of their ideal-typical knowledge of both mothers and fathers.

“I though lately: I need to mind that. When the baby is bathed, we always do it the first time, that’s how we’ve learned it. This is so standard. And last time, this man
said, ‘yes, but I actually wanted to do the first bath’. And I thought: yes, of course. So now I ask sometimes: ‘or would you prefer yourself to…?’ We have learned that: we show this and that first. But of course, I can imagine you want to do it yourself the first time. These are the things; you keep learning every day.’ [Evelien, Dutch postpartum care assistant, Q-197]

“The father sometimes feels uncomfortable [about the baby on his naked chest] – when we are there, is my experience: ‘[…], yes, I will do that to-, can I do that tonight?’ I say: ‘yes, tonight is also okay’. You know, because you can just tell that he’s thinking: ‘Then I should sit her presumably in my naked chest, with the postpartum care assistant present?’ ‘[…] And you know: talking to the child when you dress it [we tell them]: do let your voice be heard. […] [And] mother does indeed feel like [talking]: ‘well, mommy is going to...’ But such a father thinks: ‘is she also standing here? Okay, am I doing it right?’ And then I say at a given moment […]: ‘just pretend I’m not here, I’m going to stand over here.’ ‘[…] And you do listen of course. And THEN you hear [him] saying: ‘daddy is going to take your dirty diaper off’, you know. But when you’re standing right there, it’s often more difficult with fathers [laughs]. That’s funny. With a few exceptions of course right, because you always got those.’ [Sandra, Dutch postpartum care assistant, Q-198]

“And like with Moroccan families, I saw lately – I told a [colleague] – I said: ‘gee, they were really, well, it was really a unity, a man and a woman’. Moroccan family. You don’t see this so often, always a bit this – they keep this distance. […] But real buddies.” [Evelien, Dutch maternity care assistant, Q-199]

What also appeared to be crucial in interacting with fathers were the hours postpartum care assistants spent at the family home, which concerned four to eight hours a day for eight subsequent days, starting early in the morning. This provided the Dutch postpartum care assistants with much more opportunities than the midwives in all three countries – who paid the family planned visits of 30 minutes up to a few hours every (other) day in the first period – to encounter fathers, including those fathers who were experienced as more distant and away from home.

“I happen to have been three times in a row with families from Iraq […] but well, I mean, when you see this: there is again also just difference. […] Because when I look at the first family; I came in and the father opened the door, and it was really like: he looked angry at me. […] Well, the mother was upstairs and then- well you don’t understand anything of the situation. […] You know, and the next day, I came and [we were] talking, and at a certain moment […] she is telling me about the situation. And then it appears that the father... is the father of the third child, but in the end has another home in [a different city] and has a girlfriend there. And how much grief comes up then. […] And you’re thinking: yes, what- what are we going to do about this? […] Because the woman was so very neat in her house, everything spic and span, and two very nice little boys […] everything very cozy, but well, the father was nowhere to be found. But I didn’t want her to be alone at night. So, you’re going to look for: what’s going on? Well, and he comes and I say: ‘are you here or are you not here?’ Yes, he is here at night. And later on I thought: ‘wait a minute, at night, but I’m here at 8 in the morning: where are you then?’ Because he didn’t work. Well and
then eventually, he was indeed in the next room. Because you know, when something happens with such a mother; two little boys, they really can’t do anything you know. I’m like: not a thing should happen with such a woman.” [Sandra, Dutch postpartum care assistant, Q-200]

Hence, in the case of the Dutch postpartum care assistants, getting to know and interact with very diverse fathers and holding them responsible to care for their child and partner in a critical period, translated into limited leeway for fathers to be autonomous or distant.

Healthcare institutions and forms of interventions were thus found to be relevant in structuring professionals’ opportunities to actively relate to fathers. Elements that turned out to be important in this respect concerned first heightened levels of risk for child and mother; second situations of urgency and acuteness rather than prevention; and third either interacting with fathers alone or interacting with fathers and mothers in similar durations and frequencies. We can assume cross-national similarities between the same professions, which were not found in this study due to the design and sample, such as between the intensive care ward in Poland and other intensive care wards in Poland, the Netherlands and Germany, and between German paediatricians dealing with acute illnesses and Polish paediatricians running similar independent practices focused on treatment and prevention, who were interviewed, but not observed in this study.

At the same time, we can also assume differences, because the ways in which the professionals activated fathers in the cases presented above appeared to be intertwined with leave policies, as well as cultural values and professionals’ ideal-typical knowledge about fathers’ involvement and shared parenting, especially strong in the Polish and Dutch cases. Moreover, they were intertwined with how pre-and postnatal healthcare policies framed medical risks, especially in the German and Polish cases, and psychosocial risk especially in the Dutch case (see chapter 4 and 5). The latter can be demonstrated by the fact that the Dutch midwives, within a profession that is more clearly structured around mothers than fathers compared to Dutch postpartum care assistance, also increasingly reflected on potential problems of not knowing fathers in more critical situations, especially since the midwives’ opportunities to ‘know’ fathers were different.
“This woman was […] diagnosed with a mental illness […] and ran away from home at night. […] And I thought: I don’t know anything about this father. I had no clue whether he also had a history of mental illness. […] So in the end I decided: to place the child out of its home, because I also don’t know whether the child is safe with him. And this is actually striking; with that mother you’re very much occupied with screening all sorts of things […] but you actually know very little about those fathers.” [Hester, Dutch midwife, Q-201]

8.2.3 Individual professionals being active in getting to know (more distant) fathers

In the previous sections, I have shown how pre- and postnatal healthcare professionals were – through family policy and healthcare institutions – positioned differently towards mothers and fathers and they therefore had a varying range of opportunities and different inclinations to a) get to know fathers in direct face-to-face contacts and b) ascribe responsibilities to fathers within more direct ‘we-relationships’. The agency of healthcare professionals, as “street-level bureaucrats” (Lipsky 1980, p.4), in mediating between government policies and parents through their activation of mothers and fathers as caregivers was thus informed by the institutional context in which they worked.

At the same time, within such contexts, individual healthcare professionals did use their “discretionary space” (Lipsky 1980, p.13; Freidson 2001) in different ways in how they interacted with mothers and fathers, in how they depicted their roles and in how they activated them in certain ways, thereby affecting mothers’ and fathers’ chances to be involved in their children’s lives, as well as to perform and divide their working and caring tasks. One of the Dutch midwives, who had formerly worked as a postpartum care assistant, observed the following:

“I think it varies […] very much how the postpartum care assistant deals with [fathers]. And I think the postpartum care assistant can involve men much more in relation to the degree that she finds this important. So, the one emphasizes this more than the other. You know, the one creates a bit of a women’s sphere in such a postpartum period, in which the postpartum care assistant and the woman do a lot together, and the other involves the man much more in this. And finds it much more important like: ‘you have to do it as a family eventually, and… move onwards’. […] There are postpartum care assistants who send men outdoors three times a day to go for groceries again, and there are also postpartum care assistants saying: ‘you know, I’m going for the groceries and you lie down in bed with the three of you’. Or: ‘you lie down with your child on your naked chest and… experience what this feels like… and build that bond with your child’. [Hester, Dutch midwife, Q-202]
In this section, I bring individual professionals to the fore who were found to use healthcare and family policies – and their related experiences and ideal-typical knowledge – in such a way that they stood out in going beyond structures of gender and class to establish more direct ‘we-relationships’ with fathers, potentially more distant to them than mothers, and in engaging and activating various fathers in caregiving roles.

The case of Wiktor, a Polish professor and paediatrician who was the head of the ward for premature babies where most of the paediatricians in this study worked, shows that agency and judgement in creating opportunities for fathers to engage in caregiving tasks can be found at different levels. The paediatricians on this ward who interacted with mothers and fathers were rather consistent in what they said about facilitating and activating mothers and fathers to hold their baby against their naked skin through “kangarooing”. This is very much in line, first with biomedical scientific literature on attachment and decreasing health risks for premature infants and second with developments in Polish OC that incorporated physical contact between parents and babies within their standards (see chapter 4, page 113). Yet, decisions needed to be made, in this case on the management level, to create and realize such opportunities. Some of the Polish paediatricians expressed that professors who were in charge of hospital wards were found to be influential on the standards applied in the specific ward.

“We are after all a centre, I mean in neonatology there are centres of three levels of care and ours is of the highest referral level, we have the biggest pathology, the most severe patients. […] I guess each ward has its own, I think even we do, [...] we work in a slightly different way than others in the same hospital, so on each ward there are some differences.” [Felcia, Polish paediatrician, Q-203]

“It’s like this in Poland that each clinic, each professor, has some different style and different way of thinking.” [Stefana, Polish paediatrician, Q-204]

Wiktor himself stated that in this ward, they stimulated fathers to provide ‘kangaroo’ care. Within the participant observations, it was confirmed that this was not necessarily the case in any hospital or ward.

I asked [Janek, Polish paediatrician] about the skin-to-skin policy and Kangaroo care: according to the interviews this was special for this hospital. Janek confirmed: ‘yes,
we do that’. […] From a friend of his he knew that a hospital in a city nearby didn’t do it. This could also be for practical reasons, because you need a big chair in the ventilated and heated room where parents could sit with the naked baby on their naked chest. Not all hospitals had space for this. After the conversation, we were shown a big space behind glass were several incubators stood with small babies in them, attached to the devises. Doctors as well as parents were standing and walking in between the incubators. Janek pointed us to a large brown chair in the middle. This was the chair in which parents had ‘kangaroo’ moments with their babies. [Polish field notes – section 3]

Although the data was not conclusive about whether Wiktor himself had initiated the Kangaroo chair in his ward, what turned out to be important is that when he expressed he expected from fathers to perform kangarooing, both in direct contacts with parents as in managing his team, such agentic actions within the specific institutional context are potentially effective in framing fathers’ roles.

“Here, fathers perform kangarooing. […] This creation of a parenting bond, well it has to happen without this sort of- without this lactation element.” [Wiktor, Polish paediatrician, Q-205]

Marianne, a German paediatrician, appeared to be especially active within the German sample in seeking opportunities to create trust relationships with potentially more distant parents according to gender, ethnicity and class. While she claimed to know fathers in more than half of the cases in her clientele, she also provided an example of how she specifically related to fathers in encouraging them to attend her consultation hours.

"I've had men's literature as well [in the waiting room] from the start. So, I've been riding motorcycles and therefore had motorcycling magazines and things like that, and The Economist and those sorts of magazines. Yes, and that was very, very interesting, and we have validated this as well, and consequently they also noticed they were being addressed, right?” [Marianne, German paediatrician, Q-206]

According to Marianne, government regulations that made preventive examinations mandatory had accomplished that currently ‘all’ parents were attending these examinations; thereby she referred to variety in terms of parents’ class and ethnic backgrounds.

“What has also changed quite strongly is that they just all come, right. This used to be not the case. Before, it used to be common for families with a migration background and a relatively low social status that they came until [examination] U7, so the
children were two years [old]. At three years, there were then no more examinations. [...] And that’s different now; they have to come, right, because otherwise they would get a visit from the Youth Office.” [Marianne, German paediatrician, Q-207]

At the same time, Marianne also presented herself to parents as having a migration background, and speaking multiple languages herself, in order to facilitate trust relationships with parents with a history of migration.

"Parents with a second-generation migrant background [...] who want a better future for their children, so they have high expectations and demands from their children, often ask me for advice. I have lived in Africa for a long time at different ages, as a child and later also as young person or young adult, and that creates I think above all for the children for people from Africa, but partly also from France – because [...] I am bilingual [...] – so it creates a basis for trust, that they then come and discuss such questions with me and ask how they should proceed." [Marianne, German paediatrician, Q-208]

Accordingly, Marianne appeared to have many direct contacts both with fathers and with parents from various migration and social class backgrounds. Yet, when we look at the intersection between gender and ethnicity, relationships that Marianne had with fathers with a migration background turned out to be more distant.

"In other cultures,39 it’s the case that fathers simply want to be left alone, and do not have much questions at all, or just want to have a rough estimate: ‘is it dangerous or not dangerous?’ And the mothers are mainly the ones, and apparently also the - let's say - the driving force in this, who the child always faces." [Marianne, German paediatrician, Q-209]

Other German and Dutch professionals reported similar experiences, and fathers from a different ‘culture’ were thus granted much space to remain autonomous when they seemed to prefer this. Leen, a Dutch postpartum care assistant, did however extend her knowledge and experiences in involving fathers also to the fathers who appeared to remain more distant. We can see here that Leen combined her opportunities to meet more distant fathers, following from spending days at the family home, and her agency in using discretionary space to involve fathers, thereby moving most clearly beyond structures of gender, class and ethnicity, in connecting to and responsibilizing fathers in caregiving tasks.

39 The paediatrician refers later in this quote to ‘non-German speaking’ parents who are ‘perhaps not well rooted here in our culture’.

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Leen: “An Arabic man, or a Muslim man, will not easily take a child naked on [his skin]. No, he actually prefers to be away for the whole day. That’s not- it’s a women’s thing, right.”

Interviewer: “But what’s your role in this? Do you have a role in this?”

Leen: “To involve him anyway. Yes, and still you know, today again, that man was at home for a moment, done groceries, and sat on the couch, and the baby comes downstairs to drink, from the mother’s breast. Well: give it to daddy. I said: ‘can you hold him for a moment?’ [Laughs] ‘I’ll make some tea’. Or something, you know. Right on, no discussion, just in his arms. And I bring it with a smile, but in the end, the baby does lie in their arms and these daddies light up even so. They don’t dare to; daddy shouldn’t ask, I don’t know.” [Leen, Dutch postpartum care assistant, Q 210]

In this excerpt, it was shown that Leen did not know or understand exactly what was behind certain fathers not taking initiative to physically engage with their babies, but she still took a “leap of faith” (Möllering 2001) in envisioning them as if they were having a nurturing role. The excerpt shows that while doing so, she tried to grasp and make sense of this father’s response as she mentioned that in the end ‘these daddies light up even so’. We can thus see that the knowledge drawn from previous relationships with parents that Leen experienced as a postpartum care assistant – having worked for more than 20 years at parents’ homes with a diverse population in terms of gender, class and ethnicity – served as input for new interactions with diverse parents, in which fathers’ otherness and distance had become relative. In such interactions, brief and casual as they may seem, individual professionals – whose positions towards mothers and fathers were informed by their specific institutional contexts and shaped by their situated previous experiences– were at the same time able to shape and reshape mothers and fathers’ roles in the early stages of caregiving.

“Sometimes also in the relationship, you know. You should not interfere, but sometimes you are able to give this hint to that man. Recently, I received a very sweet letter of a man, also a foreign family. A girl of about 8 years [old] and then a baby. Well, the 8-year-old girl was of course very disappointed, because what can you do with a baby? You can’t play with it, mommy was dealing with the baby all day, and she withdrew to her room, didn’t want to come with the bathing. And that man was at home. [I said] to the man: ‘You know what you should do in the afternoon? You should take your bike and your daughter takes her bike and you go to McDonalds to have an ice cream.’ The weather was great. ‘You’ll go cycling together for a while.’ Well, and then from this foreign mister you receive a beautiful letter how much he has appreciated that. At that moment, his eyes were opened. Like: ’I have to give my daughter attention. When I don’t, I’ll just loose her.’ Yes, and really months later, he wrote this letter.” [Leen, Dutch postpartum care assistant, Q-211]
In Lypsky’s words (1980, p.9): “The reality of the work of street-level bureaucrats could hardly be farther from the bureaucratic ideal of impersonal detachment in decision making. On the contrary, in street-level bureaucracies the objects of critical decisions – people – actually change as a result of the decisions.” At the same time, I have shown in this chapter that the range of opportunities that individual professionals had were strongly informed by institutional contexts and their previous situated experienced that took place within this specific context. Not only family policies but also healthcare institutions and the ways in which they intersected were found to be important in how diverse healthcare professionals were inclined and able to understand and affect fathers as caregivers of their children within direct trust relationships.

8.3 Conclusion and discussion

Starting from the premise that mothers are predominantly approached as primary caregivers in family policy and healthcare institutions, within cultural values, and in professional-parent interactions (Vuori 2009; Tiitinen and Ruusuvuori 2014; Knaak 2010; Murphy 2003; Lutz 2015), this chapter has looked with further scrutiny at professionals’ favourable expectations of and trust relationships with fathers, taking diversity in fathers’ class and ethnic backgrounds into account. Following Lipsky (1980), I have drawn attention to the relative autonomy of individual professionals in their position between policies and citizens, in our case parents, within hierarchical relationships, in which they often apply stereotypical knowledge to understand specific individuals (see also Rowe 2012).

The comparative phenomenological approach used in this study however, that builds on Schutz’ (1972) concepts of how individuals get to ‘know’ and ‘affect’ others and how this relates to professionals’ (un)favourable expectations (Möllering 2001) of parents, sheds more light on varying degrees of directness and trust in interactional dynamics between healthcare professionals and fathers that might easily be overlooked. I show in this study that structures of gender and class, as input and as output of trust processes between professionals and fathers, are shaped and informed by institutional structures. This is useful to better understand the
variance in fathering roles that others have detected (Grunow and Evertsson 2016; Hofmeister and Baur 2015). An intersectionality approach (Crenshaw 1989; Lutz et al. 2011) turned out to be especially salient to see how different levels of ‘otherness’ were intertwined, reproduced and also challenged within professional-father interactions, which were in turn shaped by family policies and health care institutions.

In this chapter, I have argued that family policies and healthcare institutions coincide in and inform the extent and content of professionals’ direct interactions with fathers. In the Dutch and Polish cases, a more frequent and concrete knowing of fathers as caregivers translated in professionals contesting and adapting ideal-typical knowledge that a) framed mothers’ exclusive roles and b) presumed fathers as unfit or less fit to be caregivers. In the German case, this challenging of ideal types was not as clear and less consistent. Interactions with fathers – or the lack thereof – could therefore also confirm ideal types of fathers’ relative distance to their children and caregiver role. Gender, class and ethnicity intersected in this respect, with more privileged and ‘native’ fathers being experienced as most engaged in taking up leave and in caregiving. This study further indicates that healthcare structures were salient in how professionals ascribed either responsibility or autonomy in caregiving to diverse fathers. More direct trust relationships and responsibilities for fathers were found first in situations of heightened levels of risk for child and mother; second in situations of urgency and acuteness rather than prevention; and third in professionals either interacting with fathers alone or interacting with fathers and mothers in similar durations and frequencies.

Such structural factors turned out to be highly relevant in how individual professionals used their discretionary space to understand and affect fathers, and their inclinations and opportunities to establish ‘we-relationships’ with fathers from diverse class and ethnic backgrounds. While similarities between professionals and parents in terms of their gender, class and ethnic position turned out to be helpful in establishing mutual understandings, accepting the unknown and forming favourable expectations of parents (see chapter 7); the richness of professionals’ concrete experiences with diverse fathers who were in turn in direct (and physical) contact
with their children could also enhance such mutual understandings and favourable expectations of fathers. It were exactly these experiences that were strongly informed by the institutional context.

The relatively small sample used for this study, located within specific geographic areas, and the inclusions of professionals that were cross-nationally comparable, but not exactly similar, implies that the findings of this study are not suitable to make general claims about pre- and postnatal healthcare professions within the Netherlands, Germany or Poland. The comparative design of this study was on the other hand focused on obtaining an in-depth understanding of the interplay between varying family policy and health care institutions and professional-parent interactions. The dissimilarity between the professions in this study, with Polish paediatricians working on an intensive care ward with premature babies and German (and Polish) CHC paediatricians offering both treatment and prevention as opposed to the Dutch CHC paediatricians, turned out to be an advantage in understanding variances in how and when professionals trusted and affected fathers.

In this chapter, I have focused on contexts in which professionals used their discretionary space most clearly to challenge fathers ‘otherness’ and to make fathers responsible as caregivers. However, this is not to say that within everyday life, gender differences between mothers and fathers in caregiving roles are generally disappearing. Professionals’ roles should in this sense not be overestimated, as professionals themselves described being very much aware of. Yet, their roles should also not be underestimated. The professionals in this study were at the same time found to be important and in a way ‘life changing’ (Lipsky 1980) when they engaged fathers in caregiving, especially in the early stages of parenthood and childhood which is believed to have long-term effects on parents’ task divisions and fathers’ on-going involvement in their children’s lives (Cook et al. 2005; Marsiglio 2004; Cabrera et al. 2008).

This chapter builds on the previous chapters, with a cross-national comparison of healthcare and family policies and professionals’ situated ideal-typical knowledge about (gendered) parenting risks and responsibilities on the one hand, and on a
deeper phenomenological understanding of interactional dynamics in professional-family interactions on the other hand, in order to cross-nationally examine diverse professionals’ trust relationships with fathers, who were potentially more distant to them than mothers. The contribution of this chapter is that important linkages could be shown between institutions and interactions, which sheds light on how healthcare and family policies influenced how professionals got to know individual parents, thereby reproducing and/ or going beyond categories of gender, class and ethnicity in shaping and reshaping parents’ roles as caregivers. This research goes further than policy-based studies (Møller and Harrits 2013) in taking professionals’ agency and discretionary space into account, while it provides a more nuanced understanding of professional work (Lipsky 1980; Freidson 2001) in showing how this discretionary space is embedded within particular institutional contexts. Combining a comparative and multi-level design with a phenomenological approach can therefore be an insightful way to obtain a fuller understanding of the work of ‘street-level bureaucrats’ (Lipsky 1980), and of professional-family interactions in healthcare in particular, and as such contribute to the field of medical sociology.
9 Conclusion and discussion
9.1 Introduction

When boundaries between women’s and men’s educational and labour market opportunities are blurring in contemporary European societies (Beck 1992; Zinn 2008a) alongside an increase of gender egalitarian values (Beck and Beck-Gernsheim 2002; Luck 2006), it becomes highly salient to improve our understanding of persisting gendered parenting roles (Davis and Greenstein 2009; Bonke et al. 2005), and of how they are reproduced and shaped over the course of pregnancy, childbirth and childcare (Bühlmann et al. 2009; Grunow et al. 2012; Grunow and Veltkamp 2016). Women’s and men’s gendered divisions of working and caring tasks during the phase of family formation have predominantly been studied and compared across countries from the perspectives of welfare state policies, labour markets and “cultural family models” (Pfau-Effinger 2005; Grunow and Veltkamp 2016; Hobson and Fahlén 2009; Kremer 2010). Other case studies have paid attention to how mothers’ and fathers’ gendered roles were reproduced within expert knowledge or healthcare settings in specific countries (Vuori 2009; Knaak 2010; Murphy 2003; Müller and Zillien 2016; Tiitinen and Ruusuvuori 2014).

In this dissertation, I have argued that it is crucial to examine the distinct perspectives at play in the process of childbirth in relation to one another, that is: the (un)equal work and care divisions and pathways of women and men following childbirth and their capabilities to reconcile family and work, but also the development, health and well-being of infants and related responsibilities ascribed to mothers and fathers within society in general (see also Gornick and Meyers 2003; Saraceno 2011) and within pre- and postnatal healthcare contexts in particular. Moreover, I have proposed to examine and compare these perspectives by deconstructing representations of ‘risk’, in how particular consequences are anticipated and valued, and thus enhanced or prevented, in relation to particular perceived threats (Boholm and Corvellec 2011) as highly influenced by cultural values (Douglas 1986; 1992; Logue et al. 2016) and taken for granted assumptions about gender (Hannah-Moffat 2004).
To that end, I have performed a cross-nationally comparative, multi-level analysis in which I have used a phenomenological approach to link wider cultural understandings, policy logics and professional-family interactions in the Netherlands, Germany and Poland. The novelty of this thesis is that with this approach I have shown how professional-family interactions are vitally embedded in wider cultural understandings and policy logics, while culture is at the same time reproduced in, and policy comes to life through, these interactions. Therefore, I have brought interactional dynamics and sense making processes to the fore, as related to risk and trust in professionals’ encounters with particular mothers and fathers, which serve as context-specific mechanisms in which gendered parenting roles are reproduced and shaped. In this chapter, the theoretical and methodological implications of my dissertation as well as the strengths and limitations of this study, are discussed, followed by policy implications of my research.

9.2 Theoretical implications

9.2.1 Risk perspectives

The first implication of this research is that risk perspectives that guide pre- and postnatal healthcare policies are often not in line with risk perspective that guide family policies in terms of what ‘risks’ are at stake and in terms of who are targeted as being responsible: mothers, fathers and/ or parents in general. Since such institutions and related – or conflicting – cultural values about mothers’ and fathers’ roles and children’s development appeared to be country-specific, this also leads to particular tensions (Gale et al. 2016) that structure and inform risk perceptions and parenting roles in professional-parent interactions. Within healthcare and family policies, and accordingly in the professionals’ generalized knowledge about how to perceive and approach ‘risky’ parents and parents ‘at risk’, variation was found in the degrees of medicalization; the extent to which they ascribed autonomy to parents; the narrowness of framing care in one-on-one relationships or as distributed over several caregivers, and whether caregiving responsibilities and risk assessment were attributed exclusively to mothers, or also to fathers. Hence, this research shows that context-specific constraints and opportunities for parents, mothers and/ or fathers to address and avoid risks for
their young children and accordingly how they could or should perform and divide tasks, shape – and are shaped by – the situated interactional dynamics at play between healthcare professionals and families.

9.2.1 Interactions and trust

Amidst intensifying concerns especially with regard to children’s unknown futures, professionals are assumed to construct expectations and infer knowledge about children’s potential developments, often based on brief encounters with families. This study has shown therefore that it is salient to examine how professionals make sense of individual families, and how they get to ‘know’, ‘trust’ and ‘affect’ mothers and fathers within diverse face-to-face interactions, thereby building on “interpretative frameworks” (Schutz 1972, Brown 2015b) in which their past experiences, emotions, and tacit knowledge (Zinn 2008; Heyman et al. 2013) appears to be crucial. At the same time, this dissertation points to varying levels of proximity within professional-parent relationships (Schutz 1972), where more intimate ‘we-relationships’ allow professionals and parents to obtain a more concrete understanding of one another (Brown 2009), which enables professionals to contest their existing ideal-typical (and thus stereotypical) knowledge and to make ‘leaps of trust’ (Möllering 2001) in having favourable expectations of specific parents, despite incomplete knowledge about them and about their children’s unknown futures.

Within more remote ‘they-relationships’ on the other hand, professionals have to rely much more on the generalized ideal-typical knowledge available to them, leaving them in particular uncertainty when these stereotypes suggest correlations between parents’ (for instance ‘lower social class’) background characteristics and children’s potentially unfavourable outcomes, or between gendered expectations of intensive mothering – not fathering – and children’s secure developments. Moreover, structures of gender and class also informed the directness and intimacy of professional-parent relationships in itself, because obtaining mutual understandings appeared to be facilitated by shared stocks-of-knowledge, based on the opportunity to interact and on similarity in gender, occupational level, language, cultural values, and having comprehensive knowledge about the young
child, derived from intensive everyday experience with caregiving. This means that healthcare professionals – male and female – developed ‘we-relationships’ most straightforwardly with mothers, and especially those that shared a similar (middle-class) background and/ or a similar stock-of-knowledge about parenting with them.

9.2.2 *Shaping mothers’ and fathers’ roles in caregiving*

Hence, drawing largely on Schutz (1972) I argue that interactional dynamics and processes of sense-making and trust within encounters between healthcare professionals and families over the course of pregnancy, childbirth and childcare are particularly important mechanisms that produce – and are produced by – the framing of mothers as primarily responsible caregivers. In that sense, this research confirmed patterns within pre- and postnatal healthcare in the three countries that show a predominant targeting of mothers; more readily established direct trust relationships with mothers, and making mothers primarily responsible for caregiving and for reconciling family and work (see also Vuori 2009; Knaak 2010; Murphy 2003; Müller and Zillien 2016; Tiitinen and Ruusuvuori 2014; Veltkamp and Grunow 2012; Grunow et al. 2010; Lutz 2015). At the same time, I have shown throughout the chapters that we should not treat gender roles and the reproduction of gender roles as universal, because performing and reproducing gender takes place within specific institutional contexts (McNay 1991; Grunow and Veltkamp 2016). Accordingly, clear variance was found across countries and professions in the extent to which mothers’ roles were framed as exclusive and unparalleled (Lutz 2015), and the degree to which mothers were made primarily responsible, while this was strongly attuned to opportunities and constraints perceived as available from family policies, cultural values and specific healthcare contexts.

Moreover, this study has detected that frames of fathers’ expected active and physical engagement in caregiving (Featherstone 2009; Hofmeister and Baur 2015; Shirani et al 2012; Connell and Messerschmidt 2005), resulting into ascribing responsibilities to fathers, could very well exist parallel to a biophysical focus on mothers’ exclusive roles. This is worth paying attention to, because it shows that although mothers can in a taken for granted way be placed centrally, this does not mean that fathers cannot, or were not, at the same time activated in caregiving.
tasks. Critique on gendered parenting norms is therefore mislead when it is built on a zero-sum assumption, implying that either mothers or fathers are made responsible for caregiving.

Professionals who were (also) involved during pregnancy and the delivery were more inclined to focus on mothers. Here too, variation was found between the countries and professions in which the professionals worked – depending on the moment(s) at which they were involved with families over the course of childbirth and childcare – in the degree to which fathers were encountered, ‘known’ and ‘affected’ as caregivers, or perceived as more distant parents (for instance by being breadwinners). In line with their (and parents’) institutional context, most individual professionals depicted a variety of opportunities for mothers’ and fathers’ roles, thereby acknowledging diversity in their experience with families, and they made ‘pragmatic’ decisions in their everyday healthcare practices (see also Bröer and Bessling 2017; Lock and Kaufert 1998). Research should therefore not end with drawing conclusions about gender inequality in professional-family interactions but take a closer look at how diverse mothers and fathers are framed and approached within specific contexts and interactions.

9.2.3 Institutions and professionals’ individual actions

At the heart of my analysis lies the interplay between institutions and individual actions and interactions. Scholars (such as Lipsky 1980 and Freidson 2001) who have brought professionals’ ‘discretionary space’ and their relative autonomy in acting and ‘making’ policy on the ‘street-level’ to the fore, proved to be salient in understanding the decision-making of individual healthcare professionals in their interactions with families. While studying their sense-making processes with more scrutiny however, we can see that professionals’ hierarchic positions, agentic actions and pragmatic decisions, as well as their concrete knowledge of individual parents and the stereotypical knowledge available to them, were very much informed by institutional factors, such as family policies, cultural values and healthcare settings.
Although many professionals were keen to get to know any parent or relevant caregiver involved with a child, despite their gender, class or ethnic background, they were to varying degrees able to actually encounter, understand, trust and affect fathers and/or parents with a non-white/non-middleclass background on a more concrete level, even more so when these two levels of potential ‘otherness’ intersected (Crenshaw 1989; Lutz et al. 2011) in case of non-white/non-middleclass fathers. Within this dissertation, I have shed light on a few selected cases in which specific family policy and healthcare institutions, intertwined with individual professionals’ experiences and agentic actions, resulted in their more intimate trust relationships with, and more clear affecting of, potentially more distant fathers who were thereby trusted and influenced as caregivers. Hence, professionals’ agency indeed proved to be embedded within the institutional context (see Emirbayer and Mische 1998; Mahmood 2001), while individual professionals were at the same time found to use these institutions – perceived from the perspectives of their past experiences, immediate challenges and future expectations – in varying and ‘relatively autonomous’ (Hitlin and Elder 2007) ways.

My study moves beyond existing theories in a nuanced conceptualization of the linkages between culturally shaped institutional structures on the one hand (see Douglas 1982; Pfau-Effinger 2005; Grunow and Veltkamp 2016) and interactional dynamics, knowledge constructions of risk and of other persons, as well as trust relationships on the other hand (see Schutz 1972; Brown 2015b). With a comparative multi-level approach, I have shown the weight of culture, policy logics and of interactions and the relationships between them, and that the one is shaped, but not determined, by the other. This also improves our understanding of the situated and diverse ways in which gendered parenting roles are and can be (re)produced, and the relevance of healthcare and family policies and professional-family interactions.

9.3 Methodological implications

This dissertation is innovative in combining the phenomenological interrogation of professional-family interactions with a cross-national and ‘cross-professional’
comparison. First, the in-depth analysis of social interactions, as “fragments of a particular case” (Inglis 2010, p.510) sheds light on the “wider social whole to which it belongs”, assuming that “the micro and the macro are linked intrinsically” (2010, p.509; see also Schutz 1972, cited by Brown 2015b). Second, treating each profession (midwifery, postpartum care assistance, paediatrics) within each distinct country (the Netherlands, Germany, Poland) as a particular case that reveals particular regularities and principles in professional-family interactions enables a within-case and cross-case comparison, illuminating differences and taken for granted facets, as well as similarities that exceed the particular cases. Third, taking relevant macro-level policy institutions developed within longer-term histories (Baur and Ernst 2011; Bacchi 2009) into account (in our case pre- and postnatal healthcare policies, family policies and cultural values about family roles and child development) enhances a richer understanding of the particular cases and the differences or similarities between them.

In integrating these different angles, a phenomenological approach oriented by Schutzian theory proved to be insightful in examining the different layers of how parenting roles develop over time following childbirth within professional-family interactions. It was especially the analytical focus on professionals’ knowledge construction and sense-making processes in relation to varying degrees of directness (Schutz 1972) and concreteness (Brown 2009), professionals’ experiences within their particular institutional context, and their generalized ‘ideal-typical knowledge’ (Schutz 1972), that provided insights into the interplay between macro-level institutions and micro-level trust processes. This approach was strengthened by its integration with (welfare state) research designs that are particularly advanced in their cross-nationally comparative examinations of macro-level policies and individual-level (gendered) behaviours (see Grunow and Evertsson 2016).

9.4 Strengths and limitations of this study

This is the first multi-level, cross-nationally comparative study of pre- and postnatal healthcare professionals’ situated interactions with (expecting) mothers and fathers.
The study is therefore exploratory in its approach. A clear contribution of my research is the multi-level and multi-sited phenomenological ethnographic design. With this design, I deliver a study that goes much deeper and offers more in-depth and nuanced insights in professionals’ meaning making of mothers’ and fathers’ roles, as situated within their institutional context, than can be achieved in quantitative comparative studies (Krauss 2005). At the same time, my study develops out beyond qualitative literature in providing understandings of interactions and institutions while taking comparisons across countries into account (McElroy and Jezewski 2000).

A challenge posed by the ethnographic cross-national research design has been that I could not perform interviews with and observations of German and Polish professionals myself because of language barriers, while at the same time I was less familiar with the German and Polish institutional (policy) contexts. I had to rely therefore on secondary data for the German and Polish cases and compare this to the primary data I had gathered myself in the Netherlands, and thus had come to know and understand much better. It also means that four different researchers (two for Poland) influenced the data in different ways with their own experience, interests and tendencies in when and how to prompt the respondents to share with the interviewer their experiences and knowledge of their everyday work (McGarry 2007; Cruz and Higginbottom 2013). I was able to overcome a large part of these methodological difficulties in working with different sets of data, first by gathering cross-national data based on the same research design and research questions, second by investing in managing the data set, including organizing high quality translations, having access to the original data, and becoming familiar with the complete data set, and third in establishing close and continuing collaborative relationships with the researchers who gathered the data in Poland and Germany in which translations and interpretations could constantly be discussed and checked. These strategies, and not least the cross-national collaborations, turned out to be highly salient to this project.

A further challenge concerned a small n for the sub-sample of Polish CHC paediatricians, and the non-random cross-national and cross-professional selection of cases which were not precisely similar in their healthcare aim, such as the Polish paediatricians working at neonatology wards, Polish and German CHC professionals performing treatment and prevention, and Dutch CHC professionals solely
performing prevention in more collaborative practices. These dissimilarities proved to be insightful in providing interesting and unexpected findings, especially in how healthcare settings were differently organized in the different countries, but also in studying differently situated risk representations and their linkages to professional-family interactions. However, when the study would be performed all over again I would suggest to maintain variation, while sampling more similar cases for each country to the extent that these cases are available in a country, in order to obtain a fuller understanding of cross-national variation. This could be achieved by including more paediatricians working in CHC in Poland, and more paediatricians working in neonatology wards in Germany and the Netherlands, as well as by including CHC nurses working in Germany and in Poland, or by making more similar choices for each country about which cases are included in the study.

Further, a limitation was that participant observations were only performed for a few groups of the professional respondents (Dutch paediatricians and nurses; German midwives; German paediatricians). Although the insights gained from these observations were particularly valuable to triangulate interviews, to illuminate understandings of what professionals said they did and actually did, and to compare observations between some of the professionals (Dutch paediatricians and nurses with German paediatricians), a more comprehensive set of observations would enable a more extensive and thorough comparison of findings. The comparability of the data could therefore be improved further by performing participant observations for all countries and professionals, aiming for interviews to be more similar in length, and using an exactly similar interview guide.

The latter points to an interview topic about perceived ‘threats for children’ which was not asked in case of the German professionals. Interestingly, it has been argued that risk framings in research are problematic, because they might lead to a prioritizing of risk in how respondents understand the world (Green 2009). Others have argued in turn that risk research is designed to be sensitive to the situated construction of risk, in participants’ accounts and in interview settings (Zinn 2009). My findings indicate that by examining the wider interviews and triangulating them with the participant observations of the German professionals, ideal-typical risk knowledge could be assessed for accounts that did and did not include the interview
topic about threats. However, it was difficult to fully disentangle the impact of the slightly different interview guide on the cross-national variation that was found in professionals’ risk knowledge. Based on my research, I would therefore suggest to aim for using interview guides in a comparative design which are as similar as possible, as well as for transparency about the interview settings – which was enhanced in my research – in order to take dissimilarities into account in, and be reflexive about, the interpretation of findings.

The relatively small sample used for this study, located within specific geographic areas within the three different countries, and the inclusions of professionals that were cross-nationally comparable, but not exactly similar, implies that the findings of this study are not suitable to make general claims about pre- and postnatal healthcare professions within the Netherlands, Germany or Poland, nor about these countries more broadly. Not least because of the heterogeneity that can be expected within countries. Another limitation of this study is that it was for instance shown that the specific German region where this research was performed was by some of the respondents framed as a-typical, because of the well-developed financial sector, attracting particular employees and enhancing a stronger breadwinner norm. It could therefore be the case that what is taken for granted in gendered idealypical risk knowledge of professionals working in other areas in Germany would show different perceptions of fathers’ caregiving roles.

The comparative design of this study has however been focused on obtaining an in-depth understanding of the interplay between varying family policy and health care institutions and situated professional-family interactions. Therefore, while taking limitations to the claims of my study into account in relation to broader comparisons, this study is innovative and valuable in highlighting mechanisms of the situated reproduction of gendered parenting roles, by linking cultural values, policy logics and interactional professional-family dynamics.
9.5 Policy implications

As was shown in this dissertation, pre- and postnatal healthcare professionals are generally – but to varying degrees – positioned closer to mothers than to fathers due to social and health risk perspectives and consultation patterns within healthcare settings, family (leave) policies, cultural values of intensive mothering and maternal responsibility, feelings of mutuality and shared-stocks of knowledge. At the same time, this positions them closer to middle-class mothers, and to a modest degree: middle-class fathers, compared to non-middle class/ non-white mothers and fathers, who are often less inclined to share their experiences with professionals and adopt intensive and shared parenting ideologies (Lareau 1995; Romagnoli and Wall 2012; Reich 2005), while understanding one another can also be complicated through language, communication and cultural barriers (Holden and Serrano 1989; Feldmann et al. 2007; van Duursen et al. 2004).

For professionals themselves, a relative lack of concrete knowledge of specific groups of parents, and a relative neglect of fathers, could result into the overlooking of potential forms of ‘good’ parenting as well as ‘risky’ parenting among the more distant parents (Veltkamp and Brown 2017). Healthcare policymakers and professionals could therefore advocate reflexivity and sensitivity about the interactional dynamics of trust relationships concerning diverse parents. They could furthermore enhance higher degrees of diversity among professional employees in terms of their gender, social class and ethnic backgrounds in order to facilitate the development of concrete knowledge and understandings of a broader and more diverse range of professionals and parents.

Healthcare structures and family policies appeared to be especially influential in professionals’ (limited) opportunities to form ‘we-relationships’ with fathers. This research has focused particularly on situations in which professionals did or did not ascribe responsibilities to fathers as caregivers, in order to analytically deconstruct fathers’ roles in professional risk perspectives and trust processes. Moreover, fathers’ involvement in caregiving also represents one potential way to bring the different concerns and solutions around childbirth (in terms of gender equality,
work-family balance and child development) together (Gornick and Meyers 2003; Keizer 2015).

Policy implications of this research are therefore first that professional-father interactions can be facilitated by more extensive leave opportunities for fathers. The findings of this dissertation show that fathers’ leave directly after birth and their leave or opportunities to work flexibly in the years thereafter facilitate fathers to attend professional-family consultations. In the Dutch case, this was found to be occurring already to a modest degree due to the facilitation of fathers’ part-time work and ‘daddy days’. However, these opportunities were very much depending on the occupational sectors in which fathers worked, because parental leave is unpaid in the Netherlands and employers are granted a decisive role in offering financial compensation for parental leave and in approaching parental leave and flexibility of work as a feasible option. In the German case, fathers’ leave as it came to the fore in this study was much more focused on the period directly after birth instead of on the period thereafter. The latest reform in German parental leave since 2015 (BMFSFJ 2014) aimed at facilitating parents, and fathers in particular, to take up paid leave more flexibly, in part-time and over a longer period can in that sense be seen as promising. The same can be said about similar reforms in Polish parental leave policies since 2016 (Topiński 2015), in which efforts can also be found to facilitate both parents to use and share leave more flexibly over the first years after birth.

A second policy implication is to facilitate more frequent encounters between professionals and fathers through consultation schedules, in which more flexibility allows a better alignment between professionals’ agenda’s and full-time working parents’ agenda’s, which is especially relevant to fathers. The findings in this dissertation also indicate that when professionals were involved with families from pregnancy onwards, continuing in the period after birth, a stronger focus on mothers’ caregiving roles persisted. While this enabled the support of mothers, it at the same time shifted the focus away from fathers’ roles.

A third policy implication is therefore to support awareness and opportunities among professionals to make efforts in approaching and trusting fathers and
envisioning and anticipating their caregiving responsibilities. Professionals’ investments in engaging with fathers could in the Dutch case be enhanced while relating to cultural values of ‘shared parenting’ (Kremer 2010) and in the Polish case to values of the centrality of the family and the increased focus on fathers’ roles in this respect. In the German case, professionals could aim to engage more with fathers’ caregiving roles, while relating to more recent ideals about ‘nurturing fathers’ (Hofmeister and Baur 2015). However, my study suggests that in doing so, it is important that relatively strong breadwinner norms for German fathers are at the same time taken into account and addressed in such endeavours. It is salient to pay attention to such context-related challenges, because my data shows that policy is only one part of the story: although policies can be changed, cultural values and interactional dynamics play a central role in how policies play out.

9.6 Future research

In this dissertation, I did not look at how professionals’ ‘we-relationships’ among each other could support or undermine their ‘we-relationships’ and ‘they-relationships’ with parents. This would however provide a better understanding of dynamics that mediate between healthcare policies and individual professional-family interactions. The Dutch observations of paediatricians and nurses showed for instance that in some cases all, and in other cases a selection of, the parents who visited that day were discussed within professional briefings, in which mutual understandings between professionals could on the one hand lead to a distancing of the parents who were discussed, while the professionals were also shown to challenge and contrast each other’s ideal-typical knowledge when combining their understandings of particular parents. The German and Polish CHC paediatricians on the other hand who worked in independent practices did not have such daily discussions among colleagues, which assumes the centrality of professional-family relationships rather than professional-professional relationships, while professionals’ ideal types, and stereotype types, are in these settings at the same time contested to a much lesser degree.
On a similar note, this research did not focus on parents’ understandings of and trust in professionals, and of their child and its unknown future. Yet, including their accounts in analysing the interactional dynamics would enable a richer picture of for instance intersections between gender, class and ethnicity and how this facilitates or complicates trust relationships with (certain) professionals. Moreover, it would be particularly insightful to study professional-family interactions over time and examine how trust relationships, knowledge construction and particular mothers’ and fathers’ working and caregiving roles and task divisions develop over time in changing institutional contexts, and how this intersects with their social class backgrounds.

In order to examine the exact role of healthcare in the reproduction of parents’ gendered roles further, as more clearly disentangled from cultural values and family policies, this research could be located in settings in which family policies and cultural values about gender roles and child development are more coherent, for instance in Nordic countries such as Sweden (Evertsson 2016). A final direction of future research that I would like to suggest is to study the patterns found in this dissertation in larger amounts of respondents with a sampling strategy that enables the analysis of enough variety within and between cases, to get a more generalizable picture of conditions to and outcomes of how healthcare professionals perceive and shape mothers’ and fathers’ roles in varying institutional contexts (Ragin 1987; Wagemann and Schneider 2010; Schneider and Wagemann 2010).
Appendices
Appendix A. Interview guide

1 Introduction

Introduce the study, confirm consent and reaffirm confidentiality

Since when are you employed as a ‘name profession’? ⁴⁰

What do you like in your job? What do you find difficult?

With which other professionals do you cooperate?

What are the aims within your profession and how is this reflected in your activities?

2 Parenting standards – good parenting

Do you have examples of (future) parents’ behaviour that you would encourage and of behaviour that you would discourage?

Does it occur that you give advice that goes beyond parents’ questions? Do you have examples?
(prompt: medical/ non-medical)

How important is it to pay attention to risk and how do you calculate risk? On what type of knowledge do you base yourself? In what cases is this easier and when is it more complex?

What are the most important risks for the unborn child? And for the newborn?
(prompt: father/ mother)

Does your work know uncertainties? If so, what kind of uncertainties and how do you deal with those?

⁴⁰ Midwife; postpartum care assistant; paediatrician or nurse
3 Fathers and mothers

How do you see mothers and fathers as caretakers and (how) does this differ between them?

Do you see both fathers and mothers? Just as frequent? If not, do you know why not?

What is currently expected of (future) parents? What are your own expectations of parents?
(prompt: fathers/ mothers, before/ after birth, explicit/ implicit)

What is a good father and what a good mother?

How do you think a (future) parent can be protective or risky for a child?
(prompt: father/ mother)

Do you give fathers other advices than mothers? Do they respond differently? Can you give examples?

To what extent do you experience support for a specific role for fathers and mothers in legal institutions?

Do you experience differences in employment and being at home between fathers and mothers after the birth of their child?
How is this discussed in your consults? Can you give examples?
(prompt: parental leave, amount of hours work, flexibility of work)

Which forms of childcare do parents plan and use? How is this discussed in your consults? Can you give examples?
(prompt: professional/ informal care, amount of hours/ days, starting age)

Which problems and uncertainties do (future) parents face? (How) does this differ between fathers and mothers?
How do they deal with this and solve their problems?
(prompt: formal/ informal)

What is your role in this? Do you discuss this with parents and can you give examples?

Do you experience differences between new parents and parents that already have children? Is your role different and how? Can you give examples?

4 Personal values and norms

What do you yourself find important for a child?
(prompt: own experiences, father/ mother role)

How do you think this might influence your interaction with (future) parents?

5 Field

Does knowledge and do guidelines for supporting parents vary within “country”? If so, how?

Are all “name profession” in “country” trained the same way? Is there a common way of working or are there differences?
(prompt: education, occupational group, protected title)

6 To conclude

Did I forget something? Which questions did you find most relevant? Are there other professionals I should talk to?

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41 The Netherlands, Germany, Poland
Appendix B. Information leaflet; Dutch version

GEZONDHEIDSZORG EN NIEUW OUDERSCHAP Dit onderzoek is een deelproject van het internationale ‘APPARENT’ project, waarvan Dr. Daniela Grunow, Universiteit van Amsterdam, projectleider is. Het APPARENT project wordt gefinancierd door de ‘European Research Council’ (ERC)/ ERC Starting Grant. Prof. dr. Ria Reis is als samenwerkingspartner bij dit deelproject betrokken. De onderzoekster is Gerlieke Veltkamp, student aan de Universiteit van Amsterdam, die tevens als gezinsprofessional werkt in de jeugdpsychiatrische gezondheidszorg in Amsterdam.

Het onderzoek richt zich op ouderschapsstandaarden in Nederland en opvattingen van professionals over de rollen van ouders. Onderdeel van deze studie is hoe normen voor ouderschap in de interactie tussen professionals en aankomende ouders of ouders van een eerste kind worden onderhandeld en gevormd.

DOELEN Het doel van dit onderzoek is in de eerste plaats om ouderrollen- en standaarden in kaart te brengen, zoals deze gedefinieerd, verspreid en onderhandeld worden door professionals in de verloskunde en jeugdgezondheidszorg (JGZ) in Nederland. De relevantie hiervan is dat deze professionals directe invloed kunnen hebben op wat nieuwe ouders weten en doen, omdat bijna alle aanstaande moeders gebruik maken van prenatale en postnatale gezondheidszorg. De studie verkent hoe de professionals hun eigen rol zien in het vormen en verspreiden van sociale normen en standaarden van ‘goed’ en ‘geschikt’ ouderschap van nieuwe vaders en moeders en hoe zij hier uiting aan geven in het contact met ouders. Wat verwachten deze experts idealiter van nieuwe ouders en hoe verspreiden en onderhandelen ze deze verwachtingen in contact met specifieke ouders? Hoe zien verloskundigen en JGZ-medewerkers moeders en vaders in de rol van zorgdrager en in hoeverre ervaren zij dat deze rollen ondersteund worden door wet- en regelgeving?

In de tweede plaats heeft dit onderzoek als doel om gebruik te maken van professionals als deskundigen van het prenatale en postnatale veld, waarin zij hun werkzaamheden uitvoeren. Professionals hebben deskundige kennis over karakteristieke problemen en onzekerheden van aanstaande en nieuwe ouders, die verder kunnen gaan dan gezondheidskwesties. Ze hebben specifieke kennis over
formele regels en procedures en andere, informele, regels en praktijken en zij hebben persoonlijke expertise in het toepassen van deze kennis in contact met verschillende aanstaande en nieuwe ouders.

**METHODEN** In dit onderzoek worden 20 professionals in de verloskunde en JGZ in Nederland geïnterviewd als deskundigen in het prenatale en postnatale veld. Er wordt daarbij gepoogd om variatie aan te brengen in het werkgebied van deze experts (bijvoorbeeld door professionals binnen en buiten de Randstad te interviewen), omdat in stedelijke gebieden vaak minder traditionele en meer wisselende opvattingen over het gezin te vinden zijn dan in minder stedelijke gebieden.

Daarnaast beoogt deze studie zicht te krijgen op hoe professionals in hun dagelijkse praktijk hun kennis en verwachtingen van ouders toepassen in consulten aan ouders in al hun verscheidenheid. Er wordt toegang gezocht tot een consultatiebureau in een Centrum voor Jeugd en Gezin (CJG) om gedurende enkele maanden consulten en intakes te kunnen bijwonen en observeren. Na afloop kunnen consulten kort worden nabesproken, zodat de professional de belangrijke afwegingen en momenten in het consult kan aangeven. Uit een kleine pilot-studie die aan dit onderzoek is voorafgegaan komt naar voren dat volgens professionals (in Amsterdam) de achtergrond van ouders van invloed is op de inhoud van consulten. Een CJG in de Randstad is daarom het meest geschikt voor participerende observatie, omdat hier de meeste variatie wordt verwacht in de achtergrond van aankomende en nieuwe ouders.

**MAATSCHAPPELIJK NUT** De kennis, ervaring en werkpraktijk van professionals in de verloskunde en JGZ kan bijdragen aan meer inzicht in hedendaagse ouderschapsstandaarden in Nederland, de structuren die te vinden zijn in het prenatale en postnatale professionele veld en hoe deze velden zijn ingebed in de bredere sociale structuur. Het onderzoek kan duidelijk maken hoe standaarden van ‘goed’ ouderschap en moeder- en vaderrollen worden opgevat, gevormd en verspreid door professionals in hun interactie met verschillende aankomende en nieuwe ouders.

Voor de verloskunde en JGZ zelf kan dit onderzoek meer systematisch inzicht geven in hoe deze standaarden geïntegreerd zijn in de werkzaamheden van professionals, welke mogelijkheden en beperkingen professionals hierin tegenkomen en de mate waarin consulten inhoudelijk kunnen overeenkomen of verschillen in relatie tot ouders met verschillende achtergronddenmerken.
CENTRALE ONDERZOEKSVRAGEN Welke hedendaagse ouderrollen- en standaarden hanteren professionals in de verloskunde en JGZ? Hoe worden ouderrollen al dan niet onderscheiden voor verschillende ouders (bijvoorbeeld voor vaders en moeders) en welke motiaties liggen aan opvattingen over ouderrollen ten grondslag? Hoe worden ouderschapsnormen en- standaarden in interacties tussen professionals en aanstaande en nieuwe ouders in de dagelijks praktijk toegepast?

ACHTERGROND. Het APPARENT project bekijkt hedendaagse normen voor ouderschap en ouderschapspraktijken en hun wisselwerking in zes landen in Europa. Hierbij zijn de landen Zweden, Nederland, Duitsland, Italië, Tsjechië en Polen in de internationale samenwerking inbegrepen. Het project ontwikkelt een vergelijkend model om in de huidige samenlevingen dominante normen, voorstellingen, identiteiten en gedragingen voor moederschap en vaderschap te bestuderen. Daarbij is met name aandacht voor hoe moederrollen en vaderrollen wordt gevormd door professionals, verzorgingsstaten en populaire media. Tevens wordt meegenomen hoe culturele en institutionele normen en voorstellingen worden opgevat en in praktijk gebracht door aanstaande en nieuwe ouders. ‘APPARENT’ is een vijfjarig onderzoeksprogramma dat is gestart in Januari 2011.

ETHIEK. Het APPARENT project is ethisch gescreeend door het ‘European Research Council’s Ethical Committee’ in 2010, voorafgaand aan het verkrijgen van een fonds van het ERC. Als onderdeel van deze ethische screening heeft ook de ethische commissie van het Instituut van Sociaal Wetenschappelijk Onderzoek van de Universiteit van Amsterdam toestemming gegeven voor het onderzoeksvoorstel van APPARENT. Op 6 september 2010 heeft Prof. Dr. Hardon, als voorzitter van de commissie, een verklaring ondertekend waarin staat dat het APPARENT project aan de vereisten voor persoonsbescherming van de commissie voldoet.
Appendix C. Background characteristics respondents

Dutch Midwives

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<tr>
<th>Pseudonym</th>
<th>Age(^{42}) +/-</th>
<th>Gender(^{43})</th>
<th>Working area</th>
<th>Years experience</th>
<th>Geographic region</th>
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<td>Sophie</td>
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<td>Group practice</td>
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<td>Nienke</td>
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<td>Group practice/ b.p. courses(^{44})</td>
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<td>Noord-Holland Big city</td>
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<tr>
<td>Mia</td>
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<td>F</td>
<td>Group practice/ b.p. courses</td>
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<tr>
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Dutch postpartum care assistants

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<th>Gender</th>
<th>Working area</th>
<th>Years experience</th>
<th>Geographic region</th>
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</table>

\(^{42}\) Age estimated by interviewer, with 5 or 10 years margin

\(^{43}\) F = female, M = male

\(^{44}\) Involved in birth preparation courses
### Dutch paediatricians

<table>
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<tr>
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<th>Gender</th>
<th>Working area</th>
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<th>Geographic region</th>
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### Dutch nurses

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45 The interviews with CHC paediatricians and nurses in italics, involved with children aged 4-12/18, were only used for the study in chapter 7.
46 The interview with this CHC nurse was not used for the study in chapter 7, because this concerned a pilot interview, which was found to be relevant for the overall sample used for the rest of the chapters.
### German midwives

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Appendix D. Documents for document analysis

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*Obstetric care (OC)*

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### Poland

**Obstetric care (OC)**

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**Family policies**

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</table>

<table>
<thead>
<tr>
<th>Childcare</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Plomien (2009)</td>
<td></td>
</tr>
<tr>
<td>Keryk (2010)</td>
<td></td>
</tr>
<tr>
<td>Rybińska &amp; Szoltyszek (2014)</td>
<td></td>
</tr>
<tr>
<td>Szelewa &amp; Polakowski (2008)</td>
<td></td>
</tr>
<tr>
<td>Plantenga &amp; Remery (2009)</td>
<td></td>
</tr>
<tr>
<td>Mills et al. (2014)</td>
<td></td>
</tr>
</tbody>
</table>
Appendix E. Case-ordered descriptive meta-matrix (in excel)

Columns:

- **Respondents characteristics**
  - Years experience
  - Male/ female
  - Parent
  - Working area/ location

- **Interview characteristics**
  - Duration interview
  - Date interview
  - Location interview
  - Child present during interview
  - Transcription specifics

- **Healthcare**
  - Unified/ fragmented organization
  - Collaborations with other professionals
  - Focus/ aim in healthcare
  - Frequency interactions parents (mothers/ fathers)
  - Moment interactions (pregnancy; childbirth; until age child)

- **Parenting norms (parents; mothers; fathers)**
  - Encouraged/ good parenting
  - Discouraged/ bad parenting
  - Parents’ problems/ uncertainties/ societal expectations
  - Intensive parenting
  - Attachment parenting
    - Natural bond
    - Building a bond
    - Security
    - Sensitivity to baby’s cues/ intuition
    - Future outcomes
    - Breastfeeding
  - Inter-embodiment
    - Growing baby/ feeding
    - Skin-to-skin/ comforting/ carrying
    - Cleaning (diaper; bathing)
  - Letting go of ideals'/ acceptance
  - External childcare
    - Caregiver-child relationships
    - Early education
    - Location/ facility
    - Health/ infections
    - Responsibility
  - Child raising
    - Love, security, emotions
    - Setting limits/ boundaries
    - Rhythm/ pattern
    - Development/ stimulation
  - Mothering and fathering norms
- Working with family policies (parents; mothers; fathers)
  - Leave
  - Illness (child)
  - Flexibility/ part-time work
  - Support parents

- Doing gender (parents; mothers; fathers)
  - Experiences/ perceptions of parents’ work
  - Experiences/ perceptions of parents’ caregiving
  - Imperatives (assumptions) of parents’ work
  - Imperatives (assumptions) of parents’ caregiving
  - Division of tasks
    - Shared parenting
    - Specialization
  - Educating/ involving
    - Mothers
    - Fathers
    - Parents

- Trust relationships (parents; mothers; fathers)
  - Perceived risks
  - Doing risk work
  - Proximity in conversations
  - Ideal-typical/ stereo-typical knowledge
  - (Dis)trusting children’s situations
  - Intersection gender/ class/ ethnicity

Rows (53 respondents)

- The Netherlands
  - Midwives
    - Respondents
  - Postpartum care assistants
    - Respondents
  - Paediatricians
    - Respondents
  - Nurses
    - Respondents

- Germany
  - Midwives
    - Respondents
  - Paediatricians
    - Respondents

- Poland
  - Midwives
    - Respondents
  - Paediatricians
    - Respondents
Appendix F. Content-analytic summary table

1 Ideal types of risk

1.1 Healthcare, medicalization and social structures

<table>
<thead>
<tr>
<th>Healthcare and medicalization</th>
<th>Professional</th>
<th>M/F/P/C</th>
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</thead>
<tbody>
<tr>
<td>Limited access/ Insurance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bureaucracy/ limited time to care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical risks pregnancy/ birth</td>
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<td></td>
</tr>
<tr>
<td>Risks of medical approach pregnancy/ birth</td>
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<td></td>
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<tr>
<td>Medical risks postpartum period</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychosocial risks postpartum period</td>
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<tr>
<td>Risks medicalization postpartum period</td>
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<tr>
<td>Medical risk early years</td>
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<tr>
<td>Psychosocial risk early years</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Risks medicalization early years</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social structures/ poverty/ social problems</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parents being out of sight</td>
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<td></td>
</tr>
<tr>
<td>Government not supportive</td>
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1.2 Parenting

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<tr>
<th>Parenting</th>
<th>Professional</th>
<th>M/F/P</th>
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<tr>
<td>Social conditions and relations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Being unprepared</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lack of protection/ environmental risks child</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lack of appropriate care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Harm, abuse</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Overprotection/ anxiety</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Uncertainty/ anxiety/ high expectations/ information overload/ making comparisons</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not being reflexive, open to knowledge, vulnerable; thinking you know it all</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

47 Mother/ Father/ Parents/ Child (Child is only included in 1.1 medical risks; the other tables show to which parent(s) this ideal type was related)
Withdrawing from healthcare
Following Internet, family, peers or professional advice blindly
Neglect, because of working/ absence
Unhealthy or unsafe non-parental care
Neglect, because child is not prioritized
Taking everything on yourself
Not taking care of yourself
Too high burden
Limited sense of influence
Stress, no resilience

2 Ideal types of safe parenting

2.1 Intensive nurturing/ bonding > shelter, trust, priority

Intensive nurturing/ bonding  Professional  M/F/P  Specifics, page nr.
Love, warmth, attachment
Be sensitive to child’s needs and respond to them
Time, attention, priority
Touch and physical practices of care
Breastfeeding
Watch your child, get to know your child
Take responsibility for your child and make conscious decisions

2.2 Health > survival, healthy development

Health  Professional  M/F/P  Specifics, page nr.
Breastfeeding
Healthy food and movement
Touch and physical practices of care
Follow professional advice
Make informed choices
Watch your child, get to know your child
Be careful with dual working, day care/ nanny
(infections/ diseases) and stress
Take responsibility for your child and make conscious decisions

2.3 Growing up/ socialization > child raising, finding the way in life & society

Growing up/ socialization  Professional  M/F/P  Specifics, page nr.
Rules, limits, clarity
Take responsibility for your child and make conscious decisions
Citizenship, duties, learning to deal with the (harsh) world and with disappointment
Incentives to learn, play and develop
Giving a child space: possibility to explore and learn from own experiences

2.4 Safety

Safety  Professional  M/F/P  Specifics, page nr.
Protection from harm and danger

2.5 Being a parent > remaining available and steady

Being a parent  Professional  M/F/P  Specifics, page nr.
Accept not having control, let go of predefined expectations and planning, accept and endure hardship, go with the flow
Lower expectations of yourself as a parent (and your other roles); dare to make mistakes
Take responsibility for your child and make conscious decisions
Develop and follow own intuitions
Take care of yourself: your own limits, career, time, relationship

3. Ideal types of safe sharing

3.1 Parental care

Parental care

<table>
<thead>
<tr>
<th>Professional</th>
<th>M/F/P</th>
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</thead>
<tbody>
<tr>
<td>Be constantly at home</td>
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<td></td>
</tr>
<tr>
<td>Spend enough time with your child</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Work less, if possible</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Be involved in caring and helping</td>
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<td></td>
</tr>
<tr>
<td>Perform basic caring tasks somewhere during the day</td>
<td></td>
<td></td>
</tr>
<tr>
<td>There should be more leave</td>
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<td></td>
</tr>
<tr>
<td>Combine family, nurturing and working tasks well</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Take responsibility for care: provision and distribution of care, caring environment/relationships</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Create a steady week schedule</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Share and complement each other</td>
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<td></td>
</tr>
<tr>
<td>Share and reverse roles with each other</td>
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<td></td>
</tr>
<tr>
<td>Deal with it as a family</td>
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<td></td>
</tr>
<tr>
<td>Mothers have main caring role</td>
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</table>

3.2 Non-parental care

Non-parental care

<table>
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<tr>
<th>Professional</th>
<th>M/F/P</th>
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</thead>
<tbody>
<tr>
<td>Use grandparents/ family members</td>
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<tr>
<td>Use informal care in home setting</td>
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<tr>
<td>Be careful with dual working, day care/nanny/stress</td>
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<tr>
<td>Day care is professional</td>
<td></td>
<td></td>
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<tr>
<td>Day care provides opportunities</td>
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</table>
Day care stimulates children’s (equal) development
Day care can be protective when the domestic situation is problematic or harmful
Day care should have a low caregiver/ child ratio
Day care should be limited in days/ hours

4. Ideal types of gender, educational level/ career and ethnicity

4.1 Involvement in care

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<td>At home the first week(s)</td>
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<tr>
<td>At home the first month(s)</td>
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<tr>
<td>At home the first year(s)</td>
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<td>Partly at home the first year(s)</td>
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<td>Being involved</td>
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<td>Being (involved) on distance</td>
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<td>Not being involved</td>
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<tr>
<td>Want to take leave</td>
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<tr>
<td>Want to prolong leave/ not bring child away</td>
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<tr>
<td>Want to return to work</td>
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<tr>
<td>Want to work part-time</td>
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<tr>
<td>Want to work full-time</td>
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</table>

[^48]: As related to mothers/ fathers
[^49]: As related to higher educational level or income/ lower educational level or income of parents
[^50]: As relates to ‘native’ background/ ‘migration’ background of parents
4.2 Responsibility and division

<table>
<thead>
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<th>HE/LE</th>
<th>N/M</th>
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<td>One and a half earner model</td>
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<td>Dual earning responsibility</td>
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<td>Dual caring responsibility</td>
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<td>Mother main caring</td>
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<tr>
<td>responsibility/ direct caring role</td>
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<td>Father takes care of family environment and income</td>
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<tr>
<td>Reversed breadwinning</td>
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4.3 Parenting style

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<th>HE/LE</th>
<th>N/M</th>
<th>Specifics, page nr.</th>
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<tr>
<td>Stimulating development</td>
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<td>Focused on planning/ control</td>
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<td>Intensive parenting</td>
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<td>Emotionally distant</td>
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<td>Materialistic parenting</td>
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</tr>
<tr>
<td>Uncertainty/ many questions/ Information over dose</td>
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<tr>
<td>Centrality of feelings</td>
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<td>Technical approach</td>
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<td>Wild play</td>
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<td>Lassez-fair</td>
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<td>Confident and relaxed parenting</td>
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<td>High expectations</td>
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<td>Distributing care over the week</td>
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<td>Withdraw from healthcare</td>
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</table>
Appendix G. Ideal types and scores for ‘ideal type clouds’

Score: 1-9
Portion of professionals: 1-3 (1=0-33%; 2=34-66%; 3=67-100%)
Frequency mentioned: 1-3 (1=1x; 2=2x; 3=2+)
Value: 1-3 (1= casually mentioned; 2= emphasized; 3 = strong moral indignation or emphasis)

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<th>Profession</th>
<th>Country</th>
<th>Ideal type</th>
<th>No./ Portion Prof</th>
<th>Freq</th>
<th>Value</th>
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<td>Midwives</td>
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<td>n=7</td>
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<td>Caesarean rate</td>
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<td>3</td>
<td>5</td>
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<td>Pregnancy as pathology</td>
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<td>Separation mother-child</td>
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<td>3</td>
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<td>Uncertainty/ no confidence</td>
<td>3x/2</td>
<td>3</td>
<td>2</td>
<td>7</td>
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<tr>
<td></td>
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<td>Mother groups</td>
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<td>6</td>
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<tr>
<td></td>
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<td>Harm/ abuse</td>
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<td>4</td>
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<td>Alcohol drugs smoking</td>
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<td>Non-German speaking</td>
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<td>Improper/ unsafe caring</td>
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<td></td>
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<td>Neglect, child not priority</td>
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Appendix H. Verbatim quotations in original language

Chapter 5

Q-01
"Women are very much pathologised through German prenatal screening. [...] It is simply a different approach in our medical system. [...] Among doctors, the focus is more on risk. And on pathology. It is often misdiagnosed as a false positive. Luckily. But on the other hand, this leads to an even stronger uncertainty of the pregnant woman or the couple [...] and the self-confidence of: 'I can deliver a child', which was self-evident only two, or two and a half, generations ago." [Jana, German midwife, Q-01]

"Durch die Screening Programme in Deutschland ist es so, dass die Frauen sehr pathologisiert werden. [...] Sondern es ist einfach in unserem Medizinsystem ein ganz anderer Ansatz. [...] Mehr eh bei den Ärzten ist der Fokus mehr auf Risiko. Und auf Pathologie. Es wird viel diagnostiziert falsch positiv. Zum Glück. Aber einerseits zum Glück aber andererseits führt das zu einer noch stärkeren Verunsicherung der Schwangeren oder des Paares auch [...] und das Selbstvertrauen 'Ich kann ein Kind bekommen', was einfach noch 2 oder 2 1/2 Generationen vor uns ganz selbstverständlich war." [Jana, German midwife, Q-01]

Q-02
"Child comes out, [...] chop chop, child away, weigh it, measure it and what not. It’s rare that clinics grant women even half an hour with their child alone [...]. While I first take the baby, perform the U1, weight it, measure it, examine it more thoroughly: usually on the mother’s belly, or directly next to the mother, I’m doing all my things around the bed." [Ute, German midwife, Q-02]

„Kind raus, [...] zack zack und Kind weg, wiegen messen und was weiß ich. Selten, dass die Kliniken dann den Frauen auch mal eine halbe Stunde mit dem Kind alleine gönnen. [...] Oder ich mache erst das Baby, mache die U1, wiege das, messe das, gucke mir das genauer an; meistens auf dem Bauch der Mutter oder direkt neben der Mutter tue ich da alle meine Sachen auf dem Bett aufbauen." [Ute, German midwife, Q-02]

Q-03
Interviewer: “And how important is it to pay attention to risk and how do you calculate risk? [...] Very generally, or maybe also dangers?”
Kryżyna: “Danger is always big; in every physiology there may be big danger. If we talk about physiological birth then we do not know for sure if this is normal, straight physiology, right? So dangers are simply always there. Of course the patient should know about dangers, but we inform them only when it’s necessary, so as not to... simply not to stress the patient from the start or anything. Dangers are everywhere, and can always appear.” [Kryżyna, Polish midwife, Q-03]

“Zagrożenie jest duże zawsze z każdej fizjologii może być duże zagrożenie. Jeżeli chodzi o poród fizjologiczny, to do końca nie wiemy czy to jest taka zwykle czysta fizjologia, tak? Czyli po prostu zagrożenia zawsze są, oczywiście pacjent powinien wiedzieć o zagrożeniach, ale informujemy go wtedy, kiedy to jest konieczne, żeby też pacjenta po prostu nie, na początku po prostu nie zestrzegać pacjenta czy tam, zagrożenia wszędzie są. I zawsze mogą wystąpić." [Kryżyna, Polish midwife, Q-03]
“Well, we say to women, to simply, if they are recommended to stay in an uplifted bed, then we pay attention if she lies down. If we see that she is sitting, we tell her she nevertheless should lie down, for her safety and the child’s. However, this staying in bed gives a lot…, because practically, if the patient doesn’t lie down but sits, then the danger increases and there may be unnecessary complications. As we also half-jokingly say not to stroke that belly. But it is really the case that when you irritate the uterus, contractions might appear; the patient has a particularly high risk of giving this premature birth.” [Ewa, Polish midwife, Q-04]

“No to mówimy kobietom, żeby po prostu, jeżeli ma zalecenie leżenia na podwyszonym łóżku, to zwracamy też uwagę na to, żeby ona leżała. Jeżeli widzimy, że ona siedzi, to mówimy, że jednak powinna leżeć, że dla jej bezpieczeństwa i dziecka. Jednak to leżenie daje, bo praktycznie, jeżeli pacjentka nie leży a siedzi to zagrożenie wzrasta i może dojść do niepotrzebnych powikłań. Tak jak również, późChrtem-półserio, mówimy żeby nie głąskać się po tym brzuchu. Ale faktycznie tak jest, że jak się drażni tą macicę, to później te skurcze mogą się pojawić, zwłaszcza, że pacjentka ma duże zagrożenie tym porodem przedwczesnym.” [Ewa, Polish midwife, Q-04]

“Interviewer: ‘Are other themes discussed, or do you find themes important in birth preparation classes?’
Nienke: ‘Yes, the most important theme in my view is that people understand how a delivery works in terms of hormones. […] Knowing that hormones decline for instance with shame, the feeling you’re being watched, bright light and things like that, you really need to be considering: when I want to go to the hospital, how am I going to create a safe environment and what do I need for that […] to keep the oxytocin on a high level, and well, the adrenaline low.’” [Nienke, Dutch midwife, Q-06]
dat je dus heel erg moet gaan zoeken van nou ja ik ga wel naar het ziekenhuis of ik wil wel naar het ziekenhuis hoe ga ik dan zorgen dat ik een veilige omgeving creëer. En wat heb ik daar dan dus voor nodig. Hoe om gewoon puur te kijken, te zorgen eigenlijk, dat die oxytocine gewoon op een goed level blijft. En dan je adrenaline laag.” [Nienke, Dutch midwife, Q-06].

Q-07
“[An important aim is] that you do your risk selection in time. [...] Like, ok is this still normal, and can this still be done within my operative range, or should I transfer to an obstetrician? [...] The aim then is, I believe, [...] very simply put, the aim is of course eventually a healthy mother and a healthy child. And satisfied people, you know. That people feel they’ve been supported, that they were listened to, that they’ve had a voice in how it went, and not that it happened to them.” [Joan, Dutch midwife, Q-07].

“[Een belangrijk doel is] dat je op tijd je risico selectie doet. [...] Oké, is dit nog normaal en kan dit nog binnen mijn werkgebied of moet ik het overdragen aan de gynaecoloog? [...] Dan is het doel denk ik [...] heel simpel gezegd is het doel natuurlijk uiteindelijk een gezonde moeder en een gezond kind. En tevreden mensen, hè. Dus dat... nou ja, dat mensen ook het gevoel hebben gehad dat ze ondersteund zijn, dat er naar ze geluisterd is, dat ze... dat ze een stem hebben gehad in hoe het gebeurde en dat het niet, dat het ze niet overkomen is, zeg maar.” [Joan, Dutch midwife, Q-07].

Q-08
"Especially selection of risks, and that’s what you’re constantly doing. Actually already when you walk through the door you’re observing: ok, where are the windows and doors here, what if someone needs to get out of here? What do I do... when you would have a bleeding... where can I reanimate a baby here? You’re just... everywhere [laughs], you don’t mention this when you’re stepping inside a place, but that’s the first... You have a few doom scenarios and well, the first thing you do is observing: what am I going to do with that in this house? [...] And that’s usually during the entire delivery, well selecting for risks and observing whether it progresses normally. And when that’s not the case, yes, we have to intervene. Sometimes by going to the hospital. It can be done in different ways, sometimes it can also be done at home, you know, you pull a few tricks to get [the labour] to progress again.” [Sophie, Dutch midwife, Q-08]

“Vooral selecteren op risico, en daar ben je continu mee bezig, eigenlijk al als je een deur binnenstapt ben je aan het kijken van: ok, waar zitten hier ramen en deuren, wat als iemand hier eruit moet? Wat doe ik als ie... een bloeding kan krijgen.. wat.. eh.. waar kan ik hier een baby reanimeren, je zit... overal (lacht), dat benoem je niet als je ergens binnen komt.. maar dat is het eerste, je hebt een paar dingen, zeg maar ramschenaio’s, en je je het eerst wat je doet is zeg maar even kijken van: oh, wat ga ik daarmee doen in dit huis. En dat is meestal eigenlijk de hele bevalling door is het eh.. ja wel selecteren van risico en kijken of het normaal vordert. En.. ja, op momenten dat dat niet zo is, ja dan moeten we ingrijpen. En soms is dat door naar het ziekenhuis te gaan. Het kan door verschillende manieren, soms kan dat ook gewoon thuis, hoor, wat trucken uit de kast trekken... en.. dan.. om te zorgen dat het weer beter vordert.” [Sophie, Dutch midwife, Q-08]

Q-09
“[You sometimes [...] have such situations between the family-in-law and- and the own mother… you know, like: ‘the one is allowed to come over again, and the other... [...] And [when the family comments on that] you see such a woman completely...- you know,
when you are a postpartum woman, you’re just, you’re not steady on your feet, so you’re quite… such a postpartum woman is then completely upset […], so we try to sootha a bit in these cases.” [Evelien, Dutch postpartum care assistant, Q-09]

“Soms […] krijg je toch wel een situatie tussen de schoonfamilie en – en eigen moeder… weet je wel, van ‘die mag wel weer komen en die[…]’ En [als de familie daar commentaar op geeft] zie je ook zo’n vrouw dan ook weer helemaal – je weet zelf als je kraamvrouw bent, ben je gewoon, hè, sta je niet stevig op – op je benen, dus dan ben je best wel… nou, en dan is er – is zo’n kraamvrouw helemaal ontredderd. […] Dus dan proberen we daar ook een beetje in te sussen.” [Evelien, Dutch postpartum care assistant, Q-09]

Q-10

“[What I stimulate is that] […] when they’re having a nap in the afternoon, I say to the father, you know: ‘jump in and lie down with your wife, because hey, you don’t know how the night will be.’” [Sandra, Dutch postpartum care assistant, Q-10]

“Als ze ’s middags gaan slapen dat ik lekker tegen die vader zeg van: ‘Weet je, duik even lekker naast je vrouw, want hè, je weet ook niet hoe de nacht loopt.”’ [Sandra, Dutch postpartum care assistant, Q-10]

Q-11

“The government always says: with 80 per cent of the children it’s going well, with 20 per cent it’s not going so well and 5 per cent of those really need referral and extra intervention, so we only need to look at the 5 per cent. But that’s not true of course, because these 95 per cent, or 80 per cent, include children who can become an at risk child at a given point in time. […]And the other way around is also possible, so labelling an at risk child is very tricky, because it’s not a fixed fact. […] The main uncertainty to me is: do we really reach the children we want to reach? I always wonder. I actually believe we only see a tip of the iceberg, who we can really offer good help and support.” [Ellen, Dutch paediatrician, Q-11].

“De overheid die zegt altijd: met 80 procent van de kinderen gaat het goed, met 20 procent is dat niet zo en 5 procent daarvan heeft echt verwijzing en extra hulp en inzet nodig, dus we hoeven alleen maar te kijken naar die 5 procent. Maar dat is natuurlijk niet zo, want in die 95 procent, of voor mijn part die 80 procent, zitten kinderen die op een bepaald moment ook een risicokind kunnen worden. […] En andersom kan ook, dus het labelen van een risicokind is heel gevaarlijk, omdat het een… het is geen star gegeven. […] De belangrijkste onzekerheid voor mij is: bereiken wij wel de kinderen die we willen bereiken? Ik vraag me altijd af, ik denk zelf eigenlijk dat we maar een topje van de ijsberg zien wat we ook daadwerkelijk goede hulp en steun kunnen bieden.”’ [Ellen, Dutch paediatrician, Q-11]

Q-12

“Parents are quite vulnerable, I think, because well, […] I think the well-being of someone’s child is very important. And when you give advice, this can be much harder on parents than we think. […] It can feel as a form of criticism. […] And I don’t want to overload parents with massive information and only make them more frightened or insecure.” [Jonita, Dutch nurse, Q-12]

“Ouders zijn heel kwetsbaar denk ik, omdat, ik denk dat ze, […]: het welzijn van, van iemands kind is heel belangrijk. En, en als je iets als advies geeft dan kan dat bij ouders heel, ja harder aankomen. […] voelt het misschien toch als een soort van kritiek. [En dat] wil ik ook weer niet dat ouders worden overspoeld door zo’n zee van
informatie en daardoor alleen maar onzeker of bang worden.” [Jonita, Dutch nurse, Q-12]

Q-13
“For instance a boy, [...] who had to come back due to issues regarding growth, and he continuously heard: worrisome, short child, what to do? And then I see the mother and the father and they are both 1.60, 1.61 m or something. Then I’m like: ok. You know what I mean? That’s very annoying to parents. [...] They don’t like this. [...] This is often mentioned [by parents], that a lot of fuss has been made about nothing.”

(Ireen, Dutch nurse, Q-13)

“Bijvoorbeeld was een jongetje [...] die moest dan ook terugkomen voor de groei en die had eigenlijk continu gehoord dat ‘ja, zorgelijk, kort kind en nou, hoe moet dat nou?’
Terwijl, en dan zie ik die moeder en die vader en die zijn allebei 1,60, 1,61 ofzo. Denk ik: ja.. Ja. Snap je wat ik bedoel? En dan is dat voor ouders heel vervelend. [...] Dat vinden ouders niet leuk. [...] Dat hoor je veel terug. Dat er wel een beetje paniek wordt gezaaid, terwijl er niks is.” [Ireen, Dutch nurse, Q-13]

Q-14
Interviewer: “What are the aspects you like about your job?”
Marianne: “[...] Sometimes these relatively banal acute diseases are a large part [of the job]. This is not so interesting. [...] What I like a lot is to be in contact with children, with the families, who are in the opportunity to accompany them. Because I work here for so long, I have guided many from birth until the end of high school. And the ones who were older – when I took over this practice – are now attending again with their children. So this aspect, guiding families, to observe children growing up, to see them slowly going through life. This is very interesting. An emotionally very, very beautiful aspect of the job “

[Marianne, German paediatrician, Q-14]

Interviewerin: “Was sind dann so Aspekte, die Sie sehr an Ihrem Beruf mögen?”
Marianne: “[...] Manchmal ... von dem manchmal diese relativ banalen Akuterkrankungen einen großen Teil einnehmen. Das ist nicht so interessant. [...] Was ich eben sehr gern mag, ist in Kontakt mit den Kindern, mit den Familien, die äh Möglichkeit die Kinder zu begleiten; viele - dadurch, dass ich jetzt schon so lange niedergelassen bin - äh habe ich viele tatsächlich von der Geburt quasi bis zum Abitur äh begleitet schon. Oder sogar diejenigen die schon älter waren, als ich äh die Praxis übernommen habe, die sind äh gibt es jetzt einzelne, die auch schon wieder mit ihren Kindern zu mir kommen. Äh [...] und ja, das ist so ein Aspekt also dieses äh dieses Begleiten der Familien und äh - äh zu zusehen, wie die Kinder groß werden, und wie die dann so langsam ins Leben rausgehen. Das ist ein SEHR interessanter, oder sehr SCHÖNER - emotional sehr sehr äh schöner Aspekt des Berufes.” [Marianna, German paediatrician, Q-14]

Q-15
“It makes little sense to look at physical characteristic in the prevention. [...] Much more important is, so to speak, what people’s needs are. What problems do they face? Usually, I have known people since forever and I’ve accompanied them. So I usually don’t detect any physically exciting findings. What I can find, of course, is that a child is not really thriving well. This can be due to different things.”

[Torben, German paediatrician, Q-15]

“Das macht ja in der Vorsorge so wenig Sinn nach den nach den körperlichen Merkmalen zu schauen. [...] Viel wichtiger ist es sozusagen zu gucken, was für Bedürfnisse haben die sonst noch die Menschen, ne. Welche Probleme bestehen sonst noch. In der Regel kenne ich die Leute ja schon seit Ewigkeiten und begleite die dann.
Körperlich aufregende Befunde werde ich in der Regel nicht finden, ja. Was finde ich natürlich mal, dass ein Kind nicht so richtig gut gedeiht. Das liegt dann aber auch an verschiedenen Sachen." [Torben, German paediatrician, Q-15]

Q-16
Interviewer: "Does it also happen that a parent says: ‘Ok, then we go to someone else’?"
Torben: "Yes. Of course. [...] This is relatively common. [...] When it comes to things that don’t need to be talked about for long. [...] Some patients would like to talk about a cold for a long time, because perhaps something else should come up, and when I just don’t have the antenna that there is actually something else behind the runny nose [...] then after the second time they say, ‘He doesn’t have time for me.’ Or ‘he doesn’t take the time I need.’ This happens so fast.” [Torben, German paediatrician, Q-16]

Q-17
"I think that the strongest insecurity occurs during the care of an infant who is potentially healthy, due to the fact that while examining children who are with their mothers and theoretically should be healthy, well, you have to remain increasingly... indeed increasingly alert and there is this kind of this kind of insecurity because we don’t expect any pathology, however it may certainly occur and the whole thing is to detect everything and keep our senses at the same time and not scan every child from head to toe and don’t perform a million of tests. Because that’s not the point.” [Klaudia, Polish paediatrician, Q-17]

"myślę że największa niepewność jest wśród- przy opiece nad dzieckiem potencjalnie zdrowym, ze względu na to że badając dzieci które są przy mamach które teoretycznie powinny być zdrowe no, trzeba zachować wzmożoną, wzmożoną właśnie taką czujność i jest taka- taka właśnie nutka niepewności ponieważ nie spodziewamy się żadnej patologii, natomiast ona może się jak najbardziej zdarzyć i właśnie tą całą sztuką ją jednak mimo wszystko wylapać a z drugiej strony nie dać się zwarować i nie prześwietlać każdego dziecka od stóp do głów i nie robić każdemu miliona badań bo to też nie o to chodzi “ [Klaudia, Polish Paediatrician, Q-17]

Q-18
"I mean the aim is to help children. I’m putting a strong emphasis on preventive healthcare. And I’ve got a really idealistic vision on my job, that I also perform an educative function. I would rather treat less, and teach more and put even more emphasis on prevention.” [Stefana, Polish paediatrician, Q-18]

"Znaczy celem jest pomaganie dzieciom. Bardzo duży nacisk kładę na profilaktykę zdrowotną. No i bardzo mam taką wizję mojej pracy idealistyczną, że taka funkcja również edukacyjna. Wolalabym mniej leczyć, a więcej edukować i właśnie kłaść nacisk na profilaktykę.” [Stefana, Polish paediatrician, Q-18]
Q-19

“I think that I have to support [parents] with, for instance, some advice about food or vaccination. Even if they don’t ask about it, I think it’s my role to educate them, and if they won’t hear it from the doctor, I’m positive they will ask somewhere on a playground and may hear something contrary to generally accepted recommendations.” [Stefana, Polish paediatrician, Q-19]

„To uważam, że jak najbardziej trzeba [rodzice] wesprzeć, np. takie rady odnośnie żywienia, czy szczepienia. Nawet jeżeli o to nie pytają, to uważam, że moją rolę jest edukowanie ich i jeżeli nie usłyszą tego od lekarza, mam wrażenie, że dopytają się gdzieś w piaskownicy i usłyszą coś niezgodnego z ogólnymi zaleceniami.” [Stefana, Polish paediatrician, Q-19]

Q-20

“So it’s an enormous uncertainty and parents always want confirmation. They always want to be assured that everything is good and that they do everything right. [...] And I have the feeling that this is like a generational thing. You no longer have the mother in the house, or the grandmother.” [Sonja German paediatrician, Q-20]

“Also es ist eine enorme Unsicherheit und die Eltern möchten sich immer absichern. Die möchten sich immer absichern, dass auch alles gut ist und dass sie alles richtig machen. [...] Und das habe ich so das Gefühl, dass das so ein Generationsding. Man hat nicht mehr die Mutter im Haus, oder die Grossmutter.” [Sonja, German paediatrician, Q-20]

Q-21

“And the trend that can increasingly be recognized is that the child, the parents are increasingly incapable to assess how the child is doing. Also because of this information overload, I believe parents are lacking intuition in dealing with the child. [...] The grandmother is missing, who says: ‘be careful, first give a suppository, then wrap the calf, or wrap the waist. And you attend the paediatrician tomorrow.’ What can rather be observed is that parents are increasingly helpless and seek medical professionals with the first signs of illness. They call emergency services and [go] directly to medical centres.” [Johan, German paediatrician, Q-21]


Q-22

Interviewer: “Do women discuss with you: ‘I would like to return to work, but this doesn’t pay off with Elterngeld?’”

Isabella: “I believe [...] based on that there is an incredible mother cult in Germany which is so overwhelming, you know. So it’s such a super-hyper-hyper-mother. It’s sometimes difficult for women to find their way: What kind of mother am I? There is no orientation. It’s easy for the Scandinavian countries in my eyes. They have a royal family and can orientate on them. But our Chancellor is childless. So we have few idols - except the Klum perhaps, who looked as if she had never been pregnant after 6 weeks, or 8 days. This puts women under great pressure.” [Isabella, German midwife, Q-22]
Interviewer: "Wird das denn oft mit Ihnen besprochen, dass da Frauen sagen: "Hm, ich möchte jetzt schon gerne arbeiten gehen, aber mit dem Elterngeld, das rechnet sich nicht'?" Isabella: "Ich glaube [...] dass es in Deutschland ein unglaublichen Mutterkult gibt, der so überschießt, ja. Also es so diese Super-hyper-hyper-Mutter. Es ist manchmal schwierig, dass die Frauen so ihren Weg finden: Was bin ich für eine Mutter? Es gibt keine Orientierungshilfe. [...] Weil es die skandinavischen Länder in meinen Augen einfach haben. Die haben eine Königsfamilie und an denen können die sich entlanghangeln. Aber unsere Bundeskanzlerin, die ist Kinderlos. Also wir haben wenig Idole - außer halt die Klum vielleicht, die aber nach 6 Wochen oder nach 8 Tagen so aussah, wie als wäre sie nie schwanger gewesen. Das setzt die Frauen total unter Druck. " [Isabella, German midwife, Q-22]

Q-23

"In [name city] is the clientele, so the patients are different than in the rest of the country. So there are also large differences, and I think that they are also an enrichment. That’s also often the case with foreigners. The family forms are often also quite different, which can be good, and which can also – as I have experienced – be very burdening. [...] Many women are also speaking in other languages, so not German-speaking. This may be a problem, sometimes, in the care. So I cannot speak Turkish, but I can speak English quite well, which is very, very often requested lately. [...] I can speak Dutch, but this is very rarely asked [laughs]. I can also speak French, there is also a large demand, I have noticed. [Women] from Morocco, that is increasing.” [Gerda, German midwife, Q-23]

In [Stadtname] ist das Klientel, also sind die Patientinnen anders als auf dem Land auch. Da gibt es also auch große eh einfach Unterschiede [Holt Luft] und ehm, ich finde das sie auch eine Bereicherung. Weil gerade oft ehm, in ausländischen oder oder eh kommt immer darauf an. Aber eh so eh ganz anders oft dieser Familienzusammenhang auch da ist. Was gut sein kann [Holt Luft] was aber auch, was ich auch erfahren habe, sehr belastend sein kann. [...]Es ist auch so, dass quasi viele Frauen sa ah sind auch anderssprachig, also nicht deutschsprachig. Das stellt vielleicht auch ein Problem da, manchmal. In der Betreuung, ja. Also ich kann kein türkisch, aber ich kann ganz gut Englisch, das ist in der letzten Zeit sehr sehr sehr viel nachgefragt worden. [...] Ich spreche holländisch, aber das wird ganz selten nachgefragt (lacht). Und kann auch Französisch, so das, also da ist schon auch eine große Nachfrage merke ich. Also Maro [Frauen] aus Marokko vor allem Dingen kommen sind schon auch immer werden zunehmend. [Gerda, German midwife, Q-23]

Q-24

"For 90 per cent of the day, you encounter reasonable people. Then only 10 per cent are unreasonable people. This is simply a normal distribution. [...] The 10 per cent of difficult [people]... can sometimes also be the salt in the soup. It can also give the kick [laughs]. I find difficult patients not necessarily bad.” [Torben, German paediatrician, Q-24]

“Sie haben ja 90 Prozent des Tages mit vernünftigen Menschen zu tun. Es gibt dann nur 10 Prozent unvernünftige Menschen. Das ist einfach eine gauß’sche Normalverteilung. (...) Mit 10 Prozent schwierigen ... kann ja auch manchmal das Salz in der Suppe sein. Das kann ja auch mal den Kick geben [lacht]. Ich finde schwierige Patienten nicht unbedingt schlecht.” [Torben, German paediatrician, Q-24]
Q-25
“...I believe [...] that [midwives] take over the... what the social environment used to do back in the days, and where one was simply supported, where one was told: that’s ok, that’s normal, this will pass, this is what happens to many others as well. And I believe this is neglected, while the women... especially in [this city]; how many women are here only for professional reasons? Perhaps even only for their partner’s professional reasons? Who are completely isolated here, and perhaps due to parenthood have even fewer people who they can talk to about what happened and what’s relevant to them. And when one then talks to people who are not in the same situation, it’s perhaps, it makes it even more difficult. And I believe midwives are in a good intermediate position to really say: ‘yes, this is an insane development you’re going through. Tell me more about it.’” [Carla, German midwife, Q-25]

Q-26
“You also see many of those snarling parents, who are only snapping at the child the whole time, and stressing everything that’s not going well again and again, and this provides a very loaded atmosphere, in my view. [...] There are many [...] damaged parents, also in this area, who have experienced a lot in their childhood and in the past, or with a lot of family problems. Or just other problems; financial problems, housing problems. And I think, well, you see that when people are very occupied with other things demanding their attention, yes, that this has its effect on those children.” [Christine, Dutch nurse, Q-26]

Q-27
“I find it more difficult to see parents who have it a bit harder, and where you see this has an effect on the child. And that you need to have that talk of: yes, I understand you are worried, for instance because you have financial problems, or you are a single parent, but I see this reflected in... in your child, so to speak, and that, well, the way you deal with your child is very negative.” [Ellen, Dutch paediatrician, Q-27]
“Moeilijker vind ik het om ouders te zien die het wat moeilijker hebben en waarin je ook ziet dat dat z’n weerslag heeft op het kind. En dan toch dat gesprek aan te moeten gaan van ‘ja, ik begrijp dat je zorgen hebt, omdat je financieel bijvoorbeeld problemen hebt of dat je alleenstaand ouder bent, maar ik zie dit terug in... in je kind, zeg maar en dat, ja de manier waarop je met het kind omgaat erg negatief is.” [Ellen, Dutch paediatrician, Q-27]

Q-28

“The love is different. [...] Taking time for the children changes. [...] Nowadays so many other things also need to be done. [...] The phone, or ordering something on the Internet, or... Yes, unimportant things in my view.” [Leen, Dutch postpartum care assistant, Q-28]

“De liefde is anders. [...] De tijd voor de kinderen nemen verandert. [...] Nu moeten nog zoveel andere dingen. [...] De telefoon, of nog even wat op internet bestellen, of... Ja, voor mij onbelangrijke dingen.” [Leen, Dutch postpartum care assistant, Q-28]

Q-29

“Back in the days, it was all very natural. And now we have to pay more attention. [...] Like such a bottle: ‘convenient’, you know. I’ve had it in the first week, first, second day I came in, and then I see the baby lying in the baby bouncer [by itself], teddy bear underneath, with a bottle, like this [shows with arms]. It was two, three days old. I said: ‘what are you doing?’ ‘Yes’, she said, ‘my friend works in a day care centre, [...]’, so handy’. [Laughs] You see, then you have to go back to the start, to say, also with the bottle, right. Because with the bottle, we also try the skin-to-skin contact, you know. And also to take that moment, to put the phone away.” [Evelien, Dutch postpartum care assistant, Q-29]

“Vroeger was het allemaal heel natuurlijk, weet je. En nu moeten we er meer op kijken en doen. [...] Ook zo’n flesje, ‘makkelijk’, weet je, dat. Ik heb ook wel eens in – dat was de eerste week, eerste... tweede dag dat ik binnenkwam, en dan zie ik dat baby’tje liggen in het wippertje, met een beertje d’r onder, met een fles zo. Was het twee, drie dagen oud. Ik zeg ‘wat doe jij nou?’ ‘Ja’, zegt ze ‘mijn vriendin die werkt bij het kinderdagverblijf [...]’, zo handig.’ [lacht] Kijk, dan moet je weer helemaal terug, dat je zegt van... ook met die fles, hè. Want wij proberen ook met die fles, ook even die... die huid-op-huid contact, weet je wel. En ook dat moment nemen, ook die telefoon weleggen. [Evelien, Dutch postpartum care assistant, Q-29]

Q-30

“I expect from parents that they are as parents are supposed to be. [...] So that they don’t focus on all these gadgets; this very materialistic approach to maternity. [...] I want them to remember that interpersonal relations are the most important and we experience deficiency of them, lack of time devoted to other people, including a lack of time we devote to our own kids. So if we just hope that we will put our little munchkin between glittering and rattling toys, so we can have some time to check out Facebook or blab on the phone endlessly, it’s not really what it’s all about here.” [Olene, Polish midwife, Q-30]

“To znaczy ja mam takie oczekiwania w stosunku do rodziców, jakimi powinni być. Żeby nie skupiali się na takim gadżeciarstwie, na takim właśnie materialistycznym podejściu do kwestii macierzyństwa. [...] Żeby pamiętać o tym, że najważniejsze i najbardziej deficytowe w dzisiejszych czasach są relacje międzyludzkie, jest deficyt czasu, który poświęcimy innym ludziom, w tym deficyt czasu, który poświęcamy własnym dzieciom. Czyli jeżeli mamy nadzieję, że obłożymy malucha święcącymi i dźwigniczymi zabawkami
i dzięki temu będziemy mieli czas, żeby posiedzieć na facebooku czy gadać przez komórkę nie wiadomo jak długo, to to nie o to chodzi.” [Olene, Polish midwife, Q-30]

Q-31

“'I mean [when the grandmother’s or mother-in-law’s attitude isn’t always appropriate], stigmatising those premature babies, that they’re not as they should be. [...] There is this problem of one’s community [...] because it’s expected of a pregnant woman that she’ll be back home after three days with a healthy baby and when she comes back on her own or when something is happening, then, well, it’s not always... I mean, this ideal of the Polish mother still persists somehow, doesn’t it?’” [Janek, Polish paediatrician, Q-31]

"To znaczy, że stygmatyzacja tego wcześniaka nie, że on jest bardziej nie taki niż jest, [...] Jest ten problem tego otoczenia [...] bo jednak się spodziewa po kobiecie w ciąży, że wróci po trzech dniach do domu ze zdrowym dzieckiem, a jak wraca sama, albo coś tam się dzieje no to, to nie zawsze jest tam tak, no ten ideal matki-Polki już tam gdzie tam pokutuje nadal, nie. [Janek, Polish paediatrician, Q-31]

Q-32

Interviewer: “What are the problems and insecurities parents face, are these insecurities, problems, different for mothers and fathers?”

Urszula: "I'm not sure if it depends on being a father or a mother or rather on different factors: place of living, city, village, level of education, also self-reflexivity. [...] But I guess it doesn't really depend on if you're a father or a mother.” [Urszula, Polish paediatrician, Q-32]

Interviewer: “Tak było- a z jakimi problemami i niepewnościami muszą się zmierzyć przyszli rodzice, czy te niepewności, problemy różnią się między ojcwami i matkami?”

Urszula: "Mm, nie wiem czy to zależy od tego, czy jest się ojcem czy matką czy raczej od od innych czynników. Miejsca zamieszkania, miasto wieś, poziomu wykształcenia, mm też takiej samoświadomości, tak [...], że to nie zależy od tego czy jest się ojcem czy matką tylko raczej.” [Urszula, Polish paediatrician, Q-32]

Q-33

Interviewer: “To what extent do you experience support for a specific role for fathers and mothers in legal institutions?”

Agnieszka: “Well, in this case I can be pretty clear because practically parents,..., when the child is healthy, then generally parents don’t need any special support and can manage on their own. However, I firmly believe that in the case of children who require more care further on, exactly our preterms who require [special care], there, parents are completely left to their own devices. I mean, obviously there are physical therapists, but usually parents, especially those not so well-off, they receive absolutely no support.” [Agnieszka, Polish paediatrician, Q-33]

Interviewer: "W jakim zakresie obserwuje Pani wsparcie dla specyficznej roli ojców i matek ze strony instytucji prawnych?"

Agnieszka: "No to tutaj to akurat jestem, jakby, jakby dosyć sprecyzowana bo praktycznie rodzice jak dziecko jest zdrowe, to generalnie rodzice nie potrzebują jakiegoś wsparcia i dają sobie radę. Natomiast absolutnie uważam, że w przypadku dzieci, które wymagają później takiej czujniejszej opieki, właśnie te nasze wcześniaki, które wymagają są rodzice absolutnie na siebie skazani? To znaczy oczywiście, że są rehabilitanci, że można, ale zwykłe rodzice, szczególnie ci które k mniej zamożni są absolutnie jakby nie wspomagani." [Agnieszka, Polish paediatrician, Q-33]
“Surely in a private facility it happens less often. It’s not violence, but there is neglecting […] such as, I don’t know, not fulfilling some emotional needs, babies are often with some people… […] And that’s really horrifying here in private healthcare. And in the [public] hospital there are notoriously children that have been beaten, harassed, persecuted in some other way and you don’t even need to pay much attention, because some parents are capable of hitting the child during the conversation, because something is going wrong, because they have a dubious lifestyle, don’t treat them the way they should, or you can see a hit mark, or you can see children that are very withdrawn even during a short conversation.” [Stefana, Polish paediatrician, Q-34]

“Na pewno tutaj w takiej placówce prywatnej jest tego mniej. To nie jest przemoc, ale jest takie zaniebieranie dzieci, […] w sensie emocjonalnym, dzieci są często z osobami jakimiś. To jest właśnie straszne tutaj w prywatnej służbie zdrowia. […] Natomiast w szpitalu notorycznie dzieci bite, molestowane, gnębione na każdy inny sposób i tu nawet nie trzeba jakoś wiele zwracać uwagi, bo czasami rodzic jest nawet w stanie podczas rozmowy uderzyć dziecko, bo coś tam się że prowadzi, nie leczy jak powinno, nie pilnuje, czy widać ślady po uderzeniach, czy widać po dzieciach, które są zamknięte przy krótkiej rozmowie.” [Stefana, Polish paediatrician, Q-34]

Chapter 6

Q-35

“Ignorance is a threat, bad behaviour. […] When someone heard something here and there, and isn’t really sure, and they act contrary to what they should do. […] One mom, you know what? She wanted to carry her baby only in a sling. And it was taking her like half an hour to put it on, it was summer so we were all sweating, she put her baby in it… and the baby fell down on the tiles and bumped his head. The diagnosis was broken cranial bone. And what can I do, it was a threat for the baby. This kind of lack of knowledge and skills, striving for something specific sometimes is just not meant to be.” [Tekli, Polish midwife, Q-35]

“Zagrożeniem jest niewiedza, niewłaściwe postępowanie. […] Kiedy ktoś coś gdzieś usłysza, tam usłysza, jeszcze gdzie indziej usłyszy i postępuje niezgodnie z tym co powinniśmy. […] Jedna mama, wie pani co, chciała konieczne dziecko nosić wyłącznie w chuście. I rzeczywiście pół godziny zakładała tą chustę w lecie, więc byliśmy już wszyscy spokieni, położyła tego dzieciaka, i ten dziecko jej wypadł na głowę, na płytki. Złamanie kości czaski – taka diagnoza. No co zrobić, było to zagrożenie dla dziecka. Taka właśnie niewiedza, nieumiejętność, dążenie do czegoś widocznie nie dla każdego jest przeznaczone.” [Tekli, Polish midwife, Q-35]

Q-36

Interviewer: “How do you see fathers and mothers in their role of caregivers, and how does this differ?”

Hester: “Well, what I see concretely, is actually very little, [laughs]. I think […] You don’t just see someone bathing the child, or how someone deals with the baby when it starts to cry, how they are in the morning when they’ve had a bad night and you come in. And these are of course important issues by which you see how people deal with their child, and also deal with the stress that comes along. And how they do this together, how they solve problems together.” [Hester, Dutch midwife, Q-36]
Interviewer: “Hoe ze je vaders en moeders in hun rol als verzorgers, en hoe verschilt dit?”
Hester: “Nou wat ik.. concreet zie.. is eigenlijk heel weinig [lacht], vind ik. […] Je ziet niet iemand gewoon een kind in bad doen of hoe iemand ermee om gaat als een kind begint te huilen, hoe ze er ’s ochtends in staan, als ze een beroerde nacht hebben gehad en je komt binnen. En dat zijn natuurlijk juist belangrijke punten waarop je ziet hoe mensen omgaan met hun kind en ook omgaan met de stress die dat meebrengt. En hoe ze dat ook samen doen, hoe ze samen problemen oplossen.” [Hester, Dutch Midwife, Q-36]

Q-37
“You mainly teach parents [...] that a child should not sleep in hot rooms. Foreign mothers are fond of tucking in and the heater on 30 [degrees] and the baby must be in the crib and it must have a hat and three blankets and preferably a cloth. And then we say [...] ‘you know, you shouldn’t do that, it’s not good for your baby’. You know, these kind of threats, you tell them all about it. [...] And also with carrying and bathing; basis affirmative carrying you know [...] they are currently very keen on that you shouldn’t lift them under their arm pits, but always on two sides. And also when you walk down the stairs you know, the head over here, hold the leg and only then walk down the stairs.” [Annet, Dutch postpartum care assistant, Q-37]

Q-38
“I think that, well, every mother has maternal instinct so it’s hard to maybe talk here about some kind of a complete carelessness but well, some kind of lack of proper care that is well overheating, or exposure to cold temperatures, improper technique of breastfeeding which may lead to dehydration of a child, improper positions of a child which may lead to breathing difficulties or some kind of choking, something like that, however these are things which are kind of explained even here during mother’s stay at the maternity ward, so such basics to every mother, I think every mother is discharged with this kind of basic knowledge.” [Klaudia, Polish paediatrician, Q-38]

Q-39
“A woman came to me, second generation of immigrants [...]. Has a very good job, highly educated, [...] is a lawyer, I believe. [...] Yes, if I could tell her where you can have a caesarean. A planned caesarean. [...] She said: [...] ‘why should I still give birth and things like that? This is nonsense; no one does it anymore today. [...] So I
definitely want my caesarean. Yes and breastfeeding, no. This twaddle, we’re not going to do that in any case; I don’t want that as well’ [Laughs]. ‘I want a bottle, or… because then I can also return to work quickly and then one has to find a place quickly, a child minder, somehow’ […]. I was […] a little flabbergasted.’” [Gerda, German midwife, Q-39]


We have fewer children and that means many parents […] have never had a baby in their arms. […] [50 years ago] it was different. There was still more casualness. Today is being considered: “Should I take the diaper, or […] do I wrap like this? Or like this?” Hello? I mean…pfff [sighs].” [Jana, German midwife, Q-40]

Wir haben wenig Kinder und das heißt viele Eltern […] hatten noch nie einen Säugling im Arm. […] [Vor 50 Jahren] war es anders. Da war noch eine größere Selbstverständlichkeit. Was heute überlegt wird: “Soll ich die Windel nehmen, oder […] Wickel ich so? Oder so?” Hallo? Also ich meine pf.” [Jana, German midwife, Q-40]

“As long as they’re here in the ward with the baby they should practice as much as possible, take care of the baby because when they go home, they will feel more confident.” [Sylwia, Polish midwife, Q-41]

“I do póki są z dzieckiem tutaj na oddziale, żeby jak najwięcej ćwiczyć, opiekowali się tym dzieckiem, bo jak no wtedy idą do domu czują się już pewniej.” [Sylwia, Polish midwife, Q-41]

“And you see this more regularly nowadays you know, that children are a bit ‘neglected’… and I don’t mean… they have food and drinks, but… when it comes to love. […] Nowadays most parents work, and you see that these children are attending a day care centre for entire days. And then [others] gave birth and think it’s nice and say: ‘oh, we don’t bring the children to day care then, we leave them at home.’ But my god that they don’t know how to handle those kids. So after an hour, you already hear: ‘well, when you are this annoying, you had better gone to day [care]’, you know. Then you can just tell from people that they are not used to it anymore, caring for their own child for a whole day. And that they get very easily agitated. And I find that… I always find that so remarkable.” [Annet, postpartum care assistant, Q-42]

“En dat zie je tegenwoordig wel vaker, hoor, dat kinderen wel een beetje ‘verwaarloosd’… en dan bedoel ik niet… ze hebben te eten en te drinken, maar… qua liefde… […] De meeste ouders werken allebei tegenwoordig, en dan zie je dat die kinderen gaan hele dagen naar zo’n kinderdagverblijf. En dan zijn ze bevallen en dan
vinden ze het leuk en dan zeggen ze ‘oh, dan doen we de kinderen niet naar het kinderdagverblijf, die laten we dan thuis’. Maar, mijn god dat ze niet weten wat ze met die kinderen aan moeten. Dan na een uur, dan hoor je al: ‘nou, als je zo vervelend bent, dan had je wel beter naar het kinder...’, weetjewel. Dan merk je gewoon aan mensen dat ze het gewoon niet meer gewend zijn om een hele dag voor hun eigen kind te zorgen. En dat ze daar heel snel door geïrriteerd raken. En dat vind ik.. dat vind ik zo bijzonder altijd.” [Annet, postpartum care assistent, Q-42]

Q-43

"In a way, I find that the fathers, do not really have this competence. [...] So, when the children cry, they are more passive and compassionate. And mothers are a bit more resolute, in a way, and capable with the children ... But I think that's a matter of practice. I think that if a man would always be doing..., [...] would also hear from us: ‘You have to hold him like this, so he feels safe’ and so on. Because I believe a lack of exercise, that’s also the uncertainty, you know.” [Sonja, German paediatrician, Q-43]

“Ich finde, teilweise, dass die Väter, so das Handling nicht drauf haben, [...] Also sprich, wenn die Kinder weinen sind sie eher passiv und mitleidig, so, ja. Und Mütter sind da ein bisschen resoluter, teilweise, und können die Kinder ... Aber ich glaube das ist Übungssache, ja. Ich glaube, wenn ein Mann das immer machen würde, [...] kriegt er dann ja auch von uns gezeigt: "Sie müssen ihn fest halten, dass er sich irgendwie geborgen fühlt" und so weiter. Da fehlt es glaube ich auch an Übung und auch, das ist dann auch die Unsicherheit, ne.” [Sonja, German paediatrician, Q-43]

Q-44

"Let’s just say, when there is a very overprotective mother-child relationship, or father-child relationship, the child is wrapped in cotton wool and can’t do anything and should be protected as much as possible [...]. I try to explain how difficult it is for the child to develop autonomy. Yes, the parents themselves have achieved some autonomy, but also only because they were let go. Otherwise autonomy does not work. And, I'm also trying to explain when that begins, yes [...] autonomy already begins with three months of age]. With pauses and steps forwards, at different levels. But the blockade of a child’s autonomy development will be a disaster later in life.” [Torben, German paediatrician, Q-44]


Q-45

“In the last 10, 15 years, we can strongly observe a phenomenon, above all things I would say, we can observe that the children are in some respects perceived as an extension of the parents, especially the mothers. Fathers less, but mothers - that is, that is to say, the pain children experience has a direct and immediate effect on the parents; the parents cannot see any distance; they intervene for instance massively in examinations. [...] I have to point out to the parents more and more often: ‘please
keep back, this is an examination for your child!”’ [Marianne, German paediatrician, Q-45]

“Es gibt ein Phänomen, dass wir sehr stark beobachten und das in den letzten 10 15 Jahren würde ich sagen, vor allen Dingen wir beobachten können, dass die Kinder in in gewisser Hinsicht, wie ein verlängertes Körperteil der Eltern gesehen werden, besonders der Mütter. Väter weniger, aber Mütter - äh das heißt das also, Schmerzen, die dem Kind hinzugefügt werden, also direkt und unvermittelt auf die Eltern zurückwirken, dass die Eltern da keinen Abstand sehen können, dass sie massiv eingreifen zum Beispiel in Untersuchungssituationen. [...] Zunehmend häufig wo ich die Eltern massiv darauf hinweisen muss ‘bitte halten Sie sich zurück, das ist eine Untersuchungssituation für Ihr Kind!’” [Marianne, German paediatrician, Q-45]

Q-46

“This morning, I had a child; mother was continuously on it. [...] Normally I would discuss this, like: leave her be for a moment, or: allow her to discover things by herself, that’s always good for the development. [...] To leave them a bit, a bit more free. And to experience a bit more by herself.” [Yara, Dutch paediatrician, Q-46]

“Vanochtend had ik een kindje, moeder zat er continu bovenop. [...] Normaal zou ik dat bespreken, van: laat haar eventjes, of: laat haar zelf dingen ontdekken, dat is altijd goed voor de ontwikkeling. [...] Om ze iets, iets vrijer te laten. En even iets meer zelf te ervaren.” [Yara, Dutch paediatrician, Q-46]

Q-47

“In our times of one-child families, we don’t know how to step back out of the area of being their mother hen. And I think it’s [...] really bad; people theoretically know that we need brave, open children, who can discover the world and easily develop new friendships, but at the same time they bring up a cowardly fondler.” [Olene, Polish midwife, Q-47]

"Czasach jedynaków nieumiejętność takiego małymi kroczkami z roku na rok wycofywania się troszeczkę z tego obszaru takiego kwołkowacenia maluchowi. I to też jest jakby moim zdaniem zle i niby teoretycznie ludzie wiedzą, że potrzeba nam dzieci odważnych, otwartych na świat, na nowe znajomości, a wychowują załękniętego piesczoszka." [Olene, Polish midwife, Q-47]

Q-48

“Sometimes a child listens to father, but not to mother. You actually hear this very often. [...] And that’s because mothers often show their feelings a bit, that they care, or that they, that they... A child often knows as well that this is a weak spot of mother, this motherly feeling so to speak. And a child senses this, so it can make use of it.” [Esma, Dutch nurse, Q-48]

“Soms luistert een kind wel naar vader, maar niet naar moeder. Heel vaak zelfs hoor je dat. [...] En dat komt vaak omdat moeders ook een beetje hun gevoel laten blijken dat ze het erg vinden of dat ze, dat ze.. Een kind weet ook vaak dat dat het zwakke punt van moeder is, dat moedergevoel, zal ik maar zeggen. En dat voelt dat kind ook aan, dus die kan daar misbruik van maken.” [Esma, Dutch nurse, Q-48]

Q-49

"Or post-’68 ideas about child raising. And so forth. That’s now on it’s return. And who knows whether this experimental appetite is good for children. This needs to be
problematized one day. And well, I also see this as an important task for a paediatrician.” [Gerhard, German paediatrician, Q-49]

“Ah nach-68er Ideen von Erziehung und so weiter. Das ist ja jetzt im Umbruch. Und inzwielet eh diese Experimentierfreudigkeit für Kinder gut ist, das muss man schon manchmal problematisieren. Und ja, das betrachte ich auch als eine wichtige Aufgabe des Kinderarztes.” [Gerhard, German paediatrician, Q-49]

Q-50

“When you never think about yourself and sleep three hours a day, just to exaggerate, because the child needs all the attention, yes, you’re going to meet yourself somewhere. And that’s also a risk, because when the mother is worn out, the child can neither depend on the mother. Or the father.” [Esma, Dutch nurse, Q-50]

“Als jij nooit aan jezelf denkt en drie uur per dag slaapt, even om het te overdrijven, omdat het kind alle aandacht nodig heeft, ja dan kom je jezelf ergens tegen. En dat is ook een risico, want als die moeder er doorheen is, dan heeft het kind ook niets meer aan die moeder. Of vader.” [Esma, Dutch nurse, Q-50]

Q-51

“I say: ‘No, we are not going to have a quick shower. You are going to have a relaxed shower. The baby is nicely asleep […], you’re taking some time for yourself.’ […] Because when a mother doesn’t take good care of herself, she can’t take care of her children. […] You’re not going to endure.” [Leen, Dutch post-partum care assistant, Q-51]

“Ik zeg ‘Nee, we gaan niet even snel douchen. Je gaat even rustig douchen. De baby ligt lekker rustig te slapen […], je neemt even tijd voor jezelf.’ […] Omdat wanneer een moeder niet goed voor zichzelf zorgt, ze niet voor haar kinderen kan zorgen. […] Dan hou je dat niet vol.” [Leen, Dutch post partum care assistant, Q-51]

Q-52

“It’s important to convey to people that they don’t have to do it perfect from the beginning, you know. They should also… take relief; they shouldn’t carry the baby around all the time. My wife did this well. We’ve also had a cry-baby. She did it well. She gave it to me in the evening and that was good. Then it continued crying with me. Then she could take relief, [she] went away, did things. And yes, that’s how I also did this.” [Torben, German paediatrician, Q-52]


Q-53

“I guess I see some psychological threats, if, well, the mother goes through some kind of… stressful time connected with a tough family situation for example. […] I encourage mutual support between spouses.” [Wiktor, Polish paediatrician, Q-53]
"Myślę widzę jakieś zagrożenia psychologiczne, jeżeli tam matka przechodzi przez jakiś okres stresu związany z tym trudną sytuacją rodzinną na przykład [...] popieram z wspomaganie wzajemne współmałżonków." [Wiktor, Polish paediatrician, Q-53]

Q-54

"We’re often scared of such situations that mom gives birth to a baby and this baby becomes number one, right. [...] If we’re not in a good relation with the father [...] the child will always sense it, right?“ [Danuta, Polish paediatrician, Q-54]

"Bo często boimy się takich sytuacji że no mama rodzi dziecko i po prostu dziecko jest numerem jeden, nie. [...] A jak nie będziemy mieć dobrych relacji z ojcem z dziecka [...] to zawsze też dziecko to wyczuwa, nie?” [Danuta, Polish paediatrician, Q-54]

Q-55

"I very much point out that..., they often find it funny when I say this, but I say it in almost all families, that you should not put your child first, but your husband or wife comes first and the baby comes second. Because when your relationship is going well, your baby is well. And when your relationship is not going well anymore, you can’t hide it for your baby. [...] And they have mostly never thought about this. They throw themselves, especially those mothers, they throw themselves on the baby. And you can already see this father shrinking back.” [Idelette, Dutch postpartum care assistant, Q-55]

"Ik wijs ze er ook heel erg op dat, dat ze, dat vinden ze altijd wel heel grappig dat ik dat zeg, maar dat zeg ik.. bijna in alle gezinnen, dat je niet dat kindje op de eerste plaats moet zetten. Maar, je man of je vrouw staat op de eerste plaats en dat kindje komt op de tweede plaats. Want als je relatie goed is, gaat het met het kindje ook goed. En als je relatie niet meer goed gaat, dan kan je dat ook niet verbergen voor je kindje. [...] En dan hebben ze, daar hebben ze bijna nooit zo over nagedacht. Ze storten zich, vooral die moeders, die storten zich helemaal op dat kindje. En je ziet die vader al naar achter deinzen.” [Idelette, Dutch postpartum care assistant, Q-55]

Q-56

"The mother should be this person who provides warmth and care, and the father is more for concrete things, for setting limits, and this should of course be adequately balanced, meaning the mother should restrain the father’s efforts to set limits and the father should restrain this overprotective care” [Janek, Polish paediatrician, Q-56]

"To matka głównie powinna być taką osobą, która zapewnia takie ciepło, opiekuje się, a ojciec jest bardziej od takich rzeczy konkretnych od wymagań, no i to odpowiednio oczywiście się w miarę jakoś dogadywać, czyli matka powinna temperować te zapędy ojca w wymaganiach, a ojciec powinien temperować tą nadopiekunność opieką.” [Janek, Polish paediatrician, Q-56]

Q-57

"I like it a lot when a mother for example wants to pursue an education or something, when she has never studied before. That’s just that I’m thinking: wow, I would. I like that, when she, well wants to develop herself further. And I always like to ask: ‘ok, what do you want to do, what are you thinking of?’ Just to chat about this for a while.” [...] 

"You see, for me it would be ideal when a father and a mother both, so to speak, would be at home and would work for example. But for someone else it’s very ideal when a mother is always there for the children alone and the father takes care of the income. So that’s just not up to me... to say something about that.”
“I sometimes also have mothers of course who are just at home, who are housewives. Well, I personally don’t find this a problem at all. That’s also my personal norm, that I’m like: wonderful for the child, it gets all the attention. And mother is satisfied with it. [...] I only find it positive I must say, when a child can get complete attention at home. Yes.” [Marloes, Dutch nurse, Q-57]

“Ik vind het bijvoorbeeld heel leuk als een moeder bijvoorbeeld nog wil gaan studeren, ofzo, als ze nooit heeft gestudeerd. Dat is gewoon dat ik denk van: nou, wauw, dat zou ik.. dat vind ik leuk.. als ze, nou ja, zichzelf ook nog wil ontwikkelen. En dan vind ik het ook altijd heel leuk om te vragen van: ‘nou, wat wil je dan? En waar zit je aan te denken?’ . Om daar gewoon even over te praten.”

“Kijk voor mij zou het.. ik zou het ideaal vinden als een vader en een moeder allebei zeg maar eh.. thuis zouden zijn en zouden werken bijvoorbeeld. Maar voor iemand anders is het heel ideaal als een moeder alleen altijd voor het.. er voor de kinderen is en de vader voor de inkomsten zorgt. Dus dat is gewoon niet .. aan mij om daarover iets te zeggen.”

“Ik heb natuurlijk ook wel eens moeders die gewoon thuis zitten, die huisvrouw zijn. Ja, ik vind dat persoonlijk geen enkel probleem. Dat is dan ook weer mijn persoonlijke norm, dat ik denk van: nou, wat heerlijk voor zo’n kind, die heeft alle aandacht. En die moeder is er tevreden mee, ja. [...] Ik vind het alleen maar positief eigenlijk moet ik zeggen, als een kind gewoon volledig, alle aandacht kan krijgen thuis, ja.” [Marloes, Dutch nurse, Q-57]

Q-58

Interviewer: “Can you give an example of [...] good parenting in practice?”
Ellen: “A good one? Well, I think it’s good parenting when parents are sensitive, so adapting to their child’s need. Warmth and love in fact. And you can come up with many things related to this; safety, well, basic needs. But I think that when there is warmth and love, and attention, [the other things] automatically follow so to speak (Ellen, Dutch paediatrician – Q-58)

Interviewer: “Kun jij een voorbeeld noemen uit de praktijk van [...] een goede uitoefening van ouderschap?”
Ellen: Een goede? Ja, ik vind goed ouderschap als ouders sensitief zijn, dus inspelen op de behoefte van hun kind. Warmte en liefde in feite. En dan kun je daar heel veel omheen bedenken, veiligheid eh nou ja, basisbehoeften. Maar ik denk als er warmte en liefde is dat vanzelf eh en aandacht, dat dat vanzelf gewoon eh daarbij hoort, zeg maar.”

Q-59

Interviewer: “Can you give an example of good parenting in practice?”
Ireen: “Yes. [...] I think it’s good when the child [is in a] safe, warm... yes, grows up in a safe nest; then it’s already good. And safe; I don’t just mean that it can’t hurt itself, but also that a child does get the space to develop and can climb now and then, and when it bumps itself, that it runs to father or mother, or another caregiver, that’s also possible of course, to seek comfort. You know, safety is a very open concept.” [Ireen, Dutch nurse, Q-59]

Interviewer: “Kun jij een voorbeeld noemen uit de praktijk van een [...] goede uitoefening van ouderschap?”
Irene: “Ja. […] Ik vind goed als het kind veilig, warm eh ja in een veilig nest opgroeit, is het al goed. En veilig, dan bedoel ik niet alleen dat ie zich nergens aan kan bezeren, maar ook dat het kind de ruimte krijgt om wel te ontwikkelen en af en toe wel te klauteren, als in dat het kind als hij zich stoot dat hij naar vader of moeder of andere verzorger, dat kan natuurlijk ook, rent om daar z’n troost te zoeken. He, veilig is een heel open begrip.”

Q-60

Interviewer: “What are the main aims in your job?”

Esma: “I think the well-being of the children. That they are thriving well, that they’re doing well, feel comfortable in their skin, and especially [that they are] lovingly raised, I think. […] I think such a child […] is in a… yes, in a good nest so to speak. […] And I think attachment is important, that they do have at least one person they are well attached to and whom they can depend on. You sometimes have families where one parent for example is not mentally well, or… one parent who is absent or… one parent who has problems, like alcohol or whatever it is. That’s of course troublesome, but when the other parent takes over, I think a child can also grow up fine.” [Esma, Dutch nurse, Q-60]

Interviewer: “Wat zijn de belangrijkste doelen in je werk, van je werk?”

Esma: “Ik denk het welzijn van de kinderen. Dat ze goed gedijen, dat ze goed met ze gaat, dat ze lekker in hun vel zitten. En vooral [dat ze] liefdevol worden opgevoed, denk ik. […] In een, ja, goed nest zit, zeg maar. […] En ik denk dat hechting ook belangrijk is, dat ze minimaal één iemand hebben waar ze goed aan gehecht zijn en waar ze op kunnen vertrouwen. Soms heb je gewoon gezinnen waarbij bijvoorbeeld één ouders psychisch niet in orde is of… één ouders afwezig is of… ja één ouder eh problematiek heeft, zoals alcohol of wat dan ook. Da’s natuurlijk ook wel erg, maar als die andere ouder het overneemt of goed oppakt dan denk ik eh dat het, dat het kind ook wel goed kan groeien.”

Q-61

Interviewer: “How do you see mothers and fathers in their role as caregiver? How does this differ?”

Mia: “Mothers and fathers? Well, in general, mothers have naturally the nurturing role, because things are also happening with them bodily. And fathers don’t have this as much, bodily informed. So that’s a big difference in general. And apart from this, it’s also innate to a man and woman how you take on the caring role, right […] mothers – this also relates to the bodily [aspect] – are much more for direct nurturing, in general, and the fathers much more for… taking care of a good environment right, so for the nest.” [Mia, Dutch midwife, Q-61]

Interviewer: “Hoe zie je moeders en vaders in hun rol als verzorger? En hoe verschilt dat?”

Mia: “Moeders en vaders? Uhm… Nou, moeders hebben over het algemeen umh… uh… van nature de uh verzorgende rol. Omdat er met hun ook lichamelijk dingen gebeurt. En vaders hebben dat minder, lichamelijk gestuurd. Uh… dat is een groot verschil, over het algemeen. UH, en dan daarnaast is het ook wel het heel er het man en vrouw eigen hoe je de zorg op je neemt hè. [moeders] heeft ook weer met het lichamelijke te maken, zijn veel meer voor het directe verzorgen en uh over het algemeen, en de vaders veel meer voor het uhm… zorgen voor de goede omgeving hè, dus voor het nest.” [Mia, Dutch midwife, Q-61]

Q-62

Interviewer: “How do you see mothers and fathers in their role as caregiver, and does this differ?”
Els: “What’s only important to me is: are you involved with your child, do you deal with it in a loving way, do you respect it? And whether you are a father or a mother doesn’t matter that much.” [Els, Dutch nurse, Q-62]

Interviewer: “Hoe zie je moeders en vaders in hun rol als verzorger en verschilt dat?”
Els: “Ik vind het alleen maar belangrijk van eh, ben je betrokken bij je kind, ga je er liefdevol mee om, heb je er respect voor? En of je dan een vader of een moeder bent, dat maakt niet zoveel uit.”

Q-63
Interviewer: “Do you, as a postpartum care assistant, have expectations of parents?”
Idelette: “Yes, I expect them to take good care of their baby.”
Interviewer: “And what does this mean; and what does it mean for fathers and what for mothers?’
Idelette: “It means the same for both.” [Idelette, Dutch postpartum care assistant, Q-63]

I: heb jij zelf, als kraamverzorgende, nog verwachtingen van ouders?
Ehm,.. ja, ik verwacht dat ze goed voor het kindje zorgen.
I: En wat, wat eh houdt dat in? En wat houdt het voor vaders in en wat voor moeders?
Ehm, ik,.. het houdt voor allebei hetzelfde in. [Idelette, Dutch postpartum care assistant, Q-63]

Q-64
“When the people are like: “do I have enough [things] in the house?’, I say: when you have two breasts and four loving hands, there is enough’. ” [Leen, Dutch postpartum care assistant, Q-64]

“Als de mensen roepen van “Heb ik wel genoeg in huis”, ik zeg: als jullie twee borsten hebben en vier liefdevolle handen, is er genoeg.” [Leen, postpartum care assistant, Q-64]

Q-65
“It’s [...] good to get used to one another as a family and to see like, well what’s the rhythm we have together [...] for people to think about this at least. So it’s not about the woman who alone finds her rhythm with the child, but that the man is also important in this, you know. That you, so to speak, need to get used to one another as a family.” [Joan, Dutch midwife, Q-65]

“Het is [...] ook goed om als gezin aan elkaar te wennen en te kijken, nou wat voor ritme hebben we met elkaar [...], dat mensen daar over nadenken in ieder geval. [...] Dus dat het dus niet gaat om die vrouw die alleen haar ritme vindt met het kind, maar dat die man daar ook belangrijk in is, zeg maar. Dat je, zeg maar, als gezin aan elkaar moet wennen.” [Joan, Dutch midwife, Q-65]

Q-66
“I think many parents think they need to do many things at the same time. [...] I think the challenge is [...] for everyone [...] that you keep finding a balance: that you take sufficient care of yourself, take sufficient care of your relationship, and take sufficient care of your child or children. And I’m not sure whether all parents manage to find this balance, and that the emphasis is perhaps very much on work, career and things outside of the house.” [Thea, Dutch paediatrician, Q-66]
“Ik denk dat veel ouders eh, van zichzelf vinden dat ze eh, veel dingen tegelijk moeten doen. […] De verwachting […] voor iedereen is, […] of dat je een balans blijft vinden. Dat je voldoende voor jezelf zorgt, voldoende voor je relatie zorgt en dat je voldoende voor je kind of kinderen zorgt. En eh, nou ik weet niet of het alle ouders lukt om die balans te vinden. Dat soms het accent misschien wel erg op werk en carrière en buitenshuis dingen ligt.” [Thea, Dutch paediatrician, Q-66]

Q-67

“You see, what we have is just too short, is really too short. Mother and child really need to be together for the first year. […] Employers also don’t cooperate, right. Because when women do choose [to work] for two days [per week] for example, there is also no opportunity for that. […] Most employers then say: you don’t have enough connection to the company, so three days minimal, not less. […] And also for a man; it used to be only two days, and now they have […], now it’s going to four days right? And how long have we been talking about this? […] Sometimes the man does want to [work less], but the employer doesn’t want it, is making it difficult, you know. So yes, in this time of [economic] crisis, you don’t have such a big mouth.” [Evelien, Dutch postpartum care assistant, Q-67]

Kijk, weet je, wat wij hebben is gewoon te kort. Is echt te kort. Moeder en kind moeten echt het eerste jaar met elkaar zijn. […] ja, die werkgevers werken d’r ook niet in mee hè. Omdat vrouwen dan toch kiezen voor bijvoorbeeld twee dagen of zo. Maar ook daar is daar niet de gelegenheid voor. […] de meeste werkgevers zeggen dan, dan heb je geen… geen binding – goeie binding met het bedrijf, dus echt minimaal drie dagen, en korter niet. […] Nee. En je ziet ook voor een man, het was altijd maar twee dagen, en nu hebben ze […] Maar nu hebben ze misschien, ik geloof nu gaat het naar vier dagen hè? Hoelang zijn we daar nou al niet mee bezig? […] Nou, soms dan wil die man best wel, maar de werkgever niet, die doet daar moeilijk over, weet je wel. Dus ja, en in deze – die crisistijd, ja, heb je niet zo’n uh grote mond. [Evelien, Dutch postpartum care assistant, Q-67]

Q-68

“Those first two years are actually a blueprint for the rest of your life. And when you see that parental leave is so short that… most mothers stop breastfeeding the moment they return to work; there are many burnouts afterwards; I think the government is absolutely not supportive. […] I always say: when you think it’s too short, you should report yourself as ill. That is a great pity, but that’s the way it is in the Netherlands. […] So there should be much more, much longer leave. In any case for mothers, but also for fathers. Because when fathers have much longer leave, they also immediately feel involved with child raising, without the financial pressure that everything will go wrong.” [Mia, Dutch midwife, Q-68]

“Wat ik net zei, die eerste twee jaar, zijn eigenlijk de blauwdruk voor de rest van het leven. Als je dan ziet dat het ouderschapsverlof dermate kort is dat uh… de meeste moeders stoppen met borstvoeding geven op het moment dat ze uh moeten gaan werken, uh, dat er heel veel burnouts zijn daarna, vind ik dat de overheid het absoluut niet steunt. […] En dan zeg ik ook altijd: als het te kort blijft daarmee moet je je ziekmelden. Dat is heel er jammer, maar dat moet nou eenmaal hier in Nederland. Dus daar zou veel meer, veel langer verlof moeten komen. Sowieso voor de moeders, maar ook voor de vaders. Want ik denk als vaders veel langer verlof hebben, dat ze zich ook veel meer betrokken voelen bij de opvoeding. Zonder de druk dat het financieel dan weer helemaal misgaat.” [Mia, Dutch midwife, Q-68]
“Well, the leave policies that can be improved in the Netherlands are that a man has only got two days and a woman does have the 16 weeks leave, which is of course bizarre. And it would perhaps be nicer to move in the direction of a German or Scandinavian model, in which there are just so many days leave that can be divided between men and women. This would produce a fairer division, and I also think a more equal bond with your child.” [Marijke, Dutch paediatrician, Q-69]

“Nou, de verlofregelingen waar we verbetering in kan komen in Nederland, dat een man maar twee dagen heeft en een vrouw wel de 16 weken verlof in principe heeft. Wat natuurlijk eigenlijk bizar is, en dat het misschien wel leuker zou zijn als je meer richting een Duitsland of Scandinavisch model kan, waarbij er gewoon zoveel dagen verlof staan die verdeeld kunnen worden tussen mannen en vrouwen. Zo tocht een eerlijkerere verdeling en ik denk ook gelijkwaardigere band met je kind opleveren, denk ik.” [Marijke, Dutch paediatrician, Q-69]

“How many hours do you work and is this going to work out with breastfeeding when you return to work, how will you do that? 'These sorts of things I ask. And: 'are you going to make it, how will it be?' And when they’ve started working: 'how is it going, is it all going well?'''” [Esma, Dutch nurse, Q-70]

‘Hoeveel uur werk je en eh gaat dat lukken met borstvoeding straks op je werk en hoe doe je dat?’ Dat soort dingen, stel ik wel vragen. En eh ‘ga je dat redden, hoe gaat dat dan?’ En als ze net zijn begonnen met werken ‘hoe gaat dat, loopt het allemaal?’” [Esma, Dutch nurse, Q-70]

“As paediatricians, we have a ‘3 months consultation’, and three months is of course often such a period in which mothers’ leave ends a bit. And sometimes when there is time, and the conversation is going well, I’m inclined to ask: ‘goh, are you returning to work soon? And how are you going to do it? Do you dread to bring your child... is your child going to day care and do you dread to bring him away? ’ In order to chat a bit about: how are you going to fill it in, and to get a bit of a picture of how the care division will be when you’re working again.” [Marijke, Dutch paediatrician, Q-71]

“we hebben als arts ook een driemaandenconsult en vaak is drie maanden natuurlijk zo’n periode waarin het verlof van de moeder vaak een beetje over gaat zijn en dan soms als de tijd er is en het gesprek verder gewoon lekker loopt heb ik wel de neiging om te vragen ‘goh, moet je binnenkort weer aan het werk? En hoe ga je het dan doen? Zie je er tegenop om het kind.. gaat het naar een kinderdagverblijf en zie je er tegenop om hem weg te gaan brengen?’ Dat je het daar een beetje over hebt van: hoe ga je het straks invullen en dan krijg je een beetje een beeld van hoe ligt de zorgverdeling dan straks als je weer aan het werk bent.” [Marijke, Dutch paediatrician, Q-71]

“In general [parents] can work it out in good agreement. But it is compromising, how they solve it; it’s always compromising. [...] They adjust parental leaves with the days right, in order to need as little day care as possible, so that not four days, but only two days of day care are left. They’re working towards their child needing to attend there as little as possible. But that’s when they both have the opportunity to take parental leave. When you don’t have this, you really are going to need to bring your child four or five days to day care. And already from 10 weeks after the delivery onwards.” [Els, Dutch nurse, Q-72]
“In het grote geheel gaan ze na, in goed overleg komen ze eruit. Ja. Maar, het is schipperen. Hoe ze het oplossen. Het is altijd schipperen. […] Eh, de ouderschapsverloven die met de dagen afstemmen, hè, zodat er zo min mogelijk aan opvang nodig is. Zodat er in plaats van vier dagen kinderdagverblijf maar twee overblijven. En eh, dat ze er dan toch wel naar toe werken dat ze hun kind zo min mogelijk daarnaar hoeft. Maar dan hebben ze allebei de mogelijkheid om dat ouderschapsverlof op te nemen. Maar als je dat niet hebt, ja dan moet je kind toch echt vier dagen of vijf dagen naar het kinderdagverblijf. En dan al vanaf, eh, tien weken na de bevalling.” [Els, Dutch nurse, Q-72]

Q-73

“And sometimes [men] can arrange it and they do indeed take this extra day off, they take this [...] daddy day, right [for the child to] attend day care less often, right. Then they really have it planned: on Monday grandpa and grandma, Tuesday daddy day, Wednesday mummy, and so it alternates a bit.” [Evelien, Dutch postpartum care assistant, Q-73]

Q-74

“I shall perhaps in a specific situation, when a child is very restless and has difficulties, discuss with parents: ‘but well, but how much are you working and is it an idea maybe to arrange different childcare? Or a paid individual childcare instead of day care, which is more of a one-on-one relationship, or a bit less busy, or perhaps a family member. Or could mother maybe work a day less, or could father maybe work a day less? Or can parental leave be taken up?” [Jonita, Dutch nurse, Q-74]

“Ik zal best wel misschien in een specifieke situatie, als een kind gewoon heel veel onrust en moeite heeft, ook bijvoorbeeld met ouders bespreken ‘maar ja goed, hoeveel werken jullie en, en zou het misschien een idee zijn om eh dat, een ander soort opvang te regelen, bijvoorbeeld in plaats van een kinderdagverblijf een gastouder, wat toch wat meer eh één-eén contact is of wat minder druk, of dat misschien een familielid kan… Of dat misschien moeder eh een dag minder kan werken of vader misschien een dag minder kan werken of dat er ouderschapsverlof kan worden opgenomen. [Jonita, Dutch nurse, Q-74]

Q-75

Interviewer: “What is a good mother to you, and what is a good father?”
Sonja: […] Mh. So a good mother is on the one hand caring for the child: psychologically, in nursing, and in nourishment as well, yes. So that everything... that the NEEDS of the CHILD are addressed, so to speak. But a good mother also needs to set certain limits, which is also very important, to be capable of raising a child. […] Principally, this is exactly the same for the father [laughs]. ” [Sonja, German paediatrician, respondent’s emphasis, Q-75]

Was ist denn für Sie eine gute Mutter und was ein guter Vater?
Sonja: […] Mh. Also eine gute Mutter ist zum einen also das das, das die Versorgung des Kindes, sei es in der seelischen, sei es aber auch in der pflegerischen, sei es in der (Holt Luft) ehm, ja Ernährung auch, ja. Dass DAS alles, also dass die
BEDÜRFNISSE des KINDES sozusagen gestillt werden. Und dass aber auch eine
gute Mutter muss auch ehm eine gewisse Eingrenzung, das ist ja auch sehr wichtig.
Also, naja, ein Kind erziehen können. [...] Bezieht sich genauso auf den Vater, im
Prinzip. [lacht].” [Sonja, German paediatrician, Q-75]

Q-76
Interviewer: "What do you think is a good mother and what is a good father?"
Gerhard: [...] A good father or a good mother is the one who responds rightly in most
cases, who brings a certain intuition with which nature has endowed him, and
perhaps also his own socialization, as the case may be. That he can adequately deal
with the child. Then he is a good father or a good mother. And when he succeeds in
giving the child a framework in which it can orient itself [...] this big wide world: we
will now see what suits you best. What are all these swift images and shrill colours?
We will look for what you appreciate. That’s I think the EDUCATIONAL TASK that is
behind it ... good father good mother, yes, then it’s well done.” [Gerhard, German
paediatrician, respondent’s emphasis, Q-76]

Q-77
"But when a woman is breastfeeding, she already has a lot of contact with the child.
[...] So I really consider [breastfeeding] now as work, a new job, a new work field.
[...] Also in what a child’s needs are; communication, this nonverbal communication.
This is also very important, to recognize when a child cries and how the child
cries. And this upbringing, as is now classically seen, happens in the first months and in the
first year, actually unconscious, through the interaction between mother and child.”
[Isabella, German midwife, Q-77]

"Aber also, wenn eine Frau stillt hat sie schon, schon sehr viel Kontakt zum Kind.
Also wirklich ich sehe es wirklich mittlerweile als arbeits, neues Arbeitsfeld. [...] Oder
mit dem, was ein Kind an Bedürfnissen hat. Die Kommunikation, diese nonverbale
Kommunikation. Die ist ja auch ganz wichtig. Zu erkennen, wann brüllt ein Kind und
wie brüllt das Kind. Und Erziehung jetzt ganz klassisch gesehen, passiert ja in den
ersten Monaten und im ersten Jahr eigentlich unbewusst, über die Interaktion
zwischen Mutter und Kind.” [Isabella, German midwife, Q-77]

Q78
Interviewer: “And after birth, do women have entirely different tasks than men? Is it
then also divided that much [as during the delivery]?”
Gerda: “Well, do you mean that now, out of [laughs]?”
Interviewer: “Yes.”
Gerda: “So the women normally breastfeed the children. This is a very, very close
relationship with the children, as before. So I think the child is no longer in the belly,
it’s indeed out, but through breastfeeding it’s a very, very close relationship between the mother and the child.” [Gerda, German midwife, Q-78]

Interviewer: “Und nach der Geburt ehm, ist es dann so, dass ehm Frauen ganz andere Aufgaben übernehmen als Männer? Ist es dann auch wieder so sehr aufgeteilt?”
Gerda: “Naja, Sie meinen das jetzt aus der [lacht]?”
Interviewerin: Ja.
Gerda: Also die Frauen stillen normal die Kinder. Das ist eine sehr sehr enge Beziehung mit den Kindern, nach wie vor. Also ich glaube das Kind ist nicht mehr im bauch. Das ist dann zwar draußen [Holt Luft], aber durch das Stillen ist eine sehr sehr enge Beziehung zwischen der Mutter und dem Kind.” [Gerda, German midwife, Q-78]

Q-79
“[Midwifery education] was always primarily only about the women. [...] Men, families were never really thematized that much. It was actually really about the women and the child.” [Josefine, German midwife, Q-79]

Ähm, also vorrangig gings eigentlich immer nur um die Frauen. Wäre jetzt so - Männer, Familien würden eigentlich nie so thematisiert. Es ging eigentlich echt um die Frauen und das Kind halt danach. Ja, aber vorrangig nur die Frauen. [Josefine, German midwife, Q-79]

Q-80
“It is important to know that there is not a perfect, a perfect mother. It’s always important to downsize this claim” [Gerhard, German paediatrician, Q-80]

“Zunächst mal ist es wichtig zu wissen, dass eh keine ne perfekter oder keine perfekte Mutter ist. Diesen Anspruch zu reduzieren ist schon mal wichtig, ja.” [Gerhard, German paediatrician, Q-80]

Q-81
“And I am learning for myself just as a mother, and that is what I try to convey, to all the others, all women I care for: we are the mother we can be, in the situation where we are. And we are good enough.” [Isabella, German midwife, Q-81]

“Und ich lerne für mich gerade als Mutter, und das versuche ich zu vermitteln, auch meinen ganzen anderen, den ganzen Frauen, die ich betreue. Wir sind die Mutter, die wir sein können, ja. An dem Punkt, an dem wir sind. Und wir sind gut genug.” [Isabella, German midwife, Q-81]

Q-82
“Personally, this is so important to me, that fathers develop an emotional bond with their child [...] So, there is no mother instinct or natural intuition, [...] [but] a capacity to see another person. Of course when I’m currently...two or three days alone at home with the child, I know it a bit better.” [Clara, German midwife, Q-82]

“Das ist mir persönlich halt so wichtig, ist dass die Väter dann auch wirklich eine Beziehung zu ihrem Kind haben. [...] Also es gibt weder einen Mutterinstinkt, noch eine natürliche Intuition, [...] [aber] die Kapazitäten dafür haben, andere wahrzunehmen [...] Klar ich bin mit dem Kind momentan ... ich sage mal 2/3 allein zu Hause, natürlich lerne ich ihn gerade ein bisschen besser kennen.” [Clara, German midwife, Q-82]
**Q-83**

Interviewer: “Do you think that there are certain tasks for the mother and certain tasks the father can only do?”

Johan: “Not necessarily, no. So that can certainly be divided. So whoever stays at home in the beginning, I think it’s more natural when - there are also fathers who stay at home from the beginning and the woman goes back to work immediately - this is of course not necessarily according to nature. The mother, in the normal situation, is breastfeeding the child. Then, of course, it makes sense the mother is with the child the first months. But otherwise, I believe, this can all be distributed as desired. [...] Nowadays, there is little gender separation. So I think the transitions are fluid.”

[Johan, German paediatrician, Q-83]

**Q-84**

“My husband [...] said at some point: ‘you know, as a man, you actually have no chance. [The child] won’t be calmed down.’ [...] With children who are exclusively breastfed, that’s often the case. Fathers sometimes don’t have a chance to calm the children, because it is the breast that calms them”

[Isabella, German midwife, Q-84]

“Mein Mann [...] hat irgendwann gesagt: "Weiβt du, als Mann, du hast gar keine Chance. Der lässt sich ja gar nicht beruhigen. [...] Bei Vollgestillten Kinder ist es schon so. Haben manchmal die Väter gar keine Chance die Kinder zu beruhigen, weil es die Brust ist, die beruhigt." [Isabella, German midwife, Q-84]

**Q-85**

"My first principle is the strengthening – and I even believe the empowerment aspect – of the woman above all, so also a certain feminist claim. Yes, that women in their womanhood, in their motherhood are strengthened by me, but above all in their own individuality. "

[Carla, German midwife, Q-85]

"Mein erster Grundsatz eigentlich die Stärkung ähm und ich glaube sogar die, so so Empowerment-Aspekt. Und vor allem der Frau, also da auch so ein gewisser feministischer Anspruch, ja. Dass die Frauen eben in ihrem Frausein, in ihrem Muttersein von mir aus gestärkt werden, aber eben vor allem in ihrer eigenen Individualität gestärkt werden." [Carla, German midwife, Q-85]

**Q-86**

Interviewer: “Do you personally have a certain idea of what is a good mother and a good father?”

Gerda: ‘No, [...] I think you cannot say what is good now and what is bad. Since everyone comes with their own beliefs … what [s]he imagines, what [s]he likes to do. Of course, roles you know from childhood play a role. But also demands in the job, yes, and your own demands. Many women are nowadays also very ambitious, and not
only ambitious, they also enjoy their job, and also don’t just want to be a mother, and I think that’s completely ok. But some say: ’no, I have really been looking forward to this, and I want to dedicate myself to this child, and spend a lot of time with him, or spend a lot of time with her.’ And that’s also ok. Yes.” [Gerda, German midwife, Q-86]

Interviewerin: Und haben Sie denn so eine persönliche Vorstellung davon, was eine gute Mutter und was sein guter Vater ist?
Gerda: “Ne. […] Ich glaube da kann man nicht sagen, was ist jetzt gut und was ist schlecht. Da hat kommt jeder auch mit eigenen Überzeugungen rein … eh was er sich so vorstellt, was er gerne macht. Da spielen natürlich auch Rollen, die man kennt aus der Kindheit, wahrscheinlich eine Rolle. Aber auch Anforderungen im Beruf, ja. Und eigene Anforderungen. Viele Frauen sind da auch mittlerweile sehr ehrgeizig und wollen ha nicht nur ehrgeizig und wollen auch wirklich und haben auch Spaß an ihrer Arbeit und wollen [Holt Luft] auch nicht nur Mutter sein und ich denke … das ist auch völlig ok. Manche sagen aber auch: ”Nein. Also ich habe mich jetzt so darauf gefreut. Ich wollte unbedingt dieses Kind und ich möchte mich jetzt auch da diesem Kind widmen. [Holt Luft] Und eh mit ihm viel viel oder mit ihr viel viel Zeit verbringen.” Und das ist doch auch ok.” [Gerda, German midwife, Q-86]

Q-87
“It’s one thing to strengthen families and to give them the opportunity to provide children with a good home. This does not mean however that the mothers should not work, so that does not contradict itself at all, and it is very much presented as a contradiction.” [Marianne, German paediatrician, Q-87]

“Die Familien stärken und ihnen die Möglichkeit geben, den Kindern ein ein ein gutes Zuhause zu geben, wäre die eine Sache. Das heißt aber nicht, dass die Mütter nicht arbeiten gehen brauchen äh sollen, also das das widerspricht sich gar nicht und es wird eben ganz massiv als Widerspruch dargestellt.” [Marianne, German paediatrician, Q-87]

Q-88
“It’s very clear that when it comes to returning to work, one should express everything in a very positive way to the parents. I would never say to any parent: ”Go … rather take care of your child.” You have to frame it more positively, in the end: ’look for help’, so to speak. Also show parents the various opportunities; displaying for example how childcare provision goes; how to follow a workday routine, in combination with coming back peacefully [laughs]; with … with the job and the everyday life and the children. So to convey this rather positively, because most of them have to [work]. But also the other way around, right; there are also women who quit, and that’s also all right. Yes. So strengthening positively what the mothers want. […] Times have changed. You simply have to see that as well.” [Sonja, German paediatrician, Q-88]

Q-89

"In my view, we as women do not really have freedom of choice. [...] The pressure on women is first to stay at home [...], so the pressure to stop working, because you get Elterngeld, and then, after a year, to work again, because then the money is missing [...]. So no, I think women don’t have real freedom anymore at the moment. [...] They seldom look at: What do I really want? What will do the child good?" [Isabella, German midwife, Q-89]

Q-90

Interviewer: “I can imagine that when they get pregnant, every woman asks the question: Ok, what will it be: am I now going to spend more time with the child, or am I going back to work. Is this discussed with you?”

Gerda: “Yes, I believe this is discussed. Most have already made some decision, but one talks a lot of course also in birth preparation, so there are several couples with whom this is discussed, or in a conversation of course. So most of them decide to stay home for about a year, so parental leave for a year maximum; I think that’s the majority. And a few really take this period of 8 weeks after the birth and return to work then, return immediately.” [Gerda, German midwife, Q-90]
Interviewerin: Und wie lange bleiben Frauen durchschnittlich daheim? Jana: Ein Jahr." [Jana, German midwife, Q-91]

Q-92
"This new world citizen simply demands full attention, and that's the challenge. And if the partner then ... He possibly has three weeks vacation, and it all works in this period. He does the shopping, wraps the child, ensures the mother is supplied. But this all collapses after the three weeks." [Isabella, German midwife, Q-92]

Q-93
"[...] I have the impression [...] that it's still the case that more men pursue their professional career, also with children, than women. So women pursue this as well, but less so when it comes to spending time; they certainly make less of a career because of child-related reasons. [...] If you want to make a career and want to have children, you need a man at home who takes care of everything. And who gives up on his career. That's what it takes, but that's the exception." [Jana, German midwife, Q-93]

"Und ich meine es ist nach wie vor so,[...] dass mehr Männer ihren beruflichen Werdegang verfolgen, mit auch mit Kindern als Frauen. Also Frauen verfolgen den auch, aber ehm im zeitlichen Einsatz weniger, ja. Und ehm, machen sicherlich aus Kindergründen nach wie vor weniger Karriere. [...]Also wenn du Karriere machen willst und Kinder kriegen willst, brauchst du zuhause einen Mann, der sich um alles kümmert. Und der auf seine Karriere verzichtet. Und das gibt es auch, aber das ist doch eher die Ausnahme." [Jana, German midwife, Q-93]
"If a man works a lot, what most men in [name city] do here..., then in fact I often also don’t see where it ends. [...] If I take my husband: he wants to be there for his children, but he also has the pressure to be a breadwinner. And I believe, I believe he simply, he simply wants to be there. But that’s also difficult." [Isabella, German midwife, Q-94]

"Wenn dann ein Mann viel arbeitet, was die meisten [Stadtname] Männer hier tun... Dann ist es so, dass ich die halt dann auch oft nicht sehe. [...] Wenn ich jetzt von meinem Mann ausgehe, der will für seine Kinder da sein. Der hat aber auch den Druck der Ernährer sein zu müssen. Und ich glaube, ich glaube, er will einfach, er will einfach da sein, ja. So. Aber eh der hätte glaube ich auch schwierig." [Isabella, German midwife, Q-94]

"It's just the first year after birth, I think it's very tensed ... [...] So how will it be for the women after birth? [...] It's not always the case, but I still think in Germany, worlds are separating a bit, the man’s world and the woman’s world. In my impression, that's really very strong in Germany. I have experienced this differently in other countries, such as England, the Netherlands or France. I think it's very – it sometimes still surprises me - but very traditional. " [Gerda, German midwife, Q-95]

"Also gerade das erste Jahr nach der Geburt. Ich glaube das ist auch nochmal ganz spannend. [...] So wie geht es dann weiter für die Frauen nach der Geburt. [...] Was passiert durch so eine Geburt oder wie geht es dann weiter. Ist es eine chance oder eben auch nicht [lacht]. Weil oft dadurch sich so auch wieder die Welten oft, nicht immer, aber immer noch in Deutschland finde ich die Welten so einbisschen, dann auch scheiden. Also zwischen der wirklichen Männerwelt und Frauenwelt. Weil das ist wirklich in Deutschland noch sehr stark Ist so mein Eindruck, das habe ich in anderen Ländern auch in England, Holland oder Frankreich habe ich das anders empfunden. Ich finde das ist sehr, manchmal noch was mich dann wundert, auch doch sehr traditionell auch." [Gerda, German midwife, Q-95]

"One knows that children have basic needs, which can certainly not be satisfied to that extent, when three educators are for instance available for twenty... or four educators for twenty one-year-olds. [...] And it’s also a lot of stress for a child in day care. [...] Paediatricians, child neurologists and developmental neurologists also say that this is definitely not all good. And when... one must really look specifically and see what the staff ratio for the children is in day care."

Interviewer: "Probably only a few children have that perfect day care condition."

Johan: "I think so, yes. These are often the private ones and they're really expensive. [...] And for a mother who doesn’t earn that much, or only works for 60 per cent; two thirds of the income is then gone. [...] So there are certainly some mothers who have to consider whether they are going to be working at all, because child care is expensive. " [Johan, German paediatrician, Q-96]

Johan: "Man weiß, dass die Kinder auch Grundbedürfnisse haben und die sicherlich nicht in dem Maße befriedigt werden können, wenn zum Beispiel 3 Erzieher für 20 oder 4 Erzieher für 20 eh zw einjährige. [...] Und das ist doch auch viel Stress ist für ein Kind eben die Kita. [...] Über die, auch Kinderärzte, auch eh Kindernurologen. Also Entwicklungsnurologen, die sagen, das ist nicht unbedingt nur gut Und wenn, dann muss man sehr genau hinsehen und eh schauen, wie der Betreuungsschlüssel ist [...] von den Kindern. In der Kita, ja."
Interviewer: "Wahrscheinlich haben das nur die wenigsten Kinder wirklich, diesen perfekten Kita-Zustand."
Johan: "Das glaube ich schon, ja. Also das sind oft die privaten und die sind richtig teuer, also ... Da ... private Kitas da zahlst du schon 600, 800 Euro im Monat, locker. Und eine Mutter, die jetzt nicht so viel verdient oder nur 60 Prozent arbeitet ... da ist gleich mal zwei Drittel oder was von dem Einkommen dann WEG. Dann kommen noch die Fahrtkosten dazu. Also es gibt sicher einige Mütter, die sich überlegen müssen, ob sie überhaupt arbeiten gehen, weil die Kinderbetreuung doch teuer ist. [Johan, German paediatrician, Q-96]

Q-97
"How well are the caregivers emotionally attuned to these children, so they can recognize their needs at all – to also notice when the children are stressed, are overburdened, when they need attention, when they can be left to themselves and so on. [...] These environmental factors are really decisive, really decisive in relation to the question whether it harms children or not.[...] [The quality of the care], that is really the big problem. We have relatively few settings where one can say that one can be really satisfied with the care. [...] This is a very serious ambivalence for parents, which is a very bad case for the women [...]“ [Marianne, German paediatrician, Q-97]

"Wie gut sind die Betreuerinnen emotional auf diese Kinder eingestellt, dass sie ihre Bedürfnisse überhaupt erkennen können - auch merken, wann die Kinder gestresst sind, überfordert sind, wann sie Zuwendung brauchen, wann man sie eher laufen lassen kann und so weiter. [...] Diese Faktoren diese Umweltfaktoren sind ganz entscheidend, ganz entscheidend, bei der Frage, ob es den Kindern schadet oder nutzt. [Die Qualität der Betreuung], dass ist halt wirklich das ganz große Problem. Wir haben relativ wenige Settings wo wo man sagen kann, dass man mit der Betreuung wirklich zufrieden sein kann.[...] Das ist eine ganz schwere Ambivalenz für die Eltern. Das ist eine GANZ üble Falle für die Frauen.“ [Marianne, German paediatrician, Q-97]

Q-98
"One often doesn’t have the time, and then of course always the employer in your neck as well. The child actually cannot be ill. That has already become difficult as well. And I’m a mother myself, I have two children, so I also say sometimes: ‘Oh, if only I wouldn’t have had the desire to work, it would have been much easier’ [laughs]. Everything is simply not optimally dissolved yet; day care is not optimally solved. Also in the case of illness, I think children want to have their mother, or their father, when they are ill. They don’t want to be cared for by someone else.” [Sonja, German paediatrician, Q-98]


Q-99
"Increasingly, both parents are employed. From the point of view of the paediatrician, this is not always an advantage. In the period of early parenthood, also
of early childhood, children are most often ill. When they attend day care early on, they are often ill. [...] This often leads to a lot of stress. Mothers usually start working again after one year. [In other countries even after half a year or three months.] I think that’s just too early. In everyday practice, the children who are most frequently ill are the day care children. [...] Every four or six weeks a child is ill. This causes stress. A mother said: ‘I’m reported ill for the third time in a row because of the child. My employer is getting nervous’. [Laugh] They are getting pressure from all sides. [When I would be asked for advice], I would first ask whether they need to earn the money. If so, you don’t need to go into it, because you only give parents a guilty conscience. If you honestly ask me for human advice, not necessarily as a doctor, I also have two children myself; my wife is at home, we practice the old model. A mother at home, it’s not so socially desirable, but it relaxes the entire situation. When a child is ill, there is no immediate vacuum.” [Johan, German paediatrician, Q-99]

“Zunehmend werden Eltern bei sind beide Elternteile berufstätig. Aus Sicht des Kinderarztes nicht immer von Vorteil, gerade die frühe Elternzeit, also die frühe Kindheit, da sind die Kinder doch am kränksten, ja. Wenn die früh in der Kita sind, dann werden die natürlich häufig krank, [...] Das führt oft zu großem Stress. Die Mutter fängt wieder an zu arbeiten ... mit oftmals mit einem Jahr. [...] Das finde ich halt zu FRÜH. Und so der Alltag sieht halt doch so aus, dass die kränksten und häufigsten ehm eh also die Kinder, die am kränksten und am häufigsten krank sind, die Kita-Kinder sind. [...] Heißt alle 4 Wochen stellt oder alle 6 Wochen ist ein Kind krank. Das führt erstens zu Stress, die Mutter sagt: "Jetzt bin ich schon das dritte Mal in Folge krankgeschrieben. Wegen des Kindes. Mein Arbeitgeber wird langsam nervös." [lacht] Ja also, die kriegen von allen Seiten Druck, ja. [...] Dann .. würde ich erstmal fragen, ob es notwendig ist eh das Geld zu verdienen. Wenn ja ... muss man gar nicht weiter darauf eingehen, weil dann macht man den Eltern nur ein schlechtes Gewissen, wenn Sie mich ehrlich um um menschlichen Rat fragen, nicht unbedingt auch als als Arzt. Habe ja auch selber 2 Kinder. Meine Frau ist zuhause, wir führen noch so das alte Modell durch. Eben Mutter zuhause, was ja auch heutzutage gesellschaftlich nicht mehr so gewünscht ist, aber es entspannt doch die ganze Situation. Wenn ein Kind krank ist entsteht nicht gleich so ein Vakuum.” [Johan, German paediatrician, Q-99]

Q-100

“When both parents work, each parent then gets ten days [sickness leave]. And then they look for themselves how it fits. And often the father stays at home. So I write out forms, which can be split: for each day an extra sick report, so the parents can decide who stays at home. Those who are employed often indeed share this, it’s not the case that only the mother stays at home.” [Johan, German paediatrician, Q-100]

“Wenn beide Eltern arbeiten jedem Elternteil dann eben 10 Tage. Und dann gucken die, wie das passt. Ja und dann bleibt mal der Vater zuhause. Also ich stelle oft Bescheinigungen aus, die dann gesplittert sind für jeden Tag eine extra Krankmeldung, damit die Eltern sich entscheiden können wer bleibt zuhause. Also da die die Berufstätigkeit sind die teilen sich das oft auf. Es ist nicht so, dass immer nur die Mutter zuhause bleibt.” [Johan, German paediatrician, Q-100]

Q-101

Interviewer: “If you were to say, who is a good father and a good mother?”
Urszula: “A good father and a good mother. Hm. Loving parents, I guess that’s what it takes [...], a loving parent, but responsibly and critically, which means doesn’t allow for everything, doesn’t give it all like this, but rather sets some boundaries in the name of well understood well-being of the kid.” [Urszula, Polish paediatrician, Q-101]
Interviewer: "Kim jest dobry ojciec i dobra matka?"
Urszula: "Matka jest kochająca i odpowiedzialna i krytycznie swoje dziecko rodzicem czyli nie takim na który wszystko pozwala, wszystko co wszystko da, ale właśnie takim, który stawia dziecku granice w imię pojęć- dobrze pojętego dobra dziecka."

Q-102
Interviewer: [...] "What's important for a baby in your personal opinion?"
Urszula: [...] "Well, so they feel that they are loved, that parents devote time to them, explain them how the world works, they are close together, that's about it." [Urszula, Polish paediatrician, Q-102]

Interviewer: [...] "Co pani osobiście uważa za ważne dla dziecka?"
Urszula: [...] "Yy no to, żeby czuło, że yy że jest kochane, że rodzic poświęca yy mu czas, że tłumaczy mu świat, że przy nim jest, to chyba wszystko." [Urszula, Polish paediatrician, Q-102]

Q-103
"I guess mother is always good, she’s always the mother, if she’s good or if she’s bad, she’ll always be better or worse.” [Janina, Polish midwife, Q-103]

"W sumie matka zawsze jest dobra, zawsze jest matką, czy jest dobra czy zła, zawsze będzie lepsza czy gorsza." [Janina, Polish midwife, Q-103]

Q-104
"I always believe that it's impossible that mother hurts her baby. It’s such a bond.” [Felcia, Polish paediatrician, Q-104]

"Ja zawsze uważam, że matka nie może zrobić krzywdy swojemu dziecku. To jest taka więź, że nie da się, nie skrzywdzi matka swojego dziecka." [Felcia, Polish paediatrician, Q-104]

Q-105
"Every mother has the maternal instinct,” [Klaudia, Polish paediatrician, Q-105]

"Každa matka ma instynkt macierzyński." [Klaudia, Polish paediatrician, Q-105]

Q-106
"To give women faith and power that they can give birth [...] they can be mothers; everything that happens in their lives is practically a thing inscribed into their nature.” [Zuzanna, Polish midwife, Q-106]

"żeby dać kobietom wiarę i siłę, że mają moc rodzenia [...] mogą być matkami, że wszystko, co zdarza w ich życiu praktycznie jest taką rzeczą, która wpisana jest w ich naturę.” [Zuzanna, Polish midwife, Q-106]

Q-107
"Mothers talk with each other and are more intuitive and more flexible in taking information [...] They used to have an aunt, a grandma, a cousin; it’s still a profit of these big families” [Stefana, Polish paediatricians, Q-107]

"Matki chyba bardziej rozmawiają ze sobą i mają większą intuicję mimo wszystko i umieją wszystkie informacje [...] Które są dzisiaj mamami, gdzie tam miały ciocię,
babcią, kузynkę. I to są jeszcze profity z tych takich rodzin, gdzie tam było więcej ludzi.” [Stefana, Polish paediatricians, Q-107]

Q-108

Interviewer: “Do you have examples of (future) parents’ behaviour that you would encourage”?
Janek: “Hmmm, well in the case of mothers it’s expressing milk above all from the first days, which we’ve been strongly promoting here from... basically from the very beginning the patient is here” [Janek, Polish paediatrician, Q-108]

Interviewer: "Czy może Pan podać przykłady zachowań (przyszłych) rodziców, które Pan popiera/do których Pan zachęca/namawia?”
Janek: "Mmm, no dla matek to oddawanie pokarmu przede wszystkim od pierwszych dni co bardzo tutaj lansujemy od ... w zasadzie od samego początku kiedy pacjent tutaj jest.” [Janek, Polish paediatrician, Q-108]

Q-109

Interviewer: “If you were to tell me what role do fathers and mothers play in childcare, do these roles differ according to your observations?”
Wiktor: “Well certainly when it comes to our patients because we very, very strongly promote exclusive breastfeeding and so the mother’s role is surely stronger, even if fathers feed their children with a bottle, because for the lactation to be effective this mother has to be close to her child. […] The food is always the food of a mother.” [Wiktor, Polish paediatrician, Q-109]

Interviewer: "Gdyby pan profesor miał powiedzieć jaką rolę odgrywają ojcowie i matki w opiece nad dzieckiem, czy te role różnią się od siebie jak pan profesor obserwuje na przykład tutaj?”
Wiktor: "No na pewno yu u tych pacjentów naszych z racji tego, że promujemy bardzo bardzo agresywnie tylko i wyłącznie karmienie piersią i to ta rola matek jest na pewno większa, nawet jeżeli ojcowie karmią dzieci z butelki no to żeby ta laktacja była efektywna ta matka musi być blisko dziecka. […] Ten pokarm zawsze jest pokarmem matki.” [Wiktor, Polish paediatrician, Q-109]

Q-110

“Mother is expected, even required, to breastfeed. [...] And here, hands down, the priority for a baby is food, so it has to be there.” [Tekli, Polish midwife, Q-110]

"Od mamy oczekuje się, wręcz się narzucza, karmienie piersią. [...] Tutaj to, no nie ma co, dla dziecka priorytetem jest jedzenie, a więc musi mieć to jedzenie.” [Tekli, Polish midwife, Q-110]

Q-111

“I think that one of the major father roles should- should be, against all appearances, supporting mothers, because it is mother with her dose of hormones and maternity instinct who does excellent with this child, is probably in the majority of cases able to handle the situation, however often has so many emotions and even more physical restrictions after birth in which support is simply necessary, and I think it’s here where the father is mostly needed. Of course the creation of a father-child bond is also very important. That’s why we want fathers to be present for example during baths, or during some other activities like that, so that they can take part in them, so that they feel needed, so that they feel like they are not only needed to read a goodnight-story and that’s it.” [Klaudia, Polish paediatrician, Q-111]
"Wydaje mi się że żyj jedną z głównych ról ojca które powinny być to wbrew pozorom jest wspieranie matki, ponieważ no matka ze swoją dawką hormonów i macierzyńskiego instynktu znakomicie sobie z tym dzieciem jest- chyba w większości przypadków w stanie poradzić, natomiast często no jest to tyle emocji, tyle jeszcze takich fizycznych ograniczeń po porodzie gdzie potrzebne jest po prostu wsparcie i pomoc i tu mi się wydaje że ojciec jest najbardziej potrzebny, oczywiście sama-(niezrozumiale) budowanie więzi z dzieckiem dla ojca też jest bardzo istotne dlatego staramy się żeby ojcowie też byli y- obecni na przykład przy kąpieli, czy przy jaki takich czynnościach żeby też mogli brać udział, żeby czuli się potrzebni, żeby nie byli tylko ojcam od czytania bajki na dobranoc i to wszystko." [Klaudia, Polish paediatrician, Q-111]

Q-112

Interviewer: "What do you yourself find important for a child?"

Krystyna: "Direct contact with the father and the mother, because that has an impact on the child's future. If for example the child feels loved already, let's say, since the time like after birth. The parents will know how to proceed and all. They will be with this child all the time and they will understand this child, so the child cries, because something is happening and not only that it cries because it wants to cry, right? [...] What is a very important thing [...] skin-to-skin contact. [...] This is very popular in Western countries and in our country, truth be told, less, but already in some clinics the father holds the baby close to his chest directly after birth. [...] Of course the father should have the same role as the mother in childcare [...], both parents should simply take such responsibility and take care of such a new-born, for it to feel the skin of both father and mother." [Krystyna, Polish midwife, Q-112]

Interviewer: "Co Pani osobiście uważa za ważne dla dziecka?"

Krystyna: "Bezpośredni kontakt z ojcem i z matką ze względu na to, że to bardzo rzutuje na przyszłość dziecka. Jeżeli np. dziecko będzie czuło sie kochane już, powiedzmy od czasu takiego po urodzeniu. Rodzice będą wiedzieli, jak postępować i w ogóle. Będą cały czas z tym dzieckiem i będą rozumieć to dziecko, czyli dziecko płacze, ponieważ coś się dzieje a nie tylko, że płacze, bo chce płakać, tak? [...] co jest bardzo istotna rzeczą [...] skóra do skóry- kontakt. [...] To jest właśnie w krajach zachodnich jest bardzo rozpowszechnione i u nas, co prawda mnie, ale już niektóre kliniki, to już od razu po porodzie ojciec przystawia dziecko do swojej klatki piersiowej np. [...] Oczywiście w opiece nad dzieckiem powiniem i ojciec mieć taką samą role jak i matka, [...] rodzice oboje taka po prostu odpowiedzialność i równocześnie zajmować jakoś się takim noworodki. Zbyt czuło skórę i ojca, i matki." [Krystyna, Polish midwife, Q-112]

Q-113

"Fathers have it a bit harder because this creation of a parenting bond, well it has to happen without this sort of- without this lactation, without this element." [Wiktor, Polish paediatrician, Q-113]

"Ojcowie mają trochę trudniej bo to budowanie więzi rodzicielskiej no musi się odbyć, jakby bez- bez tej laktacji, bez tego elementu." [Wiktor, Polish paediatrician, Q-113]

Q-114

"The dad is more and more often engaged. Here [at the intensive care ward] it's perhaps unfortunately a bit, a bit limited because, because of biological reasons we can here kind of allow the mother to participate, I mean, be with the child for 24 hours a day. Dad no, not necessarily, not always. But, but we do try to at least to make them take turns." [Agnieszka, Polish paediatrician, Q-114]
"Ale tata też jest coraz częściej bardzo zaangażowany, u nas może troszeczkę niestety jest to, jest to ograniczane z tego względu, że z racji tutaj biologicznych, możemy jakby tutaj matce jakby pozwolić na uczestnictwo, znaczy być przy dziecku przez 24 godziny, tata nie, nie koniecznie, nie zawsze. Ale, ale chociaż staramy się żeby przynajmniej to było na zmianę." [Agnieszka, Polish paediatrician, Q-114]

Q-115

"But dads are expected to take care of their babies [...] to participate, sometimes maybe even to go too much into women’s intimate sphere, but women expect it. [...] Sometimes dads say they wish they had breasts to feed. So dads participate more and more in this caring, loving life on a level mom-baby.” [Tekli, Polish midwife, Q-115]

"Ale taty oczekują się tej takiej opieki nad dzieciakami [...] uczestnictwo, może nawet czasem zbyt duże wnikanie w tą sferę intymną kobiety, ale kobiety tego oczekują. [...] Zdarza się tak, że tatusiowie mówią, że gdyby mieli piersi to by karmili. A więc coraz bardziej tatusiowe gdzieś w to życie takie wychowawcze, miłosne, w to życie mama – dziecko.” [Tekli, Polish midwife, Q-115]

Q-116

"Men, fathers, they have better salaries or a more stable situation on the labour market, or they have their own company, so when the baby appears they are kind of more effective [...] so yeah, it’s more often a mum who stays at home with kids. But often, it's like in my case [...] because I had a more stable situation and higher salary, but I wanted to stay at home with my first and second child, and with the second one I wanted to stay the whole year knowing that I won’t have such an opportunity again ever in my life and what you work out with the baby at the early stages it- it's an investment into the future. Maybe it all sounds really I don't know calculated, but I love my kids and I want to devote to them and that's why I left the job at the university, because I would need to spend a lot of time afterwards on other different activities than at home, so I prefer to work at a kind of less prestigious place but have much more time for kids.” [Urszula, Polish paediatrician, Q-116]

"Panowie ojcowie mają tą y lepsze zarobki czy nie wiem czy stabilniejszą y sytuację na rynku pracy czy jeśli prowadzą własną firmę no to już się pojawia y dziecko to są w stanie y jakby może nie tyle wydajniej więcej [...] tak że tak, częściej mamy zostają w domu z dziećmi ale często tak jak na przykład w moim przypadku to było tak [...] bo ja mam stabilniejsze zatrudnienie, wyższe yy w wyższe zarobki, ale ja chciałam zostać w domu i z pierwszymi i z drugim dzieckiem i z tym drugim chciałam zostać cały rok, wiedząc, że już nigdy w życiu takiej możliwości nie będę miała a to co się w tych pierwszych latach z dzieckiem wypracuje to- to to jest inwestycja. Może to wszystko brzmi tak bardzo nie wiem, wyrażowanie z mojej strony, ale yy, z tego względu zrezygnowałem też z pracy na uniwersytecie bo musiałabym wtedy spędzać dużo czasu y poza na różnych innych aktywnościach, niż w domu, tak że wolę pracować y w mniej jakby prestiżowym miejscu zatrudnienia yy a mieć zdecydowanie więcej czasu.” [Urszula, Polish paediatrician, Q-116]

Q-117

"Right now the only option for mom is a year leave. And it is some support for the parents indeed, for the mom I mean. So that she can have this baby a whole year. ” [Tekli, Polish midwife, Q-117]
"W tej chwili jedynie co jest najlepsze dla mam to jest urlop roczny. Rzeczywiście jest to wsparciem dla rodziców, tzn. dla mamy. Żeby tego dzieciaczka móc przez ten cały rok sobie mieć. “ [Tekli, Polish midwife, Q-117]

Q-118
“I don’t really… sure, there are all these maternal leaves […] it’s just like a general norm that moms just sit at home, if I may say so, and fathers go to work and these roles don’t really change. It’s my opinion- but also it’s how the state works, so it’s provoked by the situation, and moms have a maternal leave and what do dads have, two weeks of paternal leave, so how is he supposed to…” [Danuta, Polish paediatrician, Q-118]

"Na tyle się tym nie-no na pewno tam te wszystkie macierzyńskie […] ale to myślę, że jest też wynikające z tego że- że jest po prostu ogólne przyjęte że mama siedzi w chacie za przeproszeniem a ojciec do roboty i te role się nie zmieniają. moim zdaniem- ale to też państwo, to jest wywołane też sytuacją, no mama ma macierzyński tata co ma, dwa tygodnie tacierzyńskiego, no to jak on ma się…” [Danuta, Polish paediatrician, Q-118]

Q-119
“When women have a good position and get a good salary, they care a lot about this job, so in some cases they try to come back to work as soon as they possibly can. People have some loans, commissions, sometimes it breaks their heart, but they just have to do it. […] Generally […] they have to come back to work. I think that for comfort of both mother and child, such parental leave should take three years. […] Then it’s just mother’s will if she provides the greatest care for their little sweetie, either a loving granny or a professional babysitter will hug the baby, but she herself wants to pursue her career, I surely respect it, but most women come back to work out of necessity and in tears.” [Olene, Polish midwife, Q-119]

"Ze kobiety, jeżeli mają dobrze stanowisko za dobrą kasę, bardzo im na tej pracy zależy, to w części przypadków starają się jak najszybciej do tej pracy wrócić. Ludzie mają kredyty, zobowiązania, nieraz z bolącym sercem, ale tak to się dzieje. […] Generalnie […]że muszą wracać do pracy. Ja uważam, że tak dla poczucia komfortu i matki i dziecka, naprawdę taki urlop rodzicielski powinien trwać trzy lata. […]wtedy to by była wola matki, czy zabezpieczy opiekę najwspanialszą jaką tylko może dla tego dzieciaczka, czy jakaś kochana babcia, czy sprawdzoana opiekunka przytuli, ale chce się realizować w czymś innym, ja to też szanuję, ale większość kobiet wraca do pracy po prostu z konieczności, płacąc.” [Olene, Polish midwife, Q-119]

Q-120
“Well, here I think it’s still mainly moms that stay at home, yes, but most of them, I think more often than before, there are more women who want to return to work as soon as possible, but there’s the question whether they really want to or have to. Because the job might not wait long for them, right? [Sylwia, Polish midwife, Q-120]

"No u nas myślę, nadal jest przewaga mam, które zostają w domu, tak, ale już większość myślę, że częściej niż kiedyś jest kobiety więcej, które już jak najszybciej chcą wrócić do pracy, ale no też pojawia się pytanie czy chcą, czy muszą? [Sylwia, Polish midwife, Q-120]

Q-121
“These moms who have their own business are in a better situation, because they have a lot of options here, they can both come back to work and do other stuff, but for other full-time employed women it’s a big uncertainty. They are looking for a babysitter,
they both try to work, because you know, most people have some loans and other stuff. But moms have it harder in life, I mean at work.”

Interviewer: “How is it approached during the consultation?”

Tekli: “No. Everyone knows, what’s here and now it’s here and now, and the future is the future. Nobody cares about it when the baby is born. They are happy with their little sweethearts and they leave the rest aside.” [Tekli, Polish midwife, Q-121]

Tekli: “Te mamy, które prowadzą własną działalność, one są w troszkę lepszej sytuacji, bo mają tutaj dużo możliwości, bo mogą i wrócić do pracy i robić inne rzeczy itd., ale te kobiety zatrudnione są na etacie mają jedną wielką niepewność powrotu do pracy. Często szukają opiekunki, starają się oboje pracować, bo wiadomo większość ludzi to i jakieś kredyty i inne rzeczy. Ale mamom jest trudniej w życiu, Izn. w pracy.

Interviewer: “How is it approached during the consultation?”

Tekli: Nie. Wszyscy wiedzą, to co jest teraz to jest teraz, a co będzie później to będzie dopiero później. Nikt tym się nie zajmuje po urodzeniu dziecka. Cieszą się tam tym dzieciaczkiem i takie sprawy idą na bok.” [Tekli, Polish midwife, Q-121]

Q-122

“Fathers, [...] they only sacrifice themselves in very particular situations. And financial well-being is super, super important. Not the most important, but sometimes a lack of money makes the atmosphere at home really heavy, and it leads to conflicts, which consequently also has some negative impact on the baby and their relations. So I really do understand it, I think it’s something natural. I’m sure no-one says that it’s not like this, because fathers focus more on their careers.” [Olene, Polish midwife, Q-122]

"Ojcowie, [...] wyjątkowych tylko sytuacjach jakby w tym momencie poświęcają. Względy materialne są bardzo ważne, bardzo. Nie najważniejsze, ale często po prostu niedobory finansowe zagęszczają atmosferę w domu, doprowadzają do konfliktów, co też się negatywnie odbija na dziecku i na tych relacjach. Także ja to rozumiem, że jest to moim zdaniem coś oczywistego, na pewno nikt nie odpowie w ten sposób, że tak to nie jest, no bo to właśnie ojcowie bardziej skupiają się na pracy zawodowej.” [Olene, Polish midwife, Q-122]

Q-123

“Now it varies: mums go back to work fast, daddies take leaves.” [Ewa, Polish midwife, Q-123]

"Teraz to już różnie mamy szybko do pracy wracają. Tatusiowie urlopy.” [Ewa, Polish midwife, Q-123]

Q-124

“I think that in the majority, mother stays with the baby for most of the time. However, it happens more and more that fathers also declare during conversations that they want to take some part of that paternal leave.” [Klaudia, Polish paediatrician, Q-124]

"No myślę że w zdecydowanej większości mam- matka zostaje przez większość czasu z dzieckiem natomiast yy coraz częściej zdarza się w rozmowach że- że ojcowie również deklarują się aa że chcą wziąć jakąś tam [część tego urlopu." [Klaudia, Polish paediatrician, Q-124]
Q-125

Interviewer: “What forms of childcare do parents plan and use? How is it approached during the consultation?”

Stefana: “Oh, they plan it, absolutely, they call to ask one or the other grandma, a babysitter, sometimes when they’re going on a leave they exchange: two days a mom, two days a dad. And it surely changes, for the better, slowly, step by step, but it does and you can tell. […] A lot of fathers go on these paternal leaves and they share it, more and more. It’s still a very small share, but something is getting better there.”

[Stefana, Polish paediatrician, Q-125]

Q-126

“The baby sitter that comes to our home is generally an untested person, she can’t be asked for a lung X-ray to test for tuberculosis without even talking about swab on Streptococcus or Staphylococcus. Yet, she touches the baby. Moreover, the personality of the baby-sitter is unknown and there is huge fear if the baby sitter is an unfamiliar person.”

[Żyta, Polish midwife, Q-126]

This interview what translated while transcribing, and original language verbatim quotations are not available.

Q-127

“There are lots of euro-orphans, so children left with grandma or someone, a cousin or an older sister, and their parents go abroad to seek employment. […] There is a lot more violence in a form of neglect, than strict beating or tormenting. And these neglected children are left completely alone and they have to deal with everything on their own and it’s terrifying.”

[Stefana, Polish paediatrician, Q-127]

"Dużo jest euro sierot, czyli dzieci, które są zostawione tam z babcią czy kimś, kuzynką, czy starszą siostrą i rodzice gdzieś tam jadą za pracą. […] Dużo jest takiej przemocy w formie zaniedbań, niż takiego totalnego bicia, katowania. Natomiast zaniedbane dzieci są puszczone totally samopas i wtedy muszą sobie same radzić i to jest przerazające. [Stefana, Polish paediatrician, Q-127]

Q-128

“It’s just that they were with their kid, especially for these early years. They can exchange, but they should be the ones to raise their baby, not the group of other people.”

[Stefana, Polish paediatrician, Q-128]

"Tylko żeby byli przy tym dziecku, zwłaszcza przez te pierwsze lata, mogą się wymieniać, ale żeby oni wychowywali te dzieci, a nie jakiś tam sztab osób." .”

[Stefana, Polish paediatrician, Q-128]

Q-129

“I think that the decision who takes leave is a matter of money. […] If a father has a poorly-paid job, and at the same time he’s that kind of a man who can fit into the role
of a house caretaker, cause then it’s not only the baby, but he has to take care of the whole household for these couple of months.” [Olene, Polish midwife, Q-129]

"że kto powinien na urlop pójść, to już są takie sprawy związane przede wszystkim z pieniędzmi. Jeżeli ojciec ma bardzo słabo płatną pracę, jednocześnie jest właśnie takim typem mężczyzny, który odnajdzie się w sprawowaniu opieki takiej nad domem, bo to wtedy nie tylko nad dzieckiem, ale nad domem przez tych parę miesięcy.” [Olene, Polish midwife, Q-129]

Q-130
Interviewer: “How is this discussed in your consults; […] do parents ask about leaves, the amount of time […], is such information discussed with midwives?”
Zuzanna: "Yes. To be honest, men and mums are quite knowledgeable, but there are also some who want more specific details and for sure we can help with advice. Besides, the rest of the personnel too, because our medical secretaries do well in these things. Sometimes they have broader knowledge than us who work directly with patients.” [Zuzanna, Polish midwife, Q-130]

Q-131
“Jak panie idą do domu […] wszystkie formalności zalaatwiają z nasza sekretarką. Ona jest bardzo dobrze poinformowana [o urlopie] i przekazuje im na bieżąco już przed samym wyjściem do domu, co [formy] należy zadać po kolei i jak to wygląda.” [Ewa, Polish midwife, Q-131]

Q-132
Krystyna: “Also the support of the father, most certainly yes. He should also take some time off and [they] should simply be together in some activities, support her, because it’s also a very difficult period for her […], so he should be…”
Interviewer: “Is it actually discussed during consultations with the parents?”
Krystyna: “Well, we give various tips, of course, but it also varies. It depends on the individual families. So sometimes they take time off, sometimes it’s impossible, but of course I give tips, most certainly […] they set up themselves what [happens] after maternity leave, so we tell them what this maternity leave looks like, how much they can take: before, after. How much can a man take for this care.” [Krystyna, Polish midwife, Q-132]
Krystyna: "Także wsparcie ojca, jak najbardziej tak. Też powinien sobie wziąć jakiś urlop i powinien po prostu wspólnie, razem przy pewnych czynnościach być, wspierać ją-, ponieważ to też jest bardzo trudny okres dla niej. […] także powinien być…"

Interviewer: "Jest to omawiane właśnie podczas konsultacji z rodzicami właśnie ten… Krystyna: "Tzn. my dajemy różne wskazówki oczywiście, ale to też różnie. Indywidualnie zależy od rodzin. Także Czasami jest tak, że biorą sobie, czasami jest to niemożliwe, także, ale oczywiście wskazówki jak najbardziej daję […] znaczy oni to sobie sami ustawiają, także my mówimy jak wygląda ten macierzyński ile mogą sobie wziąć: przed, po. Ile może mężczyzna sobie wziąć tak na opiekę." [Krystyna, Polish midwife, Q-132]

Q-133

Interviewer: "How is [women returning to work] discussed in your consults?"
Sylwia: "That’s very rarely, really. It’s only when, when there are children who are somehow, who require care, constant care, that’s where this keeps coming back but in general not really.” [Sylwia, Polish midwife, Q-133]

Interviewer: "Jak jest [kobiety powracające do pracy] omawiane podczas konsultacji? Sylwia: "Ale bardzo rzadko, naprawdę. To tylko, gdy są dzieci, które wówczas wymagają opieki, tak jak to daje się powtórzyć, ale ogólnie nie jest to…"

Chapter 7

Q-134

"It’s a heightened risk, but it’s not by definition already a risk. … That’s what I’ve really learned after all these years; leave them at home, those stereotypes.” [Els, CHC nurse; experience=21 years, Q-134]

"Het is een verhoogd risico, maar het is niet per definitie al een risico. … Dat is wat ik in al die jaren heel erg heb geleerd: laat ze maar mooi thuis, al die stempels.” [Els, CHC nurse; experience=21 years, Q-134]

Q-135

"One child can carry a much heavier burden than another.” [Marjan CHC doctor; experience=29 years, Q-135].

"Het ene kind heeft veel meer draagkracht dan het andere.” [Marjan CHC doctor; experience=29 years, Q-135].

Q-136

"[It] depends on who [which colleague] you talk to, is my impression; how heavily you weight [a situation] when you act and when you let go or wait and see. That’s very personal and this makes it difficult for me as a beginner. You need to develop your own [risk] boundaries.” [Christine CHC nurse; experience=3 years, Q-136].

"[Het is] net afhankelijk van wie [welke collega] je hier weer spreekt, vind ik hoor, van hoe zwaar weeg je [een situatie] en wanneer doe je er wel wat mee en wanneer laat je het gaan of kijk je het nog even aan. Dat is heel persoonlijk en dat maakt het zeker voor mij als beginner ook nog wel lastig en ook moet je daarin je eigen [risico] grenzen gaan.. leren bepalen.” [Christine CHC nurse; experience=3 years, Q-136].
"[It’s] not always as realistic, to be able to see everything. It’s a snapshot. … [Take the example of] what we had yesterday, with the mother that had thyroid cancer and told her complete story to the assistant [in reception]. If I wouldn’t have heard it from the assistant and I wouldn’t have asked, I wouldn’t have known about it at all.”

[Marijke, CHC doctor; experience=2 years. Q-137]

"[Het is] niet altijd even... reëel dat je alles kan zien. Het is, het is maar een momentopname. […] Je ziet het al met wat wij gisteren hadden met die moeder met schildklierkanker die dan bij de assistente het hele verhaal doet, en als ik het nou van de assistente niet had gehoord en ik het ook niet had gevraagd, dan had ik het helemaal niet geweten, zeg maar.” [Marijke, CHC doctor; experience=2 years. Q-137]

"In a consultation of 15 minutes, you can’t judge whether a child is abused or not…When parents provide desired answers and try to hide something; that’s possible. We can’t look inside one’s head and we see children for 20 minutes. Well then you can’t see what horrible things might happen at home - when the child is calm and cooperative during the consultation, everything is well and parents say it’s all fine.” [Jonita, CHC nurse; experience=1 year, Q-138]

"Je kan ik een consult van 15 minuten kan je niet… beoordelen of een kind mishandeld wordt of niet… Als ouders echt, zelf wenselijke antwoorden geven en iets proberen te verbergen, dan kan dat soms heel goed natuurlijk ook. Want wij kunnen niet in iemands hoofd kijken en eh wij zien de kindjes 20 minuten en ja, dan kan je niet zien, als daar afschuwelijke dingen thuis gebeuren wellicht, maar het kindje is tijdens het consult gewoon rustig, werkt gewoon lekker mee en alles gaat goed en ouders zeggen ook dat alles goed gaat. [Jonita, CHC nurse; experience=1 year, Q-138]

"Yes, and that’s just my feeling, my experience, like: this mother is a bit messed up with something…I didn’t worry about [her] child at all, for sure. But that doesn’t mean that when there are no worries at the moment, [that] they could not arise. So that’s why the child gets extra attention. Because they slip through so easily, you know.” [Els, CHC nurse; experience=21 years, Q-139]

"Ja, en dat is gewoon mijn gevoel, mijn ervaring, van: deze moeder die zit best wel in de knoop, met wat dan ook. Maar het mannetje…. Ik had helemaal geen zorgen over dat kind. Maar, dat betekent niet dat als er nu geen zorgen zijn, dat dat wel kan komen. Dus daarom heeft het even een extra aandachtspuntje, van, want het glipt er zo snel doorheen hoor.” [Els, CHC nurse; experience=21 years, Q-139]

"I find it good parenting when parents […dare] to tell you they find things difficult.” [Ellen; experience=4 years, Q-140]

"Ik vind goed ouderschap als ouders […] ook durven aan te geven dat ze dingen moeilijk vinden.” [Ellen; experience=4 years, Q-140]
“It doesn’t work to just hold things against parents, you know. You need to take care of being on the same page first, before you get them to a point [where] they will follow you.” [Coby, CHC nurse; experience=11 years, Q-141]

“Het werkt niet om ouders zo maar iets voor de voeten te gooien. He, je moet eerst zorgen dat je op dezelfde lijn zit en ze mee krijgt, zeg maar.” [Coby, CHC nurse; experience=11 years, Q-141]

“… Some parents are for some reason just closer to you and live sort of a similar life as I do, and that makes it easier, because it’s easier to sense them.” [Christine, CHC nurse; experience=3 years, Q-142]

“… sommige ouders gewoon op de één of andere manier dichterbij je staan en meer een soort zelfde leven leiden als dat ik dat doe en dat dat dan, dat dat dan wat eenvoudiger is, omdat je meer je beter toch kan invoelen.” [Christine, CHC nurse; experience=3 years, Q-142]

“… You know less richly how things are going exactly; I mean you don’t know each culture so well. But [...] when parents are open to CHC, it doesn’t matter so much which culture they come from, then I feel like I’m having a good conversation and you’re building a nice bond.” [Marijke, CHC doctor; experience=2 years, Q-143]

“… Omdat je minder levendig weet hoe dat precies gaat. Ik bedoel je kent niet elke cultuur even goed. [...] als ouders sowieso open staan voor het CB, dan maakt het eigenlijk niet zoveel uit wat voor soort cultuur het is en dan heb ik toch voor mijn gevoel een... goed gesprek en, ja dat het een leuke.. band of werkrelatie die je dan opbouwt op die manier.” [Marijke, CHC doctor; experience=2 years, Q-143]

“I see many normal children, you know. Very normal, nice parents [laughs]...[Even in the in-between cases] you’re going to figure out ‘what can I offer?’ Because it’s not about: here [risk] boundaries are crossed. At most you think: ‘it would be nicer when [the situation] would be like this’ and: ‘is it useful for this mother when I offer that [advice]? That’s actually the normal work.” [Marjan, CHC doctor; experience=29 years, Q-144]

“Ik zie heel veel hele gewone kinderen hoor. Hele gewone leuke ouders. [Lacht] [Zelfs in de grijze gevallen] dan ga je dus kijken: wat kan ik bieden? Want dan gaat het helemaal niet over: hier worden grenzen overschreden, maar hoogstens denk je van” goh, nou, dat zou best leuker zijn als [de situatie] zo was. En heeft die moeder daar wat aan als ik [met dat advise] kom. Dat is eigenlijk het normale werk.” [Marjan, CHC doctor; experience=29 years, Q-144]

“It is precisely the risky families who you often see even less, since they don’t show up [and] without leaving a message. Families who are open and express themselves...they form the easy group. But the risk group [parents], who are not open, don’t show up, don’t show disclosure and don’t see everything [like we do], that’s the difficult part. [The government] can say: ‘you are responsible for this case’, but how responsible can you be?” [Tineke, CHC nurse; experience=12 years, Q-145].
“Want juist bij de risicogezinnen zie je ze vaak nog minder, omdat ze niet verschijnen zonder bericht. [...] Gezinnen die er open voor staan en die zelf zeggen, dat is de makkelijke groep. Maar de risicogroep die niet open staat, die niet komt en die geen ingang heeft en het allemaal niet zo ziet, dat zijn, dat is de lastige stuk. En dan kan je wel zeggen: jij bent accountverantwoordelijke, maar hoe verantwoordelijk kan je zijn?” [Tineke, CHC nurse; experience=12 years, Q-145].

Q-146

“I have to confess that I’m usually focused on mother... Father is sitting there as well of course and is also a fully-fledged caregiver of his child and he has questions. But somehow, you’re sometimes missing out on signs [of the father].” [Jonita, CHC nurse; experience=1 year, Q-146]

“Ik moet wel bekennen dat ik toch vaak.. me wel richt op moeder... Terwijl op zich vader er wel gewoon bij zit en natuurlijk ook gewoon een volwaardige verzorger van z’n kind is en eh, ja en ook vragen heeft. Maar [...] dan mis je soms signalen [van vader] ofzo op de één of andere manier.” [Jonita, CHC nurse; experience=1 year, Q-146]

Q-147

Interviewer: “Do you advise on that – number of hours worked?”
Yara: “No. Only when I see for instance a mother working four days who is struggling, has a hard time, then I would discuss it.[...]

Interviewer: “And do you sometimes also advise father to work less?”
Yara: “Not really. No, never. [laughs.] No.” [Yara, CHC paediatrician; experience=7 years, Q 147]

Interviewer: “Adviseer jij daar trouwens nog in, over hoeveel uren werken?”
Yara: “Nee. Alleen als ik merk dat eh bijvoorbeeld bij een moeder die vier dagen werkt en die eh het best wel moeilijk, zwaar heeft, dan, dan bespreek ik het wel.”

Interviewer: “En adviseer je vaders dan ook wel eens om minder te gaan werken?
Yara: “Eigenlijk niet. Eigenlijk nooit. Nee. [Lacht] Nee. [Yara, CHC paediatrician; experience=7 years, Q 147]

Q-148

“The people that don’t open up; this varies a lot. ...[It’s] often also those highly educated parents, saying ‘Well, I don’t know what it is you’re doing here, playing games with the kids, but it’s actually just nonsense. And everything’s fine, I can see all is fine, right?’ Well, then you’ve also got a different type of relationship.” [Marijke, CHC doctor; experience=2 years, Q-148]

“Ook de mensen die er niet voor open staan, dat wisselt ook heel erg. [...] Ook ouders, vaak van die hoger opgeleide mensen die zeggen van ‘ja, ik weet niet wat jullie hier doen hoor, beetje spelletjes met die kinderen, maar het is eigenlijk gewoon onzin. En het gaat goed, ik zie toch dat het goed gaat.’ Ja, dan heb je ook een ander soort band.” [Marijke, CHC doctor; experience=2 years, Q-148]
Chapter 8

Q-149
Interviewer: “And do you see fathers and mothers just as frequent?”
Idlette: “Yes, a remarkable number of fathers are at home. Yes. At least for the first couple of days. It depends a bit on how the weekend falls, so to speak. Very rarely you have a father who needs to return to work immediately, but that’s really a minority. Yes, most are at home.” [Idlette, Dutch postpartum care assistant, Q-149]

Interviewer: “Zie jij vaders en moeders even vaak?”

Q-150
“I have to say I’m often seeing fathers at the consultations, who come alone with their child, or have a ‘daddy day’. Then it’s often a day, or two days [per week]. […] You see this more often in my view. Because well, a father should work part-time then, I would say, when you have a daddy day. [Laughs]. I even have fathers who always come, so I’m thinking: who is the mother again? I have those as well. Perhaps you wouldn’t have seen this a few years back, it used to be standardly the mother.” [Yara, Dutch paediatrician, Q-150]

“Ik moet zeggen dat ik in [Naam Stad] vrijwel vaak ook gewoon vaders krijg hoor eh op het bureau die alleen met hun kind komen of die een papadag hebben. Dan is het vaak een dag, of twee dagen. […]Dus dat zie je wel eh meer, heb ik het idee. Want ja, dan moet vader toch parttime werken, lijkt mij, als je een vaderdag hebt. [Lacht] Eh, dus eh, ja en ik heb ook, ik heb ook zelfs vaders die altijd komen, dus waarvan ik denk: wie is moeder ook alweer eh? Dus die heb ik ook wel, hoor. Dat had je misschien een aantal jaar terug niet eens gezien, dan was het gewoon standaard moeder.” [Yara, Dutch paediatrician, Q-150]

Q-151
“What’s funny is that I’m working on Fridays and this is really such a daddy day, so you’re suddenly having a lot of daddy’s at your consultation.” [Marijke, Dutch paediatrician, Q-151]

“Wat wel grappig is, ik werk op vrijdag en dat is echt zo’n papadag, dus dan heb je ineens allemaal papa’s op het bureau.” [Marijke, Dutch paediatrician, Q-151]

Q-152
“My impression is that the majority [of men] stays at home shortly, that is two or three weeks, and then returns to work. Sometimes even much, much earlier.” [Gerda, German midwife, Q-152]

“Mein Eindruck ist, dass der überwiegende Teil kurz, also das heißt 2 bis 3 Wochen etwa zuhause ist. Aber dann wieder arbeitet. Manchmal sogar sehr viel früher.” [Gerda, German midwife, Q-152]

Q-153
“[The partner] possibly has three weeks vacation. […] And it’s still the case for my clientele […] that very few fathers take paternity leave. So this parental leave, which
would be possible ... by the state. But it is quite often a financial calculation.”
[Isabella, German midwife, Q-153]

“Und wenn der Partner dann ... Der hat dann vielleicht 3 Wochen Urlaub. [...] Und eh es ist nach wie vor, dass das Klientel, das ich hauptsächlich betreu, ganz wenige Väter Vaterschaftsurlaub nehmen. Also diesen Erziehungsurlaub, der ja möglich wäre ... vom vom Staat aus. Aber es ist auch ganz häufig eine finanzielle Rechnung.”
[Isabella, German midwife, Q-153]

Q-154
Interviewer: “Who usually attends with the child?”
Torben: “Mother. [...] For 95 per cent of the cases, the mother attends.”
Interviewer: “And in the other 5 per cent?”
Torben: “Mixed. Sometimes grandparents. Sometimes father. [...] And that’s, well: I work during hours that those who are not at home with the child are also working, you know. So accordingly they must take up leave for this time slot and that’s not easy. Because the appointments with us are not always planned in line with fathers and mothers agenda’s.” [Torben, German paediatrician, Q-154]

Interviewer: “Wer kommt denn meistens mit dem Kind?”
Torben: “Mutter. [...] 95 Prozent kommt die Mutter.”
Interviewerin: “Und in den anderen 5 Prozent?”

Q-155
“More and more fathers are attending, in case they have parental leave.” [Sonja, German paediatrician, Q-155]

“Es kommen immer mehr Väter. Gerade wenn sie Elternzeit haben” [Sonja, German paediatrician, Q-155]

Q-156
“There used to be hardly any fathers in the practice. They only came in the weekends [...] fathers were sometimes sitting at the emergency services but other than this, I predominantly only knew the mothers. [...] It was in the first half of the 2000’s, the first decade I must say, that this has changed a lot: we have seen more and more fathers as well. And it’s now the case that fathers come along quite frequently at the U3 [examination], so when the child is five weeks old, and then often at the next examination as well. Or there are also days that we almost exclusively have men coming in the waiting room, that used to be very different.” [Marianne, German paediatrician, Q-156]

“da habe ich kaum Väter in der Praxis gesehen. Da gabs also schonmal am Wochenende, [...] wenn der Notdienst war, da saßen dann schonmal Väter, ähm, aber ansonsten kannte ich überwiegend nur die Mütter. Also so mit ähm, so in der ersten Hälfte der 2000er Jahre, des ersten Jahrzehnts, muss ich sagen, hat sich das sehr geändert - haben wir zunehmend die Väter da gesehen auch. Und mittlerweile ist es so, dass GANZ häufig bei der U3, also wenn das Kind 5 Wochen alt ist, äh die Väter mitkommen und dann OFT auch noch bei den kommenden Vorsorgen. Oder (...) äh, es
gibt auch Tage, da haben wir im Wartezimmer quasi ausschließlich Männer als Begleitung - das war früher ganz anders.” [Marianne, German paediatrician, Q-156]

Q-157
“I mean at the beginning during the first visits; dads stay at home, because they want to stay at home. In some cases they don’t want to be there, so they go to work because work is the most important thing. But generally they want to be there and really, for these two weeks they take care of their families, they try to participate in everything.” [Tekli, Polish midwife, Q-157]

"To znaczy na początku przez pierwsze wizyty tatusiowie są w domu, bo chcą być w domu. W nielicznych przypadkach nie chcą być, więc idą do pracy bo praca jest najważniejsza. Ale chcą być i rzeczywiście przez te dwa tygodnie opiekują się swoimi rodzinami, starają się gdzieś tam uczestniczyć w tym wszystkim." [Tekli, Polish midwife, Q-157]

Q-158
“I meet mothers definitely more often, but as I say, there are more and more fathers every year. What’s curious, it’s kind of a phenomenon to me, parents often come together and are both very interested, but it is very much dependent on where they work. If they have their own company, they can do it. Because I assume that a teacher and an office clerk wouldn’t be able to come to the appointment at 1 P.M., right.” [Stefana, Polish paediatrician, Q-158]

Nie no, częściej się spotykam z matkami, ale tak jak mówię, z roku na rok coraz więcej ojców. A w ogóle, co jest dla mnie fenomenem, bardzo często rodzice przyjeżdżają razem i się bardzo interesują, ale zdecydowanie to jest związane z pracą. To są rodzice, którzy mają firmy i mogą sobie na takie coś pozwolić. Bo nie wyobrażam sobie, że nauczycielka i urzędnik przyjeżdżają z dzieckiem na wizytę na godzinę 13 tak.” [Stefana, Polish paediatrician, Q-158]

Q-159
Interviewer: “How do you see mothers and fathers in their roles as caregivers? Does this differ?”
Evelien: “Very funny, because I often see that the mother says: ‘gee, I never expected him to be so… caring.’ During pregnancy the man seemed to have been more like: ‘well’, you know, and once the child is out, he is really completely… And the mother is a bit jealous because he can do things she still can’t with the baby. It’s so funny to see, like: ‘I didn’t do a diaper at all and he…’. And [he is] like: ‘No problem, I will bathe [the baby] now’, you know, these sort of things, not an issue [for him] at all.” [Evelien, Dutch postpartum care assistant, Q-159]

Interviewer: “Hoe zie je moeders en vaders in hun rol als verzorger? Verschilt dat nog?”
Evelien: “Heel grappig, want ik zie wel heel vaak dat de moeder zegt van “Goh, ik had nooit verwacht dat ie zo… zorgzaam was.” Weet je wel, dan schijnt die man dan toch een beetje uhm… in die hele zwangerschap zo van “nou ja…” weet je wel. Uh, en dan is dat kind d’r en dan is ie d’r helmaal echt… Is die moeder een beetje jaloers, want hij kan veel meer als dat zij nog kan met de baby. Is ook zo’n grappig gezicht. “Ik heb nog helemaal niet die luier gedaan en hij…” En ook zo’n… “Nee hoor, ik doe het gelijk in badje en zo.” Weet je, dat soort dingen, helemaal geen punt [voor hem].” [Evelien, Dutch postpartum care assistant, Q-159]
Interviewer: “[...] and can mothers have a protective role in a certain way, and fathers in another way?”
Tineke: “It could be, but that’s not my experience. [...] I think they can supplement each other in a good way, or that the one is stronger in this and the other in that. [...] You do have mothers of course who are a bit more caring, but this doesn’t mean fathers wouldn’t be. [...] Because when [fathers] are here at the office, they also perform fine.” [Tineke, Dutch nurse, Q-160]

Interviewer: “[...] is het daarin nog dat moeders op een bepaalde manier een beschermende rol kunnen hebben en vaders op een andere manier?”
Tineke: “Dat zou wel kunnen, maar ik heb niet die ervaring. [...] ik vind dat ze elkaar goed aan kunnen vullen of dat de één sterker is in het één en de ander sterker in het ander. [...] Je hebt natuurlijk wel moeders die wat zorgzamer zijn, maar dat betekent niet dat die vader dat niet zou zijn. [...] Want als ze hier op het bureau zijn doen ze het ook prima.” [Tineke, Dutch nurse, Q-160]

“Most fathers who I see coming here have their children very well under control and deal with them in a fun way, make jokes. Yes, relaxed, most of the time.” [Ellen, Dutch paediatrician, Q-161]

“De meeste vaders die ik hier binnen zie komen hebben hun kinderen ontzettend goed eh in het gareel en gaan leuk met ze om en eh, ja maken grapjes.. Ja, ontspannen, vaak, over het algemeen.” [Ellen, Dutch paediatrician, Q-161]

“Very often during some of my first visits when I instruct them how to bathe the newborn baby, it’s not the mom, but the dad who declares willingness to bathe the baby. ‘Look at me, when you explain, cause I’m the one who’s in charge of bathing.’ [...] Sometimes they say kind of as a joke, kind of honestly that if only they could breastfeed they would to everything around the baby.” [Olene, Polish midwife, Q-162]

Często podczas tych pierwszych wizyt położnych, kiedy pokazuję kapelą noworodka, to właśnie nie mama tylko ojciec deklaruje że to on będzie kapal. Proszę patrzeć na mnie jak Pani tłumaczy, bo to ja będę kapal. [...]Nierz ni to żartobliwie, ni to szczery słyszę, jak taki ojciec mówi, gdybym mógł tylko karmić piersią, to bym wszystko przy tym dziecku zrobił.” [Olene, Polish midwife, Q-162]

“[...] Men are not ashamed to, are not afraid to take care of children, they take part in bringing up the children, they are actually not observers of family life, they are very active in this life.” [Zuzanna, Polish midwife, Q-163]

“[...]że panowie nie wstydzą się, nie boją się opiekować się dziećmi, uczestniczą w wychowaniu dzieci, nie są właściwie takimi obserwatorami rodzinnego życia, tylko są bardzo aktywni w tym życiu.” [Zuzanna, Polish midwife, Q-163]

“It’s an absolute novelty in recent years, really, but I see that slowly these fathers are getting interested and it changes even more every year.” [Stefana, Polish paediatrician, Q-164]
"To jest zupełna nowość w ostatnich latach, naprawdę. Yyyy ale widzę, że pomalą chyba ci ojcowie zaczynają się więcej interesować i to się zmienia z roku na rok." [Stefana, Polish paediatrician, Q-164]

Q-165
"The man is then really more concerned with organizational things, earning money and so on." [Gerda, German midwife, Q-165]

"Der Mann ist dann auch wirklich mehr mit so Sachen organisatorischen Dingen, auch Geld verdienen und so weiter beschäftigt." [Gerda, German midwife, Q-165]

Q-166
"Of course I talk differently with women than with men. With men, you shouldn’t talk so much. One talks more with women [laughs]. Most men who are present at the preventive examinations take an observing role. And when everything has worked out well with the child, it takes another 5 [minutes], and then it’s ok.” [Torben, German paediatrician, Q-166]


Q-167
"At the delivery; most men are present and are also supportive towards their wives. And in the postpartum bed, it varies a lot. Some men are very clear: ‘well, those babies, that’s not really my cup of tea’ and they are holding back a bit and just return to work. And there are also many men who are very supportive and do a lot with the children, want to learn everything and are very involved. [...] I think most men are at home in the postpartum week, so they are at least bodily present and it varies [laughs] to what extent they feel engaged.” [Hester, Dutch midwife, Q-167]

"Bij de bevalling; de meeste mannen zijn daar gewoon wel bij en zijn ook ondersteunend naar hun vrouwen toe. En in het kraambed wisselt het heel erg. Sommige mannen die zijn heel duidelijk ‘nou, die baby’s, dat is niet zo mijn ding’ en eh die houden dat allemaal een beetje af en die gaan dan gewoon weer aan het werk. En er zijn ook heel veel mannen die enorm ondersteunend, die ook heel veel met.. met de kinderen doen, die ook alles willen leren.. en die daar erg bij betrokken zijn. [...] ik denk de meeste mannen zijn wel thuis, in ieder geval in de kraamweek. Dus die zijn in ieder geval lijfelijk aanwezig en het verschilt dan [lacht] in hoeverre ze... zich betrokken voelen.” [Hester, Dutch midwife, Q-167]

Q-168
Interviewer: “Do you give moms and dads different advice, do they react differently? And do you have some examples of such situations?”

Urszula: “It all depends on how everything goes along, how they share their responsibilities when it comes to children, because when it’s very traditional and it’s a mummy who is responsible for most of these important issues, including medical things, so I talk with fathers using a bit simpler language or just let them write everything down, or I ask to call the mother. But when a father is equally, or even more, responsible for these medical issues, so they kind of get that major message... It depends more on [...]
like, I don't know, the perceptual capacity of the one who takes care of the baby.”
[Urszula, Polish paediatrician, Q-168]

Interviewer: "czy pani daje ojcom inne rady niż matkom, czy ojcowie jakoś inaczej reagują na pani rady, czy ma pani jakieś przykład takich sytuacji?"
Urszula: "to wszystko zależy od tego jak się układają, jaki jest rozdział obowiązków w domu dotyczący dzieci, tak bo jeśli jest tradycyjnie, czyli mama odpowiada za wykońanie tego, co inne są w tym medycznych, no to do ojców się mówi trochę prostszym językiem albo zapisuje się im różne rzeczy na kartce albo rozmawia z nimi telefonem... to zależy bardziej od..." [Urszula, Polish paediatrician, Q-168]

Q-169
"The role of the partner varies greatly. So also when he is present; the one is just much more involved than the other. [...] I’ve had partners who were smoking outside half of the delivery [...], could be for a number of reasons. And there are also those who are overly concerned, super sweet; there are men because of whom we don’t need to do anything because they care so well. [...] And also during pregnancy; some partners you never see at consultations and others... even want to film the whole consultation [laughs]. And this is also very much dependent on the area in which you are [...]; where I have worked, with many single households or immigrants, where men are also less involved due to culture, or to be in a neighbourhood were men are overly involved in the whole happening, like ‘we are pregnant’ and [...] well, where it’s all very much planned. [...] And where it needs to fit into the picture, into work. [...] Many young graduated people who keep lingering here after college. [...] You know, that group; often dual earners and... highly educated jobs.” [Sophie, Dutch midwife, Q-169]

"De rol van de partner wisselt enorm. Zeg maar ook als ie aanwezig is, de één is gewoon veel meer betrokken dan de ander. [...] Ik heb wel partners die bijvoorbeeld de helft van de bevalling buiten staan te roken [...], dat kunnen tal van redenen zijn. En er zijn ook die overbezorgd zijn, die super lief zijn, en er zijn mannen bij die ervoor zorgen dat wij helemaal niets meer hoeven te doen, omdat die gewoon zo goed zorgen [...]. En ook in de zwangerschap, sommige partners die je neemt met een controle en anderen die willen zelfs een hele controle komen filmen... [lacht]. En ook dat is heel erg afhankelijk van in wat voor gebied je zit [...]; waar ik gewerkt heb, [waar] veel alleenstaanden of allochtonen zijn waar mannen.. ook vanuit cultuur minder betrokken zijn... of dat je in een wijk zit waar mannen over-betrokken zijn bij het hele gebeuren van: ‘wij zijn zwanger’ en [...] nou, het allemaal heel erg gepland is, zeg maar, en heel erg gewenst is. [...] En waar alles in een plaatje moet passen, binnen het werk. [...] Veel jong afgestudeerden mensen hier die blijven hangen de eerste tijd na hun studie. [...] Nou ja, die groep, dat zijn tweeverdieners vaak en... met hoogopgeleide banen.” [Sophie, Dutch midwife, Q-169]

Q-170
Interviewer: “You said: more fathers are attending compared to a few years ago. And does this mean that the role doesn’t differ [between fathers and mothers], or do you see differences?”
Yara: “No, with these families you see that it’s rather similar, that they try to be there together and to do it in a good way.”
Interviewer: “And with the others, how is it with the others?”
Yara: “Less, I think. Do you mean immigrant children for instance, or lower educated?” [Yara, Dutch paediatrician, Q-170]

Interviewer: “Je zegt: er komen meer vaders vergeleken met een paar jaar geleden. En maakt dat dan dat die rol niet verschilt, of zie je toch wel verschillen?

Yara: Nee, bij die gezinnen merk je toch wel dat het vrij ja hetzelfde, dus ze proberen er samen voor te zijn en het op een goeie manier te doen.

Interviewer: “En bij de andere, hoe is het bij de anderen?”

Yara: “Wel minder denk ik hoor. Bedoel je dan met allochtone kinderen bijvoorbeeld of, of lager opgeleiden?” [Yara, Dutch paediatrician, Q-170]

Q-171

“Of course, there are also men who are very, very much looking forward. These are usually [...] older parents, who have then also fixed their career well and the men very consciously [...] take this time as well to really be at home for a longer period, also happy to engage in many activities for the child. So apart from breastfeeding, see what they can do in changing diapers, or swaying, or calm the child down when it cries.” [Gerda, German midwife, Q-171]

“Natürlich eh gibt es auch Männer, die das, die sich sehr, sehr freuen, meistens sind das eher spätere später spät wer Gebärende oder oder Eltern werdende Eltern, die ehm meistens schon so über 40 sind, die dann auch quasi auch schon ihre Karriere an der gut gebastelt haben [...] Die sich dann eher, die die Zeit dann auch nehmen und wirklich dann auch mal zuhause sind für Einen längeren Zeitraum und sich auch freuen, das g zu gestalten und auch viele Aufgaben ehm vom Kind übernehmen. Also wa außer Stillen halt, was sie eben so machen können, ja. Also vom Wickeln, oder oder Schuckeln, oder mit dem Kind eh gehen, wenn es schreit und beruhigen.“ [Gerda, German midwife, Q-171]

Q-172

“It’s very rare in my experience that someone really takes parental leave, in what I encounter. I have also worked in an [academic] institute and this was different there, because these were all scientists. They sometimes did really take a longer time, depending on how far [in their career] they were, of course not when they were in the promotion phase. [...] I also believe that within such institutes, family policies are generally promoted and family friendly, and that it’s somehow compatible, the opportunity to take at least these two months parental leave.” [Gerda, German midwife, Q-172]

“Dass jemand wirklich Elternzeit nimmt ist nach meiner Erfahrung, so was ich immer sehe, eher selten. Eh, ich habe auch als Personal im Institut gearbeitet und da war das anders. Da waren ehm also gerade Wissenschaftler oder so, die haben dann öfters auch mal wirklich längere Zeit, ja nachdem wie weit sie waren. Wenn sie in der Promotionsphase waren, dann natürlich nicht. [...] ich glaube auch das in solchen Wissen öffentlich geförderten Instituten in der Regel ehm, dass die auch, dass das so einbisschen auch gefördert wird. Also auch eine Familienpolitik oder auch eh Familienfreundliche zumindestens Politik. Und was daher auch, wenn es irgendwie vereinbar ist, eh die Möglichkeit die mindestens diese 2 Monate Elternzeit nehmen.“ [Gerda, German midwife, Q-172]

Q-173

“Here in [this city], it’s a special case: I often don’t know the men at all in [this city], [...] not at all. I don’t recognize this from [working in] Berlin. This really stood out to
me; I always observe this with great amazement. I have actually experienced that the
women came to the delivery alone, without a man. Which I find not bad in itself, you
know. [...] I think it is quite legal if a man does not attend the delivery. But the couple
needs to clarify this." [Isabella, German midwife, Q-173]

“Hier in [Stadtname] ist es eh speziell. Ich kenne hier in [Stadtname] tatsächlich
manchmal die Männer nicht. Das ehm kannte ich so aus Berlin nicht. Und das ist mir
echt aufgefallen. Fällt mir nach wie vor auf. Ehm. Sehe ich immer mit großer
Verwunderung. Aaber ... Habe es hier auch tatsächlich erlebt, dass die Frauen alleine
zur Geburt kamen, ohne Mann. Was ich an sich nicht schlecht finde, ja. [...] Ehm ich
finde es durchaus legal, wenn ein Mann nicht mit zur Geburt geht. Aber das muss das
Paar unter sich klären. [Isabella, German midwife, Q-173]

Q-174

“[In public healthcare – in these less well-off families, not working in companies and
corporations – more responsibilities connected to childcare [are] then [taken up by]
mothers for sure. Mothers, they have 100 per cent knowledge about their kid, fathers
rarely appear. But in private healthcare there is higher activity. The younger the
child, the more their fathers appear. They know how the labour has been, how much
the baby weighed, what score on Apgar scale they had, they come with their children
on their own for an appointment or even make an appointment without their kid,
because they want to talk about some topics.” [Stefana, Polish paediatrician, Q-174]

"W państwowej służbie zdrowia na pewno większość opieki widzę... w rodzinach mniej
zamożnych mimo wszystko i mniej pracujących w takich firmach i korporacjach, yyy
na pewno mątki. Mątki to jest 100% wiedzy o dziecku, ojcowie rzadko się pojawiają.
Yyy natomiast jeśli chodzi o taką prywatną służbę zdrowia już widać większą
aktywność. Im młodsze dziecko, tym ojcowie są bardziej aktywni. Wiedzą, jak
przebiegał poród, ile dziecko ważyło, jaka była punktacja w skali Apgar, przyjeżdżają
z dziećmi sami na wizytę, czy czasami się umawiają na takie wizyty sami bez dziecka
bo chcą porozmawiać na jakieś tematy." [Stefana, Polish paediatrician, Q-174]

Q-175

“I really see that fathers are much more involved in taking care of their baby. Not to
discriminate, but I’m talking about the Dutch fathers. The foreign fathers still do not
interfere with their baby at all.” [Annet, Dutch postpartum care assistant, Q-175]

"Ik zie echt dat vaders echt veel meer betrokken zijn bij de verzorging van hun kindje.
Dan heb ik het wel over de... niet om te discrimineren, maar over de Nederlandse
vaders. De buitenlandse vaders bemoeien zich überhaupt nog steeds niet met hun
baby.” [Annet, Dutch postpartum care assistant, Q-175]

Q-176

Interviewer: “Who comes here most often with the children?”
Gerhard: “Well, usually it’s of course the mother. With younger children, then it’s the
mother. Lately also more fathers, at least for the German clientele.” [Gerhard,
German paediatrician, Q-176]

Interviewer: “Wer ist denn so meistens mit den Kindern hier?”
Gerhard: “Naja, im Normalfall ist es natürlich die Mutter. Ihr kleineres Kind ... das
dann der Mutter. In letzter Zeit auch vermehrt Väter. Zumindest so von den uh
deutschen Klientel.” [Gerhard, German paediatrician, Q-176]
“So well, it varies greatly. And with immigrants, you quite often see that fathers are not present at the delivery, out of culture or religion, so well, this is of course always something to respect. But that’s always different, because they only arrive once the baby is born. And they can be very involved from a distance, you know, but on the hallway and help out with everything that happens outside [laughs]. So a partner... that’s so diverse.” [Sophie, Dutch midwife, Q-177]

“Dus.. ja, dat loopt heel erg uiteen. En met allochtonen heb je ook nog best vaak eh.. dat je tegen komt dat mannen niet bij de bevalling zijn vanuit cultuur of religie dus ja, dat is eh, ja, dat is natuurlijk altijd te respecteren... Maar dat is ook altijd weer anders, want die komen pas bij een bevalling erbij als het kindje geboren is. En die kunnen ook heel betrokken zijn op afstand, hoor, maar op de gang en met alles helpen wat daar buiten die kamer gebeurt [lacht]. Dus een partner... dat is zo verschillend.” [Sophie, Dutch midwife, Q-177]

“So well during postpartum, I leave men relatively free. [...] So when there is a moment in which they can retreat for example. [...] Basically, I let them do how they please. I don’t have... I do invite him of course, but when I have the impression he wants to be out somehow, then I think it has its reasons. For the family.” [Imke, German midwife, Q-178]

“Also in dem frischen Wochenbett ist es, so dass ich den Männern das relativ frei lasse. [...] Zum Beispiel das ein Moment ist, wo der Mann sich auch einfach mal zurückziehen kann. [...] Und ich lasse die im Grunde genommen so laufen wie die sich das wünschen. Also ich habe jetzt nicht ... Also ich lade die Männer ein, aber ich glaub .., wenn ich jetzt den Eindruck habe der ist irgendwie freiwillig auß en und gewünscht so ein bisschen außen vor, dann denke ich wird es schon auch seinen Sinn haben. Für die Familien.” [Imke, German midwife, Q-178]

“Also in the fresh postnatal period it is, so that I leave the men relatively free. [...] When there is a moment in which they can retreat, for example. [...] Basically, I let them do as they please. I don’t have... I do invite him of course, but when I have the impression he wants to be out somehow, then I think it has its reasons. For the family.” [Imke, German midwife, Q-178]

“And I hope of course that the father doesn’t completely withdraw himself, or that the one who is not staying at home withdraws, but is also there now and then.” [Torben, German paediatrician, Q-179]

“Und ich hoffe natürlich, dass es Väter sich nicht ganz entziehen, oder derjenige, der nicht zuhause ist sich ganz entzieht. Sondern auch ab und zu dafür da ist.” [Torben, German paediatrician, Q-179]

“So what’s my point, we may say that most of the fathers actually aspire to be THIS father, who’s with the baby from the very beginning and not that father who suddenly appears when they can chat, or play, or exercise with a child. Which doesn’t mean I judge negatively about fathers who keep such distance. What’s most important is that, same as being present during delivery, [...] that all what this father does may not be forced, done against him. So that the couple, the parents, both future ones and the present ones, so that they know that there is nothing worse than forcing the partner to be present during the delivery, forcing him to participate in bathing without any argument, if he declares that instead he will work, take care of the family and do other things to relieve his partner of her duties. To understand that we are not all the same. Us, women, we know it easy, cause our maternal heartiness is caused by hormones.” [Olene, Polish midwife, Q-180]
"A baby staying in a hospital, it's a different type of contact with a doctor than a baby staying, or a visit at a family doctor, or a pediatrician, for example. So there are quite a lot of these daddies there in a hospital; children experience a trauma there, so parents always try to complement each other in taking care of their child if they can. Very often mums stay overnight, yeah, but fathers also participate in it a lot." [Urszula, Polish paediatrician, Q-181]

"Więc pobyt dziecka w szpitalu jest troszkę innym: by rodzajem, by kontaktu z lekarzem niż by pobyt dziecka czy by wizyta w poradni lekarza rodzinnego na przykład czy u pediatry. By więc tam tych tatusiów jest stosunkowo dużo w szpitalu. To jest trauma: gdy dziecko zawsze, więc rodzice starają się jeśli mogą to to uzupełniać. W tej opiece, częściej jest tak, że mamy zostają na noc, tak, ale by ojców te już też w tym." [Urszula, Polish paediatrician, Q-181]

"[The roles of mothers and fathers in childcare] are different, but not by default, it depends more on the type of relationship between parents, the approach to this baby, to having a baby in general. There are fathers who care much more than mothers, there are fathers who aren't really interested, there are marriages or- or parents where neither of them is interested in a baby, there are some, most of the people, actually, that it is more or less equal: it's not really like that it's just the mother; I see that fathers are also very engaged. I don't know about later, what it looks like in later stages, because it surely changes depending on- work, and so on, but in the period we can observe them I think that in most cases, in the majority it's like equal." [Danuta, Polish paediatrician, Q-182]

"[Role matek i ojców w opiece nad dziećmi] różnią się, ale nie z założenia, tylko bardziej różnią się od tego jaki jest układ między rodzicami, jakie jest podejście do tego dziecka, do posiadania dziecka, są ojcowie którzy siedzą zdecydowanie więcej niż mamy, są tacy, którzy się nie interesują, są tacy takie małżenstwa czy- czy rodzice którzy się w ogóle dzieckiem razem nie interesują, są tacy, dużo jest takich, co tak mniej więcej po- [po równo: nie ma wcale tak że to mama, tak teraz naprawdę jakoś by, ja tak obserwuję że ojcowie są bardzo zaangażowani, nie wiem jak to później, w późniejszych tam latach, bo to pewnie na pewno też się zmienia w zależności od tego- pracy i tak dalej, mam jednak jest więcej, ale przy tym takim okresie kiedy my możemy obserwować to na pewno myślę, że w większości no w dużej mierze to jest tak że w dużej części że po równo." [Danuta, Polish paediatrician, Q-182]
Q-183

“I’m positively surprised with how many fathers take part in caregiving, and demand
ger longer visits on the ward, because fathers in our hospital were allowed half an hour.
So they themselves say that they feel they’re discriminated against. After all they are
parents too and want to stay longer. And a large number of fathers somehow
dominate, and you can see that those parents prepare a schedule: who and when, that
it’s not only the mom but also the dad and that’s great because it shows that
especially in the case of ill children who stay longer, the engagement of both parents,
even with such, it would seem, unmanly things. [...] So I think that this role, against
all appearances, I mean they complement each other, right.” [Beata, Polish
paediatrician, Q-183]

Q-184

“For those who live in the area here, every dad rather craves the baby just like the
mom does. [...] [Fathers] were outraged, when not so long ago we still had those
rules that allowed only half an hour a day for the dad. All rebelled against it, and now
we have unlimited time, so they can just exchange, and they’re happy.” [Sylwia,
Polish midwife, Q-184]

Q-185

“I expect parents to engage themselves very actively in the process of childcare,
especially during hospitalization, so they are fully prepared when we can discharge
prematurely born patients [...] I approve mutual support of spouses, especially in this
period when these children spend a couple of months at our ward; I definitely
approve this full commitment.” [Wiktor, Polish paediatrician, Q-185]

Q-186

“We often hear afterwards that parents of premature infants can’t handle the stress
and split up.” [Wiktor, Polish paediatrician, Q-186]
"że ci rodzice nie wytrzymują tego stresu i się rozchodzą." [Wiktor, Polish paediatrician, Q-186]

Q-187

"Especially in those families where the child has some hereditary risk, a neurological risk or some other diseases; well, unfortunately it quite often turns out that mothers are left on their own." [Felcia, Polish paediatrician, Q-187]

"Później jak czasami mamy taką wsteczną informację dotyczącą dalszych losów tych rodzin, no to często szczególnie w tych rodzinach gdzie dziecko było właśnie obciążone jakimś tam ryzykiem, jakichś tam na przykład neurologicznych albo jakichś innych chorób, no niestety dosyć często się okazuje, że matki zostają same." [Felcia, Polish paediatrician, Q-187]

Q-188

Interviewer: "You just said, doctor, that fathers feel discriminated when they can come only at specific hours."

Danuta: "For sure, but there is no possibility that somebody stayed here all the time, because we would just have a crowd here, not even mentioning that everyone would come to ask about something all the time, so the doctor on duty wouldn't - what actually happens a lot, unfortunately, when fathers come in the afternoon and the doctor being on call has to take care of everything and not [...] directly of every baby. " [Danuta, Polish paediatrician, Q-188]

Interviewer: "no właśnie pani doktor mówiła, że yy ojcowie się czują dyskryminowani że mają wydzielone godziny."

Danuta: " na pewno, ale też nie byłoby możliwości żeby ktoś cały czas był bo to byśmy tutaj mieli po prostu tabuny, już nie mówiąc o tym że każdy by się informował co chwilę, a też no dyżurny nie jest- co często właśnie się niestety zdarza, że ojcowie przychodzą w tych swoich godzinach po- popołudniowych a tu są lekarze dyżurni którzy zajmują się dyżurem a nie [...] bezpośrednio każdym dzieckiem." [Danuta, Polish paediatrician, Q-188]

Q-189

Interviewer: “I would also like to ask if you notice that when men and women ask questions, whether these are different questions or similar questions?”

Johan: “Not, no. Not gender specific, no I don’t think so, not about the child. The concerns are the same; the questions are mostly the same. There are also often fathers coming along with an acute ill child, yes.” [Johan, German paediatrician, Q-189]

Interviewerin: “Ich würde nochmal gerne fragen, ob Sie denn feststellen, wenn Fragen kommen von Frauen und Männern, ob das unterschiedliche Fragen sind, oder ob die doch ziemlich dieselben Fragen haben?

Johan: Nicht, ne. Nicht Geschlechterspezifisch. Ne, also denke ich nicht. Nicht um das Kind herum, ne. Also die Sorgen sind die gleichen. Die Fragen sind meist die gleichen. Es kommen auch oft Väter, akut mit dem kranken Kind, ja.” [Johan, German paediatrician, Q-189]

Q-190

“The moment someone enters with a medical problem, he just wants to be helped and it actually doesn’t matter that much what culture you have in front of you. [...] As a general practitioner, I for instance visited a family once where I really didn’t speak the language and they didn’t speak Dutch, and there were ten family members
standing around a man who didn’t feel well. And purely based on sight, I thought: I think he’s having a heart attack. And someone could translate a few things, so I ordered an ambulance and let him be taken away, and afterwards they thought the world of me. [...] But in prevention, this is actually a bit different. [...] When you want to gain respect from a culture, you really should know much more about the background, because you can’t prove yourself with [medical interventions].” [Ellen, Dutch paediatrician, Q-190]

“Op het moment dat iemand voor een medisch probleem komt, dan wil die gewoon daarvoor geholpen worden en het maakt eigenlijk niet zo heel veel uit welke cultuur je dan voor je hebt. [...] Ik kwam bijvoorbeeld als huisarts een keer binnen bij een gezin waar ik de taal echt niet sprak en zij ook geen Nederlands. En, er waren tien gezinsleden stonden er om een man heen die zich niet goed voelde. En puur op basis van uiterlijk heb ik toen gedacht van: volgens mij heeft ie een hartaanval. En één iemand kon een paar dingetjes vertalen. Dus ik heb gewoon een ambulance laten komen en hem weg laten gaan en ik werd daarna op handen gedragen. [...] Maar in preventie ligt dat toch net een beetje anders. [...] Als je hier gewoon respect wilt krijgen van die cultuur, dan zul je toch veel meer van de achtergrond moeten weten, omdat je je niet zo kan bewijzen als.. [met medische acties]” [Ellen, Dutch paediatrician, Q-190]

Q-191

“And then they get a baby and it’s, wow, really a baby. Because well, it cries and you can’t go away and you suddenly can’t go out. [...] But I also find that important, that they know after eight days, that it’s not just ‘how do you change a diaper?’ but also ‘how do you deal with a little baby?’” [Annet, Dutch postpartum care assistant, Q-191]

“En dan krijgen ze zo’n baby en dan: wow, ja, dan is het echt zo’n baby. Want.. ja, die huilt en je kan opeens niet meer weg en ja kan opeens niet uit. [...] Maar dat is, dat vind ik ook belangrijk ook dat ze dat ook weten na acht dagen. Het is niet alleen van, hoe doe je een schone luier om? Maar ook: hoe ga je om met je baby’tje?” [Annet, Dutch postpartum care assistant, Q-191]

Q-192

“I [...] see this in these postpartum families; they are just scared stiff, by such a baby. [...] I actually throw them in the deep right away; I’m not doing the first bath alone, no: ‘you are doing the bath, I’m standing next to you.’ I try to provide them with self-confidence very soon, because they usually just find it very scary, such a tiny baby; afraid that it might break, being concerned about all sorts of things. And you do see that when you put them to work immediately – as far as possible, right, it depends of course on the extent to which they are restricted by… when the postpartum woman can’t do it; I immediately put the postpartum man to work. And you are steering from the background. So that after a few days, they feel like: I dare to do almost everything by myself, I’m not afraid to do it on my own later on. That’s my aim actually.” [Idellette, Dutch postpartum care assistant, Q-192]

“En dat zie ik ook in die kraamgezinnen, dat ze dan, dan.. ze schrikken zich gewoon rot. Van zo’n kindje.(...) wat ik vooral probeer is het zelfvertrouwen te geven dat ze het allemaal ook eh alleen durven als jij er niet meer bent. Ik ben niet een kraamverzorgster die eh, de eerste dagen alles zelf doet. Ik (...) gooi ze eigenlijk meteen al een beetje in het diepe hè, van eh niet, ik doe niet eerst het badje alleen, nee eh jij doet het badje, ik sta, ik sta ernaast. Ik probeer ze al heel gauw eh, het zelfvertrouwen te geven.. want ze vinden het vaak gewoon heel eng, zo’n klein kindje..
Bang dat het breekt en eh zich zorgen maken over van alles en nog wat. En dan zie je toch eh, als je ze meteen zelf aan de slag zet, in zover als het kan hé, het hangt natuurlijk af in hoeverre ze beperkt zijn, door....., als de kraamvrouw het niet kan, dan zet ik meteen de kraamheer aan het werk. En dat je dan toch eh, sturend op de achtergrond er bent. En dat ze dan ook echt na een paar dagen zoiets hebben van: oh, nu durf ik het bijna allemaal zelf, en eh, ja, nu vind ik het ook niet meer eng als ik straks eh er alleen voor sta. Dat is een beetje m’n doel eigenlijk.” [Idelette, Dutch postpartum care assistant, Q-192]

Q-193
“I want them both to be equally concerned with the child. And I teach them both how to care; I want the father to do it as well. And afterwards they can choose how they’ll be dividing it. I don’t interfere with that. [...] [But] I try to pass on to them of course that it’s convenient when you keep doing it both.” [Idelette, Dutch maternity assistant, Q-193]

“Ik wil dat ze allebei even betrokken zijn bij het kindje. En eh, ik leer ze ook allebei de zorg, ik wil ook dat die vader het ook eh, doet. En eh, daarna moeten ze zelf kiezen hoe ze het gaan verdelen, hoor, bemoei ik me verder niet mee. Maar ik wil wel dat ze de basis allebei zelf eh kunnen. En ik probeer ze natuurlijk wel een beetje mee te geven dat het handig is als je dat allebei blijft doen.” [Idelette, Dutch maternity assistant, Q-193]

Q-194
“My latest family [...] chose not to give a pacifier, that’s fine, it’s their good right. But the mother was full with milk and the baby had its belly full, but she wasn’t satisfied. [...] So you can’t solve that. [...] The mother needs to sleep. So who should do it? The father. [...] I say: ‘the little one has a major need to suck and your breasts are so full that she is full with three big swallows, but she does want to suck.’ So I explained to the father: ‘you need to wash your hands thoroughly and you need to go sit with your child’. And he was like: ok, so I have to do that? I say: ‘yes, you have to do that’. And then it’s fine and eventually he is doing it, and he actually likes it, you know. [...] It’s not the case that I think the mother should do everything: the father should do it just as well.” [Sandra, Dutch postpartum care assistant, Q-194]

“My laatste gezin [...] kozen ervoor om geen fopspeen te geven. Nou, dat is – dat is hun goed recht. Maar omdat die moeder zo vol zat met melk, was het kind dus uiteindelijk... buikje vol, maar nog niet verzadigd. Ja, oké, dat kan je niet oplossen. [...] Maar die moeder moet wel slapen. Dus wie moet het dan doen? De vader: [...] Ik zeg “Deze kleine heeft ontzettend veel zuigbehoeftje” [en] omdat je borsten zo vol zitten, zij neemt drie grote slokken en d’r buikje zit vol, maar ze wil nog wel sabbelen.” Dus die vader uitgelegd, ik zeg “Ja, dan moet je even goed je handen wassen”, ik zeg “En dan moet jij gaan zitten met je kind.” En dat ie echt dacht van “Oké... En dat moet ik dan gaan doen?” Ik zeg “Ja”, ik zeg “Dat moet jij dan gaan doen.” En ja, dat is dan prima en dan uiteindelijk doet ie dat ook wel. En uiteindelijk vindt ie het dan nog leuk ook, weet je wel. [...] Het is niet zo dat ik alleen maar denk dat een moeder dat allemaal moet doen; dat moet die vader net zo goed doen” [Sandra, Dutch postpartum care assistant, Q-194]

Q-195
“When a father says: ‘I’m not going to do that’, I say: ‘but it is also your baby, right?’” Or when a mother says: ‘it needs to wear this today’, I say: ‘today it’s daddy’s day, so daddy can choose which clothes the baby will wear.” [Leen, Dutch maternity care assistant, Q-195]
“Als de vader roept van “Ja, dat doe ik niet hoor”, ik zeg “Ja, maar het is toch ook jouw kindje?” Of als de moeder zegt van “Nee, dat pakje moet het aan”, ik zeg “Ja, maar het is nu vandaag een papa-dag. Dan mag papa uitkiezen welk pakje dat ze aan mag” [Leen, Dutch maternity care assistant, Q-195]

Q-196

Imke: “Because women get to know me better, they also often report problems. […] My impression is that the earlier you get to know the people in their pregnancy, the longer the contact remains afterwards.”

Interviewer: “Does this mean that a very close trust relationships develops?”

Imke: “Frequently, yes. […] It’s of course the case that I’m working here for a couple of years already. At least half – if not more – of the women who already have children also gave birth to them with me. I have guided them. I know the men. And then they are honestly not interested in a first consultation in pregnancy. So they are […] then going to work and so on and that’s also what the women find primarily important.”

[Imke, German midwife, Q-196]

Imke: “Und dadurch dass die Frauen mich besser kennen nehmen die das auch öfter in Anspruch sich auch bei Problemen zu melden. […] Und, das hat sich eigentlich bewährt und mein Eindruck ist: Je früher man die Leute in der Schwangerschaft kennen lernt, umso länger bleibt der Kontakt auch im Nachhinein bestehen.

Interviewerin: Also das heißt dann ja, dass sich da so ein sehr enges Vertrauensverhältnis entwickelt?

Imke: Häufig ja. […]Beziehungsweise ist es so, dass natürlich, dass ich hier jetzt ja schon ein paar Jahre arbeite, habe ich auch mindestens die Hälfte, wenn nicht noch mehr der Frauen haben schon Kinder. Auch mit mir dann zusammen gekriegt und ich habe die betreut. Das heißt ich kenne die Männer. Und die sind dann an einem Erstgespräch in der Schwangerschaft ehrlich gesagt auch nicht mehr so interessiert. Also die... gehen sind dann arbeiten und so weiter und das ist ja auch für die Frauen so primär so wichtig.” [Imke, German midwife, Q-196]

Q-197

“I though lately: I need to mind that. When the baby is bathed, we always do it the first time, that’s how we’ve learned it. This is so standard. And last time, this man said, ‘yes, but I actually wanted to do the first bath’. And I thought: yes, of course. So now I ask sometimes: ‘or would you prefer yourself to….?’ We have learned that: we show this and that first. But of course, I can imagine you want to do it yourself the first time. These are the things; you keep learning everyday.” [Evelien, Dutch postpartum care assistant, Q-197]

“Dat was ook vorige keer, dat ik dacht: daar moet ik ook op letten. Wij doen altijd, zo hebben we dat geleerd, dat als de baby d’r is en het gaat voor het eerst in het badje, dat doen wij altijd, als eerste het badje. Dat is zo standaard. En de vorige keer zei die man ‘Ja maar’ – later, zei die ‘Ik had eigenlijk zelf als eerste het badje willen doen.’ Toen dacht ik: oh ja, natuurlijk. Dus nu vraag ik ook eens “Of wil je misschien liever...” ‘è. Van ja, weet je, dan hebben we het zo geleerd, zo van: dan laten we het zien en dit en dat. Maar natuurlijk, ik kan me inderdaad voorstellen dat je dat zelf als eerste wil doen. Dus dan denk je: oh, dat moet ik ook maar weer opslaan. Weet je, dat zijn de dingen, je blijft elke dag - elke dag leren.” [Evelien, Dutch postpartum care assistant, Q-197]
“The father sometimes feels uncomfortable [about the baby on his naked chest] – when we are there, is my experience: ‘[…] yes, I will do that to-, can I do that tonight?’ I say: ‘yes, tonight is also okay’. You know, because you can just tell that he’s thinking: ‘Then I should sit her presumably on my naked chest, with the postpartum care assistant present?’ […] And you know: talking to the child when you dress it [we tell them]: do let your voice be heard. […] [And] mother does indeed feel like [talking]: ‘well, mommy is going to…’ But such a father thinks: ‘is she also thinking: ‘Then I should sit her presumably in my naked chest, with the postpartum care assistant present?’ […] And you know: talking to the child when you dress it [we tell them]: do let your voice be heard. […] [And] mother does indeed feel like talking: ‘ […] And you can do that tonight?’ I say: ‘yes, tonight is also okay’. You know, because you can just tell that he’s thinking: ‘Then I should sit her presumably in my naked chest, with the postpartum care assistant present?’ […] And then I say at a given moment […]: ‘just pretend I’m not here, I’m going to stand over here.’ […] And you do listen of course. And THEN you hear [him] saying: ‘daddy going to take your dirty diaper off’, you know. But when you’re standing right there, it’s often more difficult with fathers [laughs]. That’s funny. With a few exceptions of course right, because you always got them.” [Sandra, Dutch postpartum care assistant, Q-198]


“En zo bij Marokkaanse gezinnen, daar zag ik laatst – zei ik nog tegen [een collega] – ik zeg: goh, die waren nou… Dat was echt een eenheid, een man en een vrouw. Marokkaans gezin. Zie je niet zo heel veel, is toch altijd een beetje die – die afstand houden ze toch een beetje. […] Maar echt maatjes.” [Evelien, Dutch maternity care assistant, Q-199]

“I happen to have been three times in a row with families from Iraq […] , but well, I mean, when you see this: there is again also just difference. […] Because when I look at the first family: I came in and the father opened the door, and it was really like: he looked angry at me. […] Well, the mother was upstairs and then- well you don’t understand anything of the situation. […] You know, and the next day, I came and [we were] talking, and at a certain moment […] she is telling me about the situation. And then it appears that the father… is the father of the third child, but in the end has another home in [a different city] and has a girlfriend there. And how much grief comes up then. […] And you’re thinking: yes, what- what are we going to do about this? […] Because the women was so very neat in her house, everything spic and span, and two very nice little boys […] everything very cozy, but well, the father was nowhere to be found. But I didn’t want her to be alone at night. So you’re going to
look for: what’s going on? Well, and he comes and I say: ‘are you here or are you not here?’ Yes, he is here at night. And later on I thought: ‘wait a minute, at night, but I’m here at 8 in the morning: where are you then?’ Because he didn’t work. Well and then finally, he was indeed in the next room. Because you know, when something happens with such a mother; two little boys, they really can’t do anything you know. I’m like: not a thing should happen with such a woman.” [Sandra, Dutch postpartum care assistant, Q-200]

“Ik heb drie keer toevallig drie keer na elkaar bij een gezin uit Iraak gezeten […] maar ja, ik bedoel, als je dat zo ziet, ook daar zit dan weer gewoon verschil in. […] Want als ik dan naar het eerste gezin keek, ik kwam daar binnen en die vader deed open, en het was echt dat ik dacht… “Oké…” hij keek me heel boos aan. […] Nou, toen was de moeder, was dan boven. En dan – ja, dan snap je helemaal niks van de situatie. […] Weet je, en dan de volgende dag kwam ik, nou, en toen was het praten, en dan ging ze op een gegeven moment […] gaat ze me vertellen van de situatie. Nou, en dan blijkt het dus dat vader… de vader is van het derde kindje, maar uiteindelijk nog in [een andere stad] in een ander huis woont en daar een vriendin heeft. Nou ja, weet je hoeveel verdriet daar dan naar boven komt. […] En dan denk je ja, wat – wat doen we daarmee? […] Want die vrouw was zo keurig netjes in d’r huis, alles spic en span, en twee hele leuke jochies […] allemaal hartstikke gezellig, maar ja, die vader die was in geen velden of wegen te bekennen. Maar ik wilde niet dat zij ’s nachts alleen was. Dus dan moet je dat toch weer gaan – gaan zoeken van: hoe zit dat? Nou, dat hij dan komt en zegt… ik zeg “Ben je wel hier of ben je niet hier?” “Ja hij is hij is wel ’s nachts hier.” Ja, toen op een gegeven moment dacht ik: ja, wacht effe, ’s nachts, maar ik sta hier ’s morgens al om 8 uur. Waar ben je dan? Want hij werkte niet, nou, en uiteindelijk inderdaad in de ochtend toen was ie dan in de kamer ernaast. Ja, want weet je, als er toch wat is met zo’n moeder. Twee kleine jochies, die kunnen echt helemaal niks beginnen hoor. Ik denk: d’r moet toch niks gebeuren met zo’n mevrouw.” [Sandra, Dutch postpartum care assistant, Q-200]

Q-201
“This woman was […] diagnosed with a mental illness […] and ran away from home at night. […] And I thought: I don’t know anything about this father. I had no clue whether he also had a history of mental illness, […] So in the end I decided: to place the child out of its home, because I also don’t know whether the child is safe with him. And this is actually striking; with that mother you’re very much occupied with screening all sorts of things […] but you actually know very little about those fathers.” [Hester, Dutch midwife, Q-201]

“Die mevrouw die was […] een psychiatrische stoornis was bij haar gediagnosticeerd. […] [en ze] loopt midden in de nacht weg van huis en denk ik: ik weet helemaal niks van die vader. Ik had geen idee of hij ook een psychiatrische voorgeschiedenis had. […] Waarop ik uiteindelijk dacht… ja, dan het kind toch maar uit huis halen, want ik weet ook niet of dat kind bij hem wel veilig is. En dat is eigenlijk wel heel opvallend, dat je van die moeder… ben je heel erg bezig met allerlei dingen screenen […] maar eigenlijk weet je, van die vaders weet je heel weinig.” [Hester, Dutch midwife, Q-201]

Q-202
“I think it varies […] very much how the postpartum care assistant deals with [fathers]. And I think the postpartum care assistant can involve men much more in relation to the degree that she finds this important. So the one emphasizes this more than the other. You know, the one creates a bit of a women’s sphere in such a postpartum period, in which the postpartum care assistant and the woman do a lot together, and the other involves the man much more in this. And finds it much more important like: ‘you have to do it as a family eventually, and… move onwards’. […] There are postpartum care assistants who send
men outdoors three times a day to go for groceries again, and there are also postpartum care assistants saying: ‘you know, I’m going for the groceries and you lie down in bed with the three of you’. Or: ‘you lie down with your child on your naked chest and... experience what this feels like... and build that bond with your child’. [Hester, Dutch midwife, Q-202]

‘Het verschilt [...] denk ik heel erg.. hoe de kraamzorg [met vaders] om gaat. En ik denk dat de kraamverzorgster ook wel.. mannen er veel meer bij kan betrekken naar gelang hoe belangrijk zij dat vindt. Dus de één legt daar mee de nadruk op.. dan de ander. Weet je, de één creëert ook een beetje een soort van vrouwenfeertje in zo’n kraamweek, eh.. waarbij de kraamverzorgster en de.. en de kraamvrouw heel veel samen doen en de ander betrekt daar juist veel meer een man bij. En die vindt het veel belangrijker van: ja, jullie moeten als gezin het uiteindel... door. (…) Er zijn wel kraamverzorgsters die.. die mannen eh, drie keer per dag de deur uit sturen om nog een keer boodschappen te gaan doen en er zijn eh, kraamverzorgsters die zeggen ‘nou, weet je, ik doe lekker boodschappen en gaan jullie nou eens lekker met z’n drietjes in bed liggen’, of ‘ga jij nou eens even liggen met je kind op je blote buik en.. eens even ervaren hoe dat is... en die band opbouwen met een kind.’ [Hester, Dutch midwife, Q-202]

Q-203

“We are after all a centre, I mean in neonatology there are centres of three levels of care and ours is of the highest referral level, we have the biggest pathology, the most severe patients. [...] I guess each ward has its own, I think even we do, [...] we work in a slightly different way than others in the same hospital, so on each ward there are some differences.” [Felcia, Polish paediatrician, Q-203]

“’My jesteśmy środkiem jednak, no w neonatologii są ośrodki trzech referencyjności i my jesteśmy najwyższym stopniem referencyjności, mamy największą patologię , zbieramy z całego regionu, najcięższych pacjentów, najcięższe przypadki [...] Myślę że każdy oddział ma swoje, u nas myślę że nawet, my mamy różne, trochę inaczej pracujemy niż obok w tym samym szpitalu także każdy oddział jest tam jakieś różnice..’” [Felcia, Polish paediatrician, Q-203]

Q-204

“It’s like this in Poland that each clinic, each professor, has some different style and different way of thinking.” [Stefana, Polish paediatrician, Q-204]

“’nadal w Polsce jest tak, że co klinika, co profesor, to są troszeczkę inaczej, ktoś myśli inaczej.’” [Stefana, Polish paediatrician, Q-204]

Q-205

“Here, fathers perform kangarooing. [...] This creation of a parenting bond, well it has to happen without this sort of- without this lactation element.” [Wiktor, Polish paediatrician, Q-205]

”także tutaj mm ojcowie robią kangurowanie. [...]no i tutaj ojcowie mają trochę trudniej bo to budowanie więzi rodzicielskiej no musi się odbyć : jakby bez- bez tej laktacji bez tego elementu.” [Wiktor, Polish paediatrician, Q-205]

Q-206

”I’ve had men's literature as well [in the waiting room] from the start. So I’ve been riding motorcycles and therefore had motorcycling magazines and things like that, and The Economist and those sorts of magazines. Yes, and that was very, very interesting, and we have validated this as well, and consequently they also noticed they were being addressed, right?” [Marianne, German paediatrician, Q-206]
"Ich habe von Anfang an äh Männerliteratur auch gehabt, also ich habe [...] selber Motorrad gefahren und hatte dann so Motorrad- Zeitschriften und solche Sachen. Und Kapital und irgendwie so eher so Zeitschriften, die sich so an Männer gerichtet haben, ja. Und das war ganz, ganz interessant und das haben wir dann auch goutiert, also sie merkten sie wurden dann angesprochen auch, ne?" [Marianne, German paediatrician, Q-206]

Q-207

"What has also changed quite strongly is that they just all come, right. This used to be not the case. Before, it used to be common for families with a migration background and a relatively low social status that they came until [examination] U7, so the children were two years [old]. At three years, there were then no more examinations. [...] And that’s different now; they have to come, right, because otherwise they would get a visit from the Youth Office." [Marianne, German paediatrician, Q-207]

Also ganz stark hat sich verändert, dass sie eben alle kommen, ne. Das war vorher nicht so. Vorher war es vor allen Dingen in den Familien mit Migrationshintergrund und relativ niedrigem sozialen Status so, dass die in der Regel so bis zu U7 kamen, also bis die Kinder zwei Jahre waren, mit drei Jahren gab es damals noch keine Vorsorge; [...] und jetzt ist es anders; sie müssen kommen, ne. Weil sie sonst eben Besuch vom Jugendamt kriegen." [Marianne, German paediatrician, Q-207]

Q-208

"Parents with a second-generation migrant background [...] who want a better future for their children, so they have high expectations and demands from their children, often ask me for advice. [...] I have lived in Africa for a long time at different ages, as a child and later also as young person or young adult, and that creates I think above all for the children for people from Africa, but partly also from France – because [...] I am bilingual [...] – so it creates a basis for trust, that they then come and discuss such questions with me and ask how they should proceed. " [Marianne, German paediatrician, Q-208]

"Eltern mit Migrationshintergrund der zweiten Generation, [...] die für ihre Kinder eine bessere Zukunft wollen, die also GANZ HOHE Erwartungen und Anforderungen für Ihre Kinder haben und mich da dann häufig um Rat fragen. [...] Ich habe längere Zeit in Afrika gelebt in verschiedenen Alterszeiten auch, als Kind und später auch als Jugendliche und oder junge Erwachsene und das schafft glaube ich vor allen Dingen für die Kinder für die Menschen aus Afrika, aber auch teilweise auch aus Frankreich, weil ich da die Sprache dann eben weil ich bilingual bin an der Stelle, schafft das so eine Vertrauensbasis, dass sie dann kommen und solche Fragen mit mir diskutieren und fragen, wie sie weiter vorgehen sollen." [Marianne, German paediatrician, Q-208]

Q-209

"In other cultures, it’s the case that fathers simply want to be left alone, and do not have much questions at all, or just want to have a rough estimate: ‘is it dangerous or not dangerous?’ And the mothers are mainly the ones, and apparently also the - let’s say - the driving force in this, who the child always faces." [Marianne, German paediatrician, Q-209]

"Und in anderen Kulturkreisen ähm ist es so, dass ähm zum Teil Väter einfach weitgehend in Ruhe gelassen werden wollen, und gar nicht viel Fragen haben, oder nur ganz knapp eine grobe Einschätzung haben wollen - ist es jetzt gefährlich oder nicht gefährlich äh und die Mütter eigentlich hauptsächlich diejenigen sind, und offenbar auch die - sagen wir mal"
Q-210
Leen: “An Arabic man, or a Muslim man, will not easily take a child naked on [his skin]. No, he actually prefers to be away for the whole day. That’s not- it’s a women’s thing, right.”
Interviewer: “But what’s your role in this? Do you have a role in this?”
Leen: “To involve him anyway. Yes, and still you know, today again, that man was at home for a moment, done groceries, and sat on the couch, and the baby comes downstairs to drink, from the mother’s breast. Well: give it to daddy. I said: ‘can you hold him for a moment?’ [Laughs] ‘I’ll make some tea’. Or something, you know. Right on, no discussion, just in his arms. And I bring it with a smile, but in the end, the baby does lie in their arms and these daddies light up even so. They don’t dare to; daddy shouldn’t ask, I don’t know.” [Leen, Dutch postpartum care assistant, Q 210]

Leen: “Een Arabische man of een moslimman, zal niet gauw een kind bloot op zich nemen. Nee, die is het liefst eigenlijk de hele dag weg. Dat is niet – een vrouwending hè.”
Interviewer: “Maar wat is jouw rol daar dan in? Heb jij daar een rol in?”
Leen: “Om hem d’r toch bij te betrekken. Ja. en toch hè, nu ook vandaag weer, die man die was eventjes thuis, boodschappen doen, en die zat op de bank, en de baby komt naar beneden om te drinken, bij de moeder aan de borst. “Nou, geef ‘m maar aan papa.” Ik zeg “Uh, kan jij ‘m even vasthouden.” [lacht] “Kan ik even thee zetten.” Zo iets, weet je wel. Hupakee, geen discussie, gewoon in zijn armen. En dat breng ik dan wel met een lach, maar uiteindelijk ligt die baby toch in hun armen en dan stralen die papa’s toch. Ze durven het zelf niet, papa hoeft niet te vragen, ik weet het niet.” [Leen, Dutch postpartum care assistant, Q 210]

Q-211
“Sometimes also in the relationship, you know. You should not interfere, but sometimes you are able to give this hint to that man. Recently, I received a very sweet letter of a man, also a foreign family. A girl of about 8 years [old] and then a baby. Well, the 8-year-old girl was of course very disappointed, because what can you do with a baby? You can’t play with it, mommy was dealing with the baby all day, and she withdrew to her room, didn’t want to come with the bathing. And that man was at home. [I said] to the man: ‘You know what you should do in the afternoon? You should take your bike and your daughter takes her bike and you go to McDonald’s to have an ice cream.’ The weather was great. ‘You’ll go cycling together for a while.’ Well, and then from this foreign mister you receive a beautiful letter how much he has appreciated that. At that moment, his eyes were opened. Like: ‘I have to give my daughter attention. When I don’t, I’ll just loose her.’ Yes, and really months later, he wrote this letter.” [Leen, Dutch postpartum care assistant, Q-211]

“Tussen de relatie ook wel eens hè. Je mag je er dan niet mee bemoeien, maar soms kan je toch net eventjes een hint geven aan die man. Pas een hele lieve brief teruggekregen, was ook een buitenlands gezin. Was een meisje van een jaar of 8 en toen een baby. Nou, dat meisje van een jaar of 8 was natuurlijk zo teelurgesteld, want wat heb je nou aan een baby, je kan er niet mee spelen, niks, mama was de hele dag maar met die baby bezig, en zij trok zich terug op de kamer, wilde ook niet bij het badje komen kijken. En die man die was thuis. Tegen die man van “Weet je wat jij vanmiddag moet doen? Jij moet vanmiddag je fiets pakken en je dochter pakt de fiets, en dan ga je naar McDonald’s even lekker een ijsje halen.” Het was prachtig weer. “Dan gaan jullie lekker samen een stukje fietsen.” Nou, en dan van een buitenlandse meneer krijg je een prachtige brief dat ie dat zo gewaardeerd heeft. Toen zijn zijn ogen opengegaan, van “He, ik moet mijn oudste dochter aandacht geven. Als ik dat niet doe dan verlies ik haar gewoon”, hè, met aandacht. Ja, en
echt, maanden daarna, na de kraamtijd, schreef die brief.” [Leen, Dutch postpartum care assistant, Q-211]
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Summary

This dissertation examines the increased public interest in mothers’ and fathers’ parenting roles over the course of childbirth and early childcare, and parents’ and children’s life course development as the (anticipated) result of this. In chapter 1, three rather separate scientific conversations are integrated, framing concerns about a) child development in relation to parents’, and in particular mothers’, performances, b) the (lack of) facilitation of work-family balances through varying family policies and c) gender inequality as a result of gendered parenting and work practices. The main contributions of this dissertation are:

1. that these concerns are studied by looking not just at family policy institutions but also at healthcare institutions and the extent to which concerns about children’s, mothers’ and fathers’ roles and futures are interrelated or conflicting
2. a cross-national comparison between the Netherlands, Germany and Poland to detect and deconstruct variety and similarity in these contexts and institutions, and
3. employing a multi-level approach focused on macro-level policies on the one hand and situated micro-level interactions between healthcare professionals and families in which policies are enacted on the other hand.

The focus in this study is first on gender, as a social structure embedded in institutional and interactional levels of society, in which specific roles for mothers and fathers are produced, reproduced and changed, and second on perceptions of risk, implying that particular events are approached and prioritized as adverse outcomes in need of avoidance, for some groups rather than for others.

On the macro-level, this dissertation studies risk perspectives in cross-nationally and cross-professionally varying institutions, as formal and informal webs of interrelated norms, reflected and shaped in context-specific historical trajectories, healthcare and family policies, and cultural norms about gender and parenting roles in the Netherlands, Germany and Poland. On the micro-level, it interrogates professionals’ perceptions and professional-family interactions within these countries, in which
professionals’ situated experiences and stereotypical forms of knowledge are shaped and contested in professional-family relationships. These relationships and intensities of knowing families can, influenced by professionals’ (policy informed) positions, be more intimate or more distant, as structured through factors of gender and social class. The overarching research question of my study is:

*How do healthcare and family policy institutions and professional-family interactions in the Netherlands, Germany and Poland culturally construct risk and responsibility in anticipating and valuing particular consequences for children and parents, and how does this contribute to the reproduction and shaping of mothers’ and fathers’ gendered parenting roles?*

In **chapter 2**, this dissertation is embedded in sociological theory about the interplay between institutional contexts and the sense-making processes of social actors to give meaning to the world around them, particularly regarding gender roles, risk perceptions and understandings of family life and work. I draw on the work of Alfred Schutz (1972) who offers a framework to examine how motivational and interactive processes contribute to, and are shaped by, wider social structures, and thus how the meaning of social phenomena can be unpacked by studying the intended meaning of human acts and interactions on the micro-level. Likewise, Mary Douglas (1986, p.45) encourages us to approach individual minds as “society writ small” and therefore to study both culturally varying institutions and situated interactions, which is according to Barbara Risman (1987) especially salient in the case of structures and experiences related to gender and parenting.

In my research, institutions such as healthcare and family policies are therefore studied and deconstructed in relation to the underlying cultural perceptions of what is seen as dangerous and in need of protection and what risks and responsibilities are depicted in varying contexts (Douglas 1966; 1992; Boholm and Corvellec 2011). More particularly, I focus on the (gendered) categories and forms of social grouping on which these institutions are based, as well as how this translates into notions of sameness and difference, normality and pathology, safety and danger (Douglas 1986; 2013 [2008]; Harrits and Møller 2011), and how this is formulated by centres of knowledge and governance (Foucault 1992; Rose and Miller 1992).
In the phenomenological part of my research, namely the study of how these risk perceptions and categories are on the ‘street-level’ (Lipsky 1980) enacted by professionals interacting with families, the theoretical focus is on understanding how professionals use their ‘discretionary space’ (Lipsky 1980; Freidson 2001; Duyvendak et al. 2006) to apply categories (Harrits and Møller 2011) and get to know risk in individual cases (Heyman et al. 2013), thereby also using tacit forms of knowledge to form trust (Zinn 2008) and have favourable expectations despite of incomplete knowledge (Möllering 2001; Brown et al. 2009). These interactional dynamics are in this thesis understood first in relation to intensities of knowing others, resulting either in having detailed knowledge, mutuality and familiarity in ‘we-relationships’ or in more remoteness and reliance on stereotypical knowledge in ‘they-relationships’ (Schutz 1972, p.163-187). Second, these intensities of knowing and trust are understood within the broader social and institutional contexts that influence professionals’ positions to and knowledge of particular parents, especially in relation to dimensions of gender and social class.

In chapter 3, I describe the methodological approach, research design, data sample, collection and analysis and ethical considerations of this research, as well as how I position my research within the wider sociological field. My study concerns a cross-national comparative (Jørgensen 2015) focused ethnography (Hammersley and Atkinson 2007) performed at multiple sites within healthcare contexts spread over different countries (Clerke and Hopwood 2014). Hence, the type of ethnography I employ in this study deals with distinct problems in specific contexts, while the research is conducted in highly specialized fields (Knoblauch 2005; Wall 2015) of pre- and postnatal healthcare.

The focus is on participants’ “common behaviours and shared experiences, based on the assumption that the participants share a cultural perspective” with other participants in the same context (Wall 2014, 3). The study is designed to get an understanding of healthcare professionals’ views, practices and knowledge construction (Bogner and Menz 2009), while they interact with (expecting) families at different time points over the course of pregnancy, childbirth and early childcare within cross-nationally and cross-professionally different contexts. Taking an ethnographic, constructivist and interpretative phenomenological approach to
knowledge construction means that knowledge is derived from sense-making processes and interpretations of everyday life and interactions (Hammersley and Atkinson 2007), with an interest in how professionals, as social actors, are influenced by the (sub) cultures in which they live (Harrits 2016). To make sense of constructions of risk and trust in pre-and postnatal healthcare and family policy institutions, and in professional-family interactions, I combine data sources of in-depth semi-structured interviews, participant observations (Hammersley and Atkinson 2007) and policy documents (Fairclough 2004; Hajer 2005; Yanow 1999; 2014).

The sites which are chosen for this research concern (three urban areas in) the Netherlands, Germany and Poland. The data consists of in-depth interviews with pre- and postnatal healthcare professionals (n=53; 23 in the Netherlands, 12 in Germany and 18 in Poland), participant observations (61 in the Netherlands, 55 in Germany and an ethnographic visit next to hospital observations during the interviews in Poland) and policy documents of midwifery, postpartum care, child healthcare and family policies. Pre- and postnatal healthcare professionals who had repeated institutionalized contact with parents over the course of pregnancy, childbirth and early childcare were purposively selected for this study, which were: midwives (5 in the Netherlands; 7 in Germany; 9 in Poland), postpartum care assistants (5 in the Netherlands, where part of the midwife’s tasks are delegated to postpartum care assistants), paediatricians (5 in the Netherlands, 5 in Germany, 9 in Poland) and nurses (5 in the Netherlands, where paediatricians share and alternate responsibilities with nurses).

An affiliated German and Polish researcher have been recruited to gather the German and the Polish data. The interviews were performed in the original language, recorded with informed consent, transcribed, translated and anonymized (Hammersley and Atkinson 2007) and all the participant observations were afterwards typed out into detail as field notes (Clifford 1990). Working with primary and secondary data has several challenges, which I dealt with through basing the complete data set on the same research design, research questions and interview questions and through collaborating closely with the other researchers, as colleagues, over the entire process of fieldwork preparation, data collection, data translation and data analysis which has
helped to prevent the loss of meaning due to language differences (Temple, Edwards and Alexander 2006).

A ‘within-case’ and ‘cross-case’ (Miles, Huberman and Saldana 2013, p.100) ‘thematic analysis’ has been employed by means of encoding qualitative information in order to detect ‘themes’ within the data set, as underlying patterns that organize the various observations (Boyatzis 1998). The policy documents, interview transcripts and extensive field notes from observations were analyzed for all countries and cases separately and later comparatively through open, constant comparison, using an ‘iterative-inductive’ and ‘abductive approach’ rooted in grounded theory (Tavory and Timmermans 2009).

In chapter 4, I present the results of the policy and document analysis and show that a deconstruction of macro level institutions of obstetric care (OC), child healthcare (CHC) and family policies in the Netherlands, Germany and Poland sheds light on how ‘risk objects’, potentially posing a threat, and ‘objects at risk’, potentially being in danger from this threat (Boholm and Corvellec 2011) are culturally constructed (Douglas 1992) in relation to pregnancy, childbirth and early childcare. In general, an increasing focus on ‘risk objects’ and ‘objects at risk’ in (and following) childbirth was detected in all three countries and within the various policies (see also Rothstein 2006). However, the kinds of risks represented within policies and the contradictory ways in which these risk constructions played out were context-specific.

*Risk constructions in OC*

Variation was found in the framing of pregnancy, childbirth and early childcare as ‘pathology’ (in German and Polish policies), and thereby as risk object, or as ‘physiology’ (in the Netherlands) thereby reflecting lower levels of risk per se, while ‘risk selection’ and mothers’ influence on decision-making became highly salient in the Dutch OC context. Variation was also shown in terms of strategies and responsibilities to address risks in: a focus on medical and/ or (psycho)social approaches; the framing of responsibilities for the state and/ or the family; privileging more exclusive relationships or collaborative models of sharing and distributing care, and in ascribing responsibility to parents in general, and/ or explicitly to mothers, fathers or to both. The strongest emphasis on risks, vulnerability and protection has
been found in the German OC system. Within Polish OC policies, reforms following the collapse of the socialist state in 1989 have changed risk perceptions in which a purely biomedical approach has come to be perceived as posing risks to women’s rights and family relationships. Hence, within new Polish OC standards, mothers’ influence on decision-making, time for family relationships directly after birth and a larger role for midwives, mothers and the wider family have been institutionalized within the persisting medical model.

Risk constructions in CHC
CHC policies in all three countries have framed child development as the main ‘object at risk’ that is to be protected and enhanced. As ‘risk objects’, policies in these countries have recognized ‘parenting’ as potentially posing a threat to child development. Within the Dutch policies, predefined population-based risk factors informed CHC examinations for all children; within German policies individual parenting risks were seen as intertwined with broader societal developments, and within Polish policies parenting was not as formally assessed in examinations and mainly focused on medical and physical elements in caregiving. A medical focus on diseases and disorders was generally stronger in German and Polish CHC policies.

Risk constructions in family policies
A protective approach within German and Polish institutions was reflected in the fact that children’s needs were a more central ‘object at risk’ within German and Polish family policies, addressed through parental caregiving in one-on-one relationships by extensive paid parental leave policies within both countries. Moreover, while German and Polish family leave policies were explicitly focused on enhancing gender equality, these efforts were not made in Dutch family policies in which a stronger emphasis on individual responsibility was found. In Dutch family policies, children’s needs have been a much more recent concern and only in relation to childcare facilities, while the more pronounced labour market risks have been addressed by facilitating parents to negotiate and share caregiving responsibilities early-on through part-time work and subsidized childcare. German family policies and especially Polish family policies were on the other hand not as focused on and as successful in investing in childcare facilities compared to Dutch family policies.
Contradictory risk constructions within each country context

The main contradictions found in the policy document analysis within the Dutch case concerned on the one hand a low-risk, everyday life approach to pregnancy, childbirth and early childcare, and accordingly limited opportunities through family policies to enact parental caregiving roles in early childcare, while the parental role and attachment relationships have on the other hand been increasingly emphasized within OC and CHC risk signalling policies. The latter developments therefore imply a more protective approach to parenting and child development which does not fit with current Dutch family policies.

In the German case, two strong risk approaches came to the fore that contradicted one another. On the one hand, the protective approach to children, mothers, and the family, as well as an emphasis on bonding and exclusive (professional and family) relationships, was particularly strong and facilitated through healthcare institutions and parental leave policies. On the other hand, a more recent public investment approach has been detected which intends to enhance gender equality and social equality through state influence on childcare facilities and early education.

In the Polish case, a full-time dual earner economy and state investment model in family life could be traced back to the socialist legacy, which still informs Polish healthcare, labour market and family policy institutions. Already under communism, these institutions functioned parallel to and have been balanced with the central role ascribed to the family, and to mothers in particular, as intertwined with the central position of the Catholic Church. Within contemporary (reformed) policies aimed at pregnancy, childbirth and early-childcare, these contradictory values – now entangled with Western European values of individualization – can still be found. On the one hand, policies reflect a public investment approach to full-time dual earning and gender equality in the labour market, while policies on the other hand emphasize a protective approach to children through prioritizing parental care, fathers’ involvement in caregiving, attachment relationships and assuming informal care being performed within the family.

In chapter 5, I examine how policies are shaped on the spot through healthcare professionals, as public service workers, who follow national policies on the one
hand, while making assessments on a case-by-case basis on the other hand. The analysis in this chapter of how and to what extent professionals’ ideal-typical knowledge about risk in the data set can be related to their institutional context is shown in two themes. The first theme is closest to the previous chapter in showing how professionals negotiate and make sense of the healthcare policy framework in which they are situated on the one hand and their everyday work in which they are dealing with individual cases and pragmatic challenges on the other hand.

In the second theme, I show how the professionals related parenting risks to broader societal processes in pointing to developments that resembled ‘individualization’, changing roles and communities, and a clustering of problems and vulnerabilities for some particular groups.

**Professionals negotiating risks related to the healthcare policy framework**

A conclusion is first that cross-nationally and cross-professionally different patterns could be detected in how professionals negotiated different risk knowledges in relation to their medical contexts. Hence, the ‘risk objects’ and ‘objects at risk’ in healthcare policy contexts described in chapter 4 were on the one hand clearly reflected in what professionals framed as ‘risk objects’ and ‘objects at risk’. On the other hand, however, processes of ‘medicalization’ and of professionals’ increased responsibilities in ‘risk detection’ (especially for the Dutch CHC professionals) were at the same time perceived as ‘risk objects’ in itself, potentially resulting into ‘mothers’ or ‘parents’ anxiety, insecurity or lack of cooperation.

In contexts with stronger medical (or psychosocial) risk policy frameworks, such as in OC and Dutch and Polish CHC, professionals’ tensions in working with and opposing these risks in everyday practice appeared to be stronger. This shows that even within (clinical) healthcare settings, processes of ‘medicalization’ and intensifying perceptions of risk (Rothstein 2006) are not determining professionals’ risk knowledge, but professionals who work in these settings need to negotiate different forms of knowledge (Bröer and Besseling 2017; Lupton 1997b). In the relative absence of strong encompassing healthcare frameworks – which was found to be more strongly the case for Dutch postpartum care assistants and German paediatricians – the pragmatic challenges in parenting which these professionals
experienced in their everyday practice came to the fore as more central in their ideal-types of risk than medically or psychosocially informed risks.

Furthermore, in the ideal-typical knowledge detected in the professionals’ accounts in this study, medical risk frameworks were shown to be intertwined with categories of gender. This was especially the case for the professionals working in OC, where professionals consistently depicted mothers and children as the vulnerable ‘objects at risk’ on whom their tasks were focused. When ‘objects at risk’ were related to health and addressing pathology, it was mothers and children who were perceived as vulnerable, however when ‘objects at risk’ were related to broader issues such as ‘having influence on decision-making in childbirth’ and ‘getting used to a baby’, as a demanding and unfamiliar situation, fathers were by the Dutch professionals (not by the German midwives) more easily included in perceptions of being vulnerable as well.

Professionals framing and negotiating parents as ‘at risk’ or as ‘risky’

In the accounts of the German professionals, the most clear and coherent emphasis was placed on changing community and family structures, resulting into parents, and often mothers, being perceived as ‘helpless’ and ‘isolated’, which was however also suggested to relate to the [Rhein-Main] area in particular. Several of the German paediatricians stated that they facilitated parents’ access to healthcare. The German midwives in this study saw a role for themselves to support mothers, especially when social structures were absent. The protective approach towards parents, and especially mothers, in German OC, CHC and family policies (see chapter 4) was therefore reflected in the German professionals’ ideal-typical risk knowledge, in which they framed parents rather as ‘at risk’ than as ‘risky’.

In contrast, a stronger depiction of how societal changes affected parenting, which supposedly made parenting more ‘risky’ for children, came to the fore in the accounts of Dutch and Polish professionals, who placed a stronger emphasis on parents’ individual responsibility. The Dutch CHC professionals most clearly and coherently focused on socioeconomic inequality and how this translated in problematic behaviour of parents who faced an accumulation of problems. In these accounts, categories in parents along lines of social class were detected, in which
particular concerns were formulated as ‘risk factors’. Some of the Polish professionals also related parents’ socioeconomic class positions (as intertwined with public or private healthcare) to particular forms of ‘risky’ parenting, but this was not as structurally addressed. Hence, the professionals’ ideal types about parenting risks showed cross-national differences in focusing on parents ‘at risk’ of failing societal structures and/ or parents being ‘risky’ to their children due to socioeconomic positions within a changing society, who were therefore expected to adapt their behaviour.

In chapter 6, I present and discuss the contradictory cultural values in professionals’ accounts between parents’ caregiving and working roles, and values about gender equality and gendered responsibilities.

*Gendered norms in caregiving risks*

Ideal types about risky parenting were in many cases coherent across the professionals in this study, suggesting that these generalized forms of knowledge were overall not largely dependent on cross-nationally different institutions and/ or cultural values. My findings indicate that the perception of improper care for babies was mostly related to mothers and/ or to parents in general, and in some occasions to fathers not being competent. The focus on mothers rather than parents was strongest in the accounts of the Polish professionals. The framing of risks for babies in terms of physical care and in terms of spending time with the baby easily translated in parents’, and often mothers’, responsibilities to invest in becoming competent.

While this partly reflected ‘intensive parenting’, and more specifically ‘intensive mothering’ ideology, it also diverged because professionals emphasized *physical care* (rather than extending caregiving beyond this), and because it was not so much an increased *intensity* that professionals promoted and were concerned about, but it was rather their perception of parents’ decreasing time and attention for children amidst various distractions in contemporary societies they were concerned about. Especially Dutch and Polish professionals felt that mothers’, and families’, caregiving roles in the early stages of a child’s life were increasingly under strain. ‘Intensive parenting’ and ‘intensive mothering’ ideologies were most strongly
contested by a majority of the professionals (apart from Dutch and German midwives) through the coherent framing of overprotection as a clear risk to children’s autonomy, mothers’ health and well-being and fathers’ involvement. Here, a (potentially) more problematic relationship was suggested between mothers and (overprotective) caregiving or child raising.

These findings therefore shed light on professionals’ reflexivity and experienced-based knowledge, as we have also seen in the previous chapter. Rather than simply incorporating and conveying specific parenting ideologies, the professionals appeared to be knowledgeable about the diverse (and sometimes adverse) effects of intensive approaches to parenting and to mothering, and we could thus see that healthcare policies (stimulating attachment relationships) and parenting ideologies came to be intertwined with on the one hand professionals’ taken for granted gender norms about mothers’ primary roles, and on the other hand with their more nuanced everyday experiences.

Gendered norms in reconciling caregiving and working responsibilities
Interesting variation came to the fore in the degree to which mothers’ roles were essentialized (more strongly in the Polish and German cases, and in midwifery) and the degree to which parallel expectations of fathers’ active and nurturing roles were presented (more strongly in the Dutch and Polish cases). The healthcare professionals in this study turned out to be hesitant and heterogeneous in perceiving a role for themselves in influencing mothers’ and fathers’ work and care divisions, while mothers’ choices and employments were in all contexts acknowledged and supported. At the same time, it was found that children could in the views of the majority of professionals very well be ‘at risk’ through mothers’ absence and (specific forms of) external childcare.

Both professionals’ concerns about (particular) external childcare, and the ways in which professionals perceived constraints in work-family balances were strongly informed by family policies, and by how this became relevant in specific healthcare contexts and professional interactions. It was found that especially mothers’ pragmatic challenges were placed centrally, and fathers’ roles in obtaining a work-family balance within the family were only to a modest degree perceived as
relevant (mainly in the Dutch and Polish cases). Gendered task divisions were therefore importantly reproduced in professionals supporting pragmatic solutions in which constraints following from the institutional context were hardly challenged but rather confirmed (Waitskin 1989), although a minority of younger professionals formed an exception to this. Such pragmatic solutions on the other hand also provided the openings in which professionals facilitated parents’ shared task divisions and fathers’ caregiving roles.

While I have shown in the previous chapter that cross-national variation was found in how professionals pragmatically related to their medical context, this variation was much less found when it came to perceived parenting risks and responsibilities in the first stages, with only minor differences that drew on cultural values in relation to the institutional context. This assumes that cross-nationally different depictions of gendered parenting risks and responsibilities relied on the interaction between healthcare policy-based knowledge and other institutional sources of knowledge and values. In a similar sense, it was found that the variation in family policies alone did not straightforwardly translate into professionals’ situated and gendered ideal-typical knowledge about parenting risks and responsibilities. Rather, it was found that gendered risk and responsibility depictions were informed by the integration of different sources of knowledge.

**Chapter 7**, written together with Patrick Brown, pays attention to professionals’ everyday case-by-case interpretations of ‘risk’ and how professionals come to know risk. The practices of risk-assessment within professional-parent(s)-child interactions in Dutch CHC centres are examined with a particular interest in uncertainty when professionals work with ‘precautionary risk approaches’ in which possible events are anticipated and intervened (Alaszewski and Burgess 2007). By inquiring into the phenomenological lifeworlds of professionals’ risk assessment practices, we have: therefore a) developed understandings of how inexorable uncertainties around ‘risk’ assessment were overcome through practices of intuition, emotion and trust (Zinn 2008); b) analysed how such sense-making practices were shaped by the relative socio-cultural proximity of the parent-other to the professional-self (Schutz 1972; Van Duursen et al 2004); and c) explored how
these ‘modes of knowing’ were embedded within social structures, not least those of gender and class.

In interrogating the very nature of risk-work itself, we found that the application of formal-rational risk assessment based on ‘risk groups’, as derived from knowledge of correlations between certain factor-categories and outcomes, had limitations. This knowledge was invoked but found to be of limited utility in overcoming uncertainty when making decisions in specific cases. Where possible, professionals overcame this looser categorical basis for considering future possibilities with a phenomenologically more concrete relational basis of knowing family futures. The manner by which detailed personalized knowledge was used as a basis for drawing inferences about future parenting behavior and outcomes, in conjunction with emotions and intuitions, is more accurately captured by conceptualizations of relational trust rather than formal-rational models of risk assessment (Zinn 2008).

We found that ‘we-relationships’, in which communication was sufficiently open for concrete knowledge of parents and their practices to be elicited, were more likely to be built with parents who the professionals felt an affinity with, that is to say parents who more fully shared stocks-of-knowledge with the predominantly white-Dutch middle-class female professionals. We thus argue in this chapter that social structures of gender, class and ethnicity can be seen as active both through the differing potential for we-relationships to be formed and via the generalizing and stereotyped knowledge applied in their absence. Non-hegemonic, and thus less familiar, class- and ethnic- background parents were less likely to develop we-relationships with professionals and therefore to be trusted; and within rather distant ‘they-relationships’ they were more likely to be deemed risky on the basis of risk-groups and/or taken-for-granted assumptions. Similar assumptions also directed professionals’ attention towards mothers rather than fathers when assessing family contexts, with we-relationships forming more straightforwardly with women who were implicitly assumed and thus encouraged to adopt chief responsibility.

In chapter 8, I ask to what extent, how and when professionals did envision fathers as caregivers, because it is in the envisioning of such roles – central to their profession –
that professionals try to understand and affect others’ (in our case fathers’) future-oriented motives and actions. In other words: I investigated how and when professionals trusted fathers as if their possible future caregiving roles would occur and as if this would be favourable for children’s futures (Lewis and Weiger 1985, p.969, cited by Möllering 2001, p. 414; Schutz 1972, p.148), thereby also making the ‘leap of trust’ with fathers.

I show in this chapter that family policies and healthcare institutions coincided in and informed the extent and content of professionals’ direct interactions with fathers. In the Dutch and Polish cases, a more frequent and concrete knowing of fathers as caregivers through paternity and parental leave or flexible working hours translated in professionals contesting and adapting ideal-typical knowledge that a) framed mothers’ exclusive roles and b) presumed fathers as unfit or less fit to be caregivers. In the German case, this challenging of ideal types was not as clear and less consistent. Interactions with fathers – or the lack thereof – could therefore also confirm ideal types of fathers’ relative distance to their children and caregiver role. Gender, class and ethnicity intersected in this respect, with more privileged and ‘native’ fathers being experienced as most engaged in taking up leave and in caregiving. This study further indicates that healthcare structures were salient in how professionals ascribed either responsibility or autonomy and choice in caregiving to diverse fathers. More direct trust relationships and responsibilities for fathers were found first in situations of heightened levels of risk for child and mother; second in situations of urgency and acuteness rather than prevention; and third in professionals either interacting with fathers alone or interacting with fathers and mothers in similar durations and frequencies.

Such structural factors turned out to be highly relevant in how individual professionals used their discretionary space to understand and affect fathers, and their inclinations and opportunities to establish ‘we-relationships’ with fathers from diverse class and ethnic backgrounds. While similarities between professionals and parents in terms of their gender, class and ethnic position turned out to be helpful in establishing mutual understandings, accepting the unknown and forming favourable expectations of parents (see chapter 7), the richness of professionals’ concrete experiences with diverse fathers who were in turn in direct (and physical) contact
with their children could also enhance such mutual understandings and favourable expectations of fathers. It was exactly these experiences that were strongly informed by the institutional context.

I conclude in chapter 9 that it is crucial to examine the distinct perspectives at play in the process of childbirth in relation to one another, that is: the (un)equal work and care divisions and pathways of women and men following childbirth and their capabilities to reconcile family and work, but also the development, health and well-being of infants and related responsibilities ascribed to mothers and fathers within society in general (see also Gornick and Meyers 2003; Saraceno 2011) and within pre- and postnatal healthcare contexts in particular. In this dissertation, I have investigated and compared these perspectives by deconstructing representations of ‘risk’, in how particular consequences are anticipated and valued, and thus enhanced or prevented, in relation to particular perceived threats (Boholm and Corvellec 2011) as highly influenced by cultural values (Douglas 1986; 1992; Logue et al. 2016) and taken for granted assumptions about gender (Hannah-Moffat 2004).

A theoretical implication of my research is that I highlight the different risk perspectives in healthcare and in family policies, thereby illuminating country-specific tensions in the risks at stake and the persons and parties targeted as responsible over the course of pregnancy, childbirth and early childcare. Moreover, I point to interactions and trust and to the salience of studying how professionals make sense of and get to ‘know’, ‘trust’ and ‘affect’ mothers and fathers within varying face-to-face interactions. Thereby, my research on the one hand shows and confirms that interactional mechanisms make mothers primarily responsible for caregiving, while I show on the other hand how this happens to varying degrees and in context-specific ways and that this does not exclude mechanism in which fathers are activated and made responsible for caregiving at the same time. I thus show that professionals’ hierarchic positions, agentic actions and pragmatic decisions, as well as their concrete knowledge of individual parents and the stereotypical knowledge available to them, are very much informed by institutional factors, such as family policies, cultural values and healthcare settings.
This dissertation is innovative in combining the phenomenological interrogation of professional-family interactions with a cross-national and cross-professional comparison. First, the in-depth analysis of social interactions sheds light on the “wider social whole to which it belongs”, assuming that “the micro and the macro are linked intrinsically” (Inglis 2010, p.509). Second, treating each profession (midwifery, postpartum care assistance, paediatrics) within each distinct country (the Netherlands, Germany, Poland) as a particular case that reveals particular regularities and principles in professional-family interactions enables a within-case and cross-case comparison, illuminating differences and taken for granted facets, as well as similarities that exceed the particular cases. Third, taking relevant macro-level policy institutions developed within longer-term histories (Baur and Ernst 2011; Bacchi 2009) into account enhances a richer understanding of the particular cases and the differences or similarities between them.

The analytical focus on professionals’ knowledge construction and sense-making processes in relation to varying degrees of directness (Schutz 1972) and concreteness (Brown 2009), professionals’ experiences within their particular institutional context, and their generalized ‘ideal-typical knowledge’ (Schutz 1972) provided insights into the interplay between macro-level institutions and micro-level trust processes. This approach was strengthened by its integration with (welfare state) research designs which are advanced in their cross-nationally comparative examinations of macro-level policies and individual-level (gendered) behaviours (see Grunow and Evertsson 2016).

Important policy implications following from my research are that it would be salient for policy makers and professionals to be reflexive about the effects of both policies and professional-family interactions on how professionals are more or less able to anticipate ‘secure’ developments for individual children and families, and on how professionals are positioned differently towards diverse mothers and fathers. This complicates professionals’ opportunities and inclinations to assess risks for all parents as well as to ascribe and teach responsibilities to them. Alongside reflexivity, it would be helpful when a) diversity among the professionals in terms of their gender and ethnic and social class background would be promoted and b) when leave policies would be extended (especially in the
Netherlands, given the recent policy reforms in Germany and Poland) in order for fathers to be able to more frequently attend professional consultations, and thus take responsibilities in, and be made responsible for, caring for their child.
Abstract

Anticipating ‘secure’ developments

*How pre- and postnatal healthcare professionals work with risk and trust and (re) shape mothers’ and fathers’ roles in the Netherlands, Germany and Poland*

Promotors: prof. dr. Daniela Grunow and dr. Patrick Brown

How are risk and gender constructed in pregnancy, childbirth and early childcare? With an interest in parenting and gender (equality), this dissertation integrates the separate concerns within healthcare and developmental, welfare state and feminist studies by looking at constructions of risk and gender in and through healthcare and family policy institutions and healthcare professionals, with whom parents and expecting parents of a new-born child concretely and repeatedly interact. Building on sociological theory about the interplay between institutional contexts and the sense-making processes of social actors to give meaning to the world around them, particularly regarding gender roles, risk perceptions and understandings of family life and work, the theoretical approach is based on the phenomenology of Alfred Schutz in understanding larger social phenomena from micro-level interactions, as sense-making processes based on people’s situated experiences and levels of proximity and knowing others in inter-personal relationships. The work of Mary Douglas and Boholm & Corvellec is used to study how culture informs institutions and perceptions of risk, danger and responsibilities, which is complemented with concepts of uncertainty and trust, as well as professionalism and governance. This research concerns an ethnographic cross-national and multi-level design with research conducted in three neighbouring European countries: the Netherlands, Germany and Poland, in which 53 interviews with healthcare professionals (midwives, postpartum care assistants, paediatricians and nurses) are triangulated with 116 participant observations and 47 policy documents.
This dissertation highlights the different risk perspectives in healthcare and in family policies, thereby illuminating country-specific tensions in the risks at stake and the persons and parties targeted as responsible over the course of pregnancy, childbirth and early childcare. Moreover, it points to interactions and trust and to the salience of studying how professionals make sense of and get to ‘know’, ‘trust’ and ‘affect’ mothers and fathers within varying face-to-face interactions. Thereby, this research on the one hand shows and confirms that interactional mechanisms generally make mothers primarily responsible for caregiving, while it shows on the other hand how this happens to varying degrees and in context-specific ways and that this does not exclude mechanism in which fathers are activated and made responsible for caregiving at the same time. Professionals’ hierarchic positions, agentic actions and pragmatic decisions, as well as their concrete knowledge of individual parents and the stereotypical knowledge available to them, are thus found to be very much informed by institutional factors, such as family policies, cultural values and healthcare settings. This dissertation is innovative in combining the phenomenological interrogation of professional-family interactions with a cross-national and cross-professional comparison. Moreover, it has produced policy implications that stimulate reflexivity about the effects of policies on professional-family interactions, about the extent to which professionals are able to anticipate ‘secure’ developments for individual children and families, and about how professionals are positioned differently towards mothers and fathers, also in relation to their socioeconomic backgrounds. Therefore, this research promotes a) the enhancing of diversity among the professional population and b) facilitating fathers’ access to leave and healthcare consultations.
Korte samenvatting

Anticiperen op ‘veilige’ ontwikkelingen

_Hoe professionals in de geboortezorg en jeugdgezondheidszorg met risico en vertrouwen werken en de rollen van moeders en vaders (her)vormen in Nederland, Duitsland en Polen._

Promotors: prof. dr. Daniela Grunow en dr. Patrick Brown

Hoe wordt risico en gender geconstrueerd met betrekking tot zwangerschap, geboorte en de zorg voor een jong kind? Dit proefschrift is gericht op ouderschap en gender (gelijkheid) en integreert de afzonderlijke interesses binnen gezondheidszorg- en ontwikkelingsonderzoek, onderzoek naar verzorgingsstaten en feministisch onderzoek. De focus is op percepties van risico en gender in en door gezondheidszorg- en familiebeleid en binnen de kennis van gezondheidszorgprofessionals zelf, met wie (aanstaande) ouders van een pasgeboren kind concreet en herhaaldelijk contact hebben. De theoretische benadering is gebaseerd op sociologische theorie over de wisselwerking tussen institutionele contexten en begripsvorming van individuen, en dan met name op de fenomenologie van Alfred Schutz die ons aanmoedigt om bredere sociale verschijnselen te bezien vanuit interacties op het microniveau, waarin mensen elkaar proberen te begrijpen vanuit hun eerdere ervaringen binnen interpersoonlijke relaties, rekening houdend met verschillende niveaus van nabijheid en ‘kennen’. Het werk van Mary Douglas en Boholm & Corvellec wordt gebruikt om de invloed van cultuur op instituties en percepties van risico, gevaar en verantwoordelijkheid te bestuderen, aangevuld met de theoretische concepten ‘onzekerheid’ en ‘vertrouwen’ enerzijds en ‘professionalisme’ en ‘bestuur’ anderzijds. Dit onderzoek gebruikt een etnografisch cross-nationaal en multi-level design waarbij onderzoek is gedaan in de drie Europese buurlanden Nederland, Duitsland en Polen aan de hand van 53 interviews met gezondheidszorgprofessionals (verloskundigen, kraamverzorgsters, jeugdartsen en jeugdverpleegkundigen), getrianguleerd met 116 participerende observaties en 47 beleidsdocumenten.
Dit proefschrift belicht de verschillende perspectieven op risico binnen gezondheidszorg- en familiebeleid, en specifieke nationale spanningen tussen de risico’s en de personen en partijen aan wie verantwoordelijkheid wordt toegekend binnen de zwangerschap, geboorte en zorg voor een jong kind. Het wijst ook op interacties en vertrouwen, en het belang van onderzoek naar hoe professionals moeders en vaders begrijpen, kennen, vertrouwen en beïnvloeden in rechtstreekse interacties. Daarmee laat dit onderzoek aan de ene kant zien dat interactionele mechanismen moeders primair verantwoordelijk maken voor zorg, terwijl het aan de andere kant toont dat dit in verschillende maten en op context-specifieke manieren gebeurt, en dat het tegelijk mechanismen waarin vaders worden geactiveerd en verantwoordelijk gemaakt voor zorg niet uitsluit. De hiërarchische posities, zelfstandige keuzes en pragmatische beslissingen van professionals, en ook de beschikbare concrete kennis van individuele ouders en van stereotype informatie, blijken daarmee sterk gefaciliteerd te zijn door institutionele factoren zoals familiebeleid, culturele percepties en gezondheidszorginstituties. Dit proefschrift is innovatief in het combineren van fenomenologisch onderzoek naar interacties tussen professionals en families met cross-nationaal en cross-professioneel onderzoek. Daarbij heeft het beleidsimplicaties opgeleverd die reflexiviteit stimuleren omtrent de effecten van beleid en interacties tussen professionals en families op hoe professionals meer of minder in staat zijn om te anticiperen op ‘veilige’ ontwikkelingen van individuele kinderen en families, en omtrent verschillen in hoe professionals gepositioneerd zijn ten opzichte van diverse moeders en vaders. Naast reflexiviteit moedigt dit onderzoek daarom ook aan tot a) het vergroten van diversiteit onder de professionele populatie en b) het faciliteren van vaders’ toegang tot verlof en gezondheidszorgconsulten.
Zusammenfassung

‘Sichere‘ Entwicklungen vorhersehen

Wie prä- und postnatale Expertinnen und Experten im Gesundheitswesen mit Risiken und Vertrauen umgehen und die Rollen von Müttern und Vätern in den Niederlanden, Deutschland und Polen (um)formen.

Betreuung: Prof. Dr. Daniela Grunow und Dr. Patrick Brown


In dieser Dissertation werden die unterschiedlichen potentiellen Risiken in der Gesundheits- und Familienpolitik sowie Länder-spezifischen Spannungen zwischen den Risiken und den Personen und Partien, die als verantwortlich für den Verlauf der...

Streszczenie

Przewidywanie ‘bezpiecznego’ rozwoju

*Jak pracownicy służby zdrowia zajmujący się opieką pre- i postnatalną radzą sobie z ryzykiem i zaufaniem w (prze)kształcaniu ról matki i ojca w Holandii, Niemczech i Polsce*

Promotorzy: prof. dr. Daniela Grunow i dr. Patrick Brown

W jaki sposób podczas ciąży, narodzin i wczesnej opieki konstruowane są ryzyko oraz pleć? Niniejsza dysertacja jest owocem zainteresowania tymi tematami rodzicielstwa oraz (równości) płci i łączy w sobie kwestie opieki zdrowotnej, rozwoju, państwa opiekuńczego i feminizmu. Praca ta przedstawia analizę konstrukcję ryzyka oraz płci w obszarze służby zdrowia i instytucji zajmujących rodziną oraz u pracowników służby zdrowia, z którymi przyszli rodzice i opiekunowie noworodka wchodzą w powtarzalne interakcje. Opierając się na teorii socjologicznej wzajemnego oddziaływania kontekstów instytucjonalnych i procesów nadawania sensu światu przez aktorów społecznych, w szczególności w odniesieniu do ról płciowych, percepcji ryzyka i zrozumienia życia rodziny, podejście teoretyczne pracy stanowi fenomenologia Alfreda Schutza dotycząca zrozumienia większych fenomenów społecznych z poziomu interakcji na mikro-poziomie jako procesów tworzenia sensu w oparciu o ludzkie doświadczania i stopnie bliskości, oraz znajomość relacji interpersonalnych. Podstawą analizy tego, jak kultura przenika instytucje, percepcje ryzyka, zagrożeń i odpowiedzialności były prace Mary Douglas oraz Boholm i Corvellec, które uzupełniono o pojęcia niepewności i zaufania, jak również profesjonalizmu i dowodzenia. Badanie miało charakter etnograficzny i obejmowało wiele narodów i poziomów. Zostało ono przeprowadzone w trzech sąsiadujących ze sobą krajach europejskich: Holandii, Niemczech i w Polsce, gdzie przeprowadzono 53 wywiady z pracownikami służby zdrowia (położne, położne środowiskowe, pediatrzy i pielęgniarki) i dokonano triangulacyjzacji z obserwacjami 116 uczestników i uczestniczek oraz 47 dokumentami dotyczących strategii.
Niniejsza dysertacja kładzie nacisk na ukazanie zróżnicowanych perspektyw ujmowania ryzyka w służbie zdrowia i strategiach rodzinnych, rzucając tym samym światło na ważne dla danego kraju napięcia w opisanych wyżej ryzykach oraz osoby i strony uważane za podmioty odpowiedzialne w czasie trwania ciąży, porodu i we wczesnej opiece zdrowotnej. Co więcej, praca ta wskazuje na interakcje i zaufanie oraz na istotność analizowania tego, jak profesjonalisci postrzegają sens i poznaną, ufają i oddziałują na matki i ojców w ramach bezpośrednich kontaktów. W związku z tym badanie to z jednej strony pokazuje i potwierdza, że mechanizmy interakcyjne czynią z matki osobę głównie odpowiedzialną za opiekę nad dzieckiem, przy czym dzieje się to w różnym stopniu i w różny sposób zależny od kontekstu i nie wyklucza to mechanizmów aktywizujących ojców i jednocześnie przekazujących im odpowiedzialność za opiekę. Pozycja hierarchiczna profesjonalistów, działania mające na celu uleganie ich autorytetom i ich decyzje pragmatyczne oraz konkretna wiedza na temat poszczególnych rodziców i stereotypowa wiedza dostępna dla nich sprawia, że są oni pod znaczącym wpływem czynników instytucjonalnych, takich jak strategie rodzinne, wartości kulturowe i kontekst służby zdrowia. Dyseracja ta stanowi innowację łączącą rozważania fenomenologiczne na temat interakcji między profesjonalistami a rodziną z porównaniem między państwami i między zawodami. Co więcej, w pracy sformułowano implikacje dla polityki, które zachęcają do refleksji na temat wpływów strategii i interakcji między profesjonalistami a rodzinami na to, jak profesjonalisci są w stanie przewidzieć „bezpieczny” rozwój dla poszczególnych dzieci i rodzin, i jak profesjonalisci przyjmują odmienne pozycje w stosunku do różnych matek i ojców. Poza refleksją badanie to promuje także a) wspieranie różnorodności wśród profesjonalistów i b) ułatwianie dostępu ojców do zwolnień i konsultacji zdrowotnych.
Acknowledgements

“How important it is for us to recognize our heroes and she-roses”, said Maya Angelou. Indeed, this dissertation builds directly and indirectly on many important others and I’m happy to acknowledge at least a part of them in particular.

First of all, I am very grateful to the professionals working in Dutch, German and Polish healthcare services who were open and willing to share their views, practices and time with me to improve our understanding of the dynamics and complexities of their important work. It was a great pleasure to learn from your experiences and wisdom, which has been inspiring to me as a researcher and also as a parent. I hope I have succeeded in my aim to employ a critical social science perspective while at the same time doing justice to your work, including its strengths and vulnerabilities.

My first supervisor Daniela Grunow has been of major influence on my development as a researcher and on the quality and clarity of this dissertation. Already as a teacher in the bachelor and later in the research master, you have encouraged me and pointed me towards starting a career in Sociology not least by inviting me to your international research project in which this dissertation is embedded. With your analytical eye and sensitivity to all that is messy and not (yet) sharp, you have greatly contributed to the accomplishment of this comparative and qualitative study. Moreover, I very much appreciate how you have always been approachable and responsive, and how you facilitated me and my family to find a balance between working and caring for young children, thereby being an example of an employer who promotes gender equality in words and in deeds. My second supervisor Patrick Brown has embodied the interpretive side of this sociological coin, which has been highly salient to this dissertation. Being advanced in phenomenological theory and research with a sharpness in scrutinizing complexity, you have contributed to making this explorative study a fascinating journey, as vitally embedded in larger processes of risk and trust. You have always been very accessible, kind and attentive and I very much appreciate collaborating with and learning from you. Accordingly, I feel blessed with two gifted and wonderful promotors, which has been an especially fruitful combination. I also want to thank the other respected members of my exam
committee, Heather Hofmeister, Claudius Wagemann and Helma Lutz, for your engagement in the defense and your critical yet constructive contributions.

I am indebted to Alexandra Ils and Katarzyna Adamczyk, who have been involved in the data collection in Germany and Poland and have thus been engaged in a substantive part of this research project. You have also been very helpful in coordinating and checking translations, discussing the data and cross-national differences and in helping me with all sorts of questions. I have greatly enjoyed working and sharing this together. A huge thank you goes out to the both of you! Many thanks also to the translators Lukasz Pakula from Choices, Marta Fratczak, Malgorzata Zawilińska-Janash and Frederik Zeisberger. I want to thank Ria Reis and Marjanne Bontje for helping me with getting access to professionals in the earlier stages of the data collection in the Netherlands, and Ria in particular for helping me to think the study through and offering an enriching environment for affiliated researchers in children’s and youth studies to get in touch and exchange ideas. It has been inspiring and fun to work in the broader Apparent team with great colleagues. Katia, I think of our extensive talks and sharing of experiences and pictures on the long rides together in the train back and forth to and from Frankfurt. Kristina and Marysia, it was valuable and fun to start this project together in Amsterdam, and to continue with you in Frankfurt, and I am happy that we are still in touch. Aline, Alexandra, Christian and Sandra, I have very good and warm memories of our time together in (and beyond) Frankfurt. All of your comments on, contributions to and support for this dissertation have been very helpful and encouraging. Moreover, I have learned from the larger Apparent meetings, workshops and conferences.

My research has also benefited from working at the University of Amsterdam for the Sarphati project in the later stages of writing up my thesis. Christian, Mutsumi, Else, Gerben and Archana, our constructive and open conversations and sharing of ideas have been elevating and offered new insights and inspiration which has also been beneficial for my thesis. Christian, thank you for your useful comments on the conclusion. I am very glad to continue working with you in this environment.

I want to thank my former colleagues and managers, as well as the families I worked with, in the social youth and psychiatry sector in Amsterdam for teaching me what it
means to work as a professional and to be engaged in supporting families amidst all uncertainties in life. I am especially grateful to Erik Jongman and Madeleine Kroonen who have helped and enabled me to align my interests in this field more clearly with my capacities and ambitions, especially in relation to starting the research master and PhD, initially aside of working in a new role in the professional field.

Many thanks to my friends who have shown an interest and offered welcome distractions throughout the process, and a special thanks to Alisa, Marijke, Marijke, Job and Anouk for supporting me in this endeavor. It has been essential to have been surrounded by my family and my family in law, and to be a part of such strong bonds, which makes me feel truly blessed and grounded. In the final stages of this dissertation, my four sisters Jellie, Géronne, Jildau and Jacomijn have helped me out where they could in accomplishing and checking the appendices and administrative tasks, as well as in offering play dates for the kids. I am happy to have you close as the headstrong and talented women that you are, each in your own way. Which automatically brings me to my perceptive and sharp-witted mother and analytical and energetic father. Mam en pap: much of what I learned about trust, society, family and being a parent, I learned from you. You usually tend to be critical about what is taken for granted, while you are at the same time engaged and never indifferent. Thank you for how you stood behind me and helped me with finishing and defending this dissertation, alongside my tasks in the family. I also want to thank my parents in law, with whom I am blessed, for being involved in our lives and in this project.

“Other things may change us, but we start and end with family” (Anthony Brandt). Having reached the end of the acknowledgements that can more easily be captured in words, I think of you Wouter, Marie, Thom and the new (still mysterious) one. Where is trust, closeness and distance more fundamental than in the most intimate forms of walking and growing together? While my involvement in this project has not always been easy, it has also brought us a lot and we have never let go of each other. Wouter, thank you for your loyalty, for the equal sharing of work and care, for your concrete help along the process and for your never-ending interest in what occupies me. I am so happy with you as my companion and still feel that together we’re invincible.

Marie, Thom and little one, loves of my life, let’s hope for and trust in the future that awaits us. I dedicate this work to you.
Curriculum Vitae

In 1981, Gerlieke Veltkamp was born in Den Helder, the Netherlands, as the second of five daughters of Wilco and Jolanda Veltkamp. After high school, she started a study in Literature but soon switched to Social Work in Zwolle and finished her bachelor there in 2003. She worked as a juvenile probation officer and later as a functional family therapist in the forensic sector in Amsterdam from 2003 until 2010, after which she started studying Sociology at the University of Amsterdam. In the Research Master, Gerlieke specialized in Health, Care and the Body with a focus on families and children, Institutions and Inequality, and Migration and Integration and graduated Cum Laude in 2012. Alongside her PhD at the Goethe University in Frankfurt, she worked as a researcher and policy writer at the Bascule Amsterdam in the youth psychiatry sector and from 2015 onwards in the function of postdoctoral researcher at the University of Amsterdam. Her research in this project focused on families, young children, health and inequality from a longitudinal ethnographic perspective. In 2018, Gerlieke starts as a postdoctoral researcher in a new international project focused on adolescents in urban contexts as ‘co-creators’ of their health. Gerlieke lives in Almere with her husband Wouter and their children Marie, Thom and a third one on the way.