

ENGLISH ABSTRACTS OF THE CHAPTERS OF THE BOOK  
"BIRTH-GIVERS' VOICES: EXPERIENCES, CARE PRACTICES  
AND BIRTH CULTURE IN TRANSITION" (IN FINNISH:  
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Introduction: How birth-givers voice emerged in the public

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As #metooinchildbirth -campaign was launched in 2019 in Finland, it shared birth stories including what was called "obstetric violence" ("synnytysväkivalta", literally translated as "birth violence") on its website. The campaign, and especially the term "obstetric violence", initially received a mixed response but over time it changed the terms of the Finnish debate on gender equality. In the debate, talking about the "women-friendliness" of the welfare state had meant women's equal opportunities for independent and self-determined life, public participation and working life, but childbirth and its corporeality had largely been absent. The equal citizen had appeared as a genderless and disembodied being. Thus, the rights of the birth-giver and birth care had not been particularly taken into account in the equality debate.

From the perspective of safety and public health, the Finnish pre-natal and birth care have undoubtedly been of high quality, but they were not especially oriented toward "women-specific" vulnerabilities, needs or rights, but the health of the unborn child and the mother. Birth activists brought up the physicality of pregnancy and childbirth and the human rights of the birth-giver in a new way naming birth violence as structural, gendered violence. This brought the voice of birth-givers in the Finnish public discussion in a new way.

While following the campaign and the response it got in the media through sociological eyes, we sensed that the controversy was related to a broader cultural shift, which we set out to investigate in the social scientific project Battles over birth – Finnish birth culture in transition (Koneen Säätiö, 2020-25). In the light of diverse qualitative data, our study sheds light on different actors and their perspectives in the field of childbirth, such as birth-givers, parents and professionals. The aim of the study was to increase understanding and build bridges between different perspectives.

In the public discussion, the voice of birth-givers has risen so powerfully in the last seven years that we can speak of the politicization of childbirth. At the heart of the transformation of birth culture has been the clearing of space for the personal, experiential and bodily perspectives of birth, which are important in themselves. At the same time as the public debate and the care culture have opened up to birth experiences, material resources and services have become scarce, e.g. birth preparation training. The network of birth facilities has been reduced, birth care has been centralized and care has been streamlined in a short-sighted manner. The crisis of care in Finnish social and health services has increasingly come to the fore in public discourse. As a negative consequence of short-sighted efficiency measures, birth professionals experience strain and ethical stress in their work. Childbirth is a powerful and vulnerable situation, during which the support received or its lack have long-term impact. The book is motivated by a social scientific perspective, but the authors represent almost ten fields. The book's interdisciplinary approach sheds light on childbirth, birth experiences, professionals' perspective, care practices and systems at a tense turning point. Most of the book's chapters are based on peer-reviewed scientific research, but there are also a few perspective articles from the field.

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## Chapter 1. Obstetric violence in dispute

*Keiju Vihreäsalo*

In this chapter, I examine the #MinäMyösSynnyttäjänä (#metooinchildbirth) campaign, which was launched in May 2019. Herein, I attempt to identify the kinds of experiences labelled obstetric violence, why campaign activists controversially labelled the experiences described in birth narratives as obstetric violence, and why specifically the campaign was launched in spring 2019. First, I examine experiences of birth violence based on the birth narratives (n = 30) published on the campaign website. Second, I reflect on the experience of obstetric violence as a tool for activism and the broader context which explains the emergence of the concept of obstetric violence in the Finnish discourse.

In the analysis of narratives of violence during childbirth, I draw attention specifically to the objectification of birthers: that is, their experiences are

characterised by objectification. In the birth stories shared on the campaign website, birthers described being treated as impersonal bodies whose feelings and experiences held little importance. This enabled treating birthers in ways termed obstetric violence. The phenomenon of obstetric violence describes objectification and its consequences, consisting of rough interactions detaching birthers from social conventions, transforming them into objects of birth care. An objectified body can be treated in ways deemed unacceptable if the birther was viewed as a person whose experiences matter. Objectification also conflicts with the right to self-determination. Thus, objectification and self-determination cannot coexist.

In the narratives of obstetric violence in the campaign, deeply traumatic and personal experiences meet activism, rendering shameful private moments public and political. Sharing and naming experiences become possible through digital forums, the use of which is linked to the fourth wave of feminism. Naming these experiences obstetric violence and linking them to gendered power structures were justified for several reasons. First, the global movement against obstetric violence provided the ready-made concept of obstetric violence and linked the phenomenon to structural violence against women. Second, #MeToo had, on a global and historical scale, exceptionally and abruptly called into question sexual harassment and its hidden structures, highlighting that something frustratingly difficult to combat could be articulated and condemned. Third, the issue of violence had also existed at the forefront of feminist activism for decades, with its goals of personal integrity and self-determination and gender-based violence representing an essential structural problem. This reality was also recognised in international human rights conventions. Finally, the experience of objectification, naming it, and activism were all interlinked. Naming suffering an injustice serves as a prerequisite for activism, such that unnamed suffering is difficult to recognise as an injustice, which can bring people together.

Theoretically, my analysis lies at the intersection of phenomenological studies of shame and Foucauldian power analysis. My research also draws upon feminist studies focused on the control of reproductive bodies and analyses of waves of feminism.

In practice, my findings can be utilised when taking into account the effects of objectification on the experiences of birthers. More specifically, when objectified, the right to self-determination cannot be realised, given that it requires that the birther is treated as a human being. One concrete way to avoid objectification is to greet the birther at the beginning of the patient-carer relationship and maintain a continuous dialogue with her throughout the birth event.

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## Chapter 2. Birth professionals in an ethical turning point of care culture: Professionals' affects, emotion work, and changing care practices after the Me Too in Childbirth campaign

*Vilma Kaipainen & Kaisa Kuurne*

The Me Too in Childbirth campaign, launched in 2019, brought to light experiences of obstetric violence and thereby challenged the notion of a high-quality childbirth care system. In our study, we examine birth professionals in the midst of the transformation of birth culture initiated by this mobilization. The research is based on personal accounts, shared in interviews and written for us, from midwives assisting in births (N=10), obstetricians (N=12), and two anesthesiologists. We analyze the material using narrative methodology, aiming to understand the professionals' lived experiences as well as their understanding of childbirth care and birth experiences, and how they believe activism has affected care practices. We read the professionals' accounts as a shift in the boundary conditions of birth professionals' ethical agency, given that activists opposing obstetric violence challenged the ethics of care.

According to our analysis, the Me Too in Childbirth campaign initially surprised many healthcare professionals, as childbirth care in Finland is generally regarded as safe and of high quality. The term "obstetric violence" was understood to imply intentional harm. The professionals' first reactions were filled with emotion, which we interpret through the lens of affect theory. Many experienced the campaign as an attack that needed to be defended against. Despite these affective first reactions, a shared understanding of the campaign's usefulness developed over time among professionals. The concept of obstetric violence was seen as difficult on the one hand, but at the same time necessary, because it succeeded in shaking up normalized care practices and their ethics. In light of new ethical demands, birth professionals' ethical agency was seen to require skillful balancing between the needs and safety of the birthing person and the baby. Ultimately, professionals felt they are on the same side as birthing people and want to do their work well and ethically. Concrete changes in care practices have, according to professionals, been observed as a result of the mobilization: patients are better informed, consent is requested more often, routine interventions are performed less frequently, and more attention is now paid to the encounters.

The concept of obstetric violence remains partly contested, but professionals consistently view the changes it has prompted in care practices and ethics as positive. The campaign placed ethical care and the requirement for individualized attention at the center, yet the care system does not everywhere provide sufficient conditions for this. Efforts to streamline childbirth care have increased professionals' workload and narrowed the practical boundary conditions of ethical agency, slowing the cultural change toward better care. Ethical caregiving can be supported, for example, through staffing that

enables unhurried work, by promoting continuity of care, and through work-counselling and continuing education on the birthing person's autonomy and encounter.

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### Chapter 3. A battle for a shared birth experience during the COVID-19 pandemic: Political mobilisation of expecting parents, restriction policies and birth experiences

*Kaisa Kuurne & Anna Leppo*

As the COVID-19 pandemic progressed in early 2020, significant restrictions were imposed on healthcare services, including maternity care. In this chapter, we analyze firstly the societal dispute in Finland surrounding the restriction policies related to hospital births specifically regarding the extent to which a support person, typically the other parent, was entitled to be present in the maternity hospital. Secondly, we analyse the lived experiences of Finnish birth-givers in the spring of 2020. The research data consists of 48 written birth narratives from the COVID-19 spring of 2020, public health communication materials, a petition titled "Rights for Expecting Parents" ("Oikeuksia odottajille"), media texts, 14 interviews with birth-givers, and informant interviews with other stakeholders (2 activists, 12 midwives, and 2 obstetricians). Through a mixed-method qualitative analysis, we construct a picture of what transpired in the birthing field during the spring of 2020.

The COVID-19 pandemic forced healthcare districts to make rapid decisions amidst significant uncertainty. The unforeseen crisis provided governments and medical professionals with a mandate to employ very restrictive control measures that citizens are not accustomed to in contemporary liberal western societies. The pandemic demonstrated how a global health threat created conditions under which the legitimate and accepted exercise of power within society was reshaped and also contested. In the Finnish context, medical experts systematically advocated for stricter restriction policies than politicians.

The strict restrictions rendered medical authority visible but also generated a counterforce: the political mobilisation of parents, which exerted considerable pressure on healthcare districts to lift restrictions. Deep down this battle concerned the question of to whom does the birth belong: to the family

or to the hospital? For expecting parents, the other parent was not merely a support person but a genuine stakeholder. From the perspective of healthcare districts, the only actual patient was the birthing individual. Parents fought for their rights as parents, while healthcare districts focused on safety and risk management.

Parents in our data felt that the birth of their child and the beginning of family life equally belonged to both parents. The absence of a partner during various stages of birth particularly caused feelings of loneliness, vulnerability, and helplessness for birth-givers. These experiences of vulnerability highlighted the importance of being together during the entire birth process. Our analysis shows that the politics of shared parenthood have been internalized not only by Finnish mothers but also by fathers.

Parents perceived the unit of birth as not just the mother but the couple together. In their experience, they formed a joint birthing unit that was disrupted precisely when it was supposed to be together. Thus, the struggle for a shared birth experience did not only concern the so-called support person's right to be present but also the birthing body itself, which can, instead of being an individual body, be considered a kind of "social body." Rather than safety, this focus places values and morals to the core of the dispute, which are typically excluded from "neutral" medical justifications. The results provide valuable insights into the significance of experiencing birth together. Furthermore, the results contribute to a broader understanding of the relationship between medical authority and citizen mobilization.

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#### Chapter 4. Diverse life-worlds of birth-givers, care paradigms and the formation of birth experiences

*Kaisa Kuurne & Anna Leppo*

The Finnish birth field is diverse, polyphonic and sometimes tensions arise. Birth is approached from very different values, meanings and understandings of safety. Previous research on birth experiences has mostly examined the formation of negative or positive birth experiences. A deeper understanding of the different life-worlds of birth-givers has so far been mainly absent in the literature.

In this chapter, we aim to understand the diversity of experiences and situations of birth-givers and give a voice to very different birth-givers. We examine birth experiences as part of birth-givers' subjective life-worlds, which are shaped in relation to previous experiences, values and social environments. We analyse life-worlds and birth experiences in light of different paradigmatic approaches to birth care (technocratic, humanistic and holistic approaches). The first of these focuses on the medical monitoring and control of childbirth, and the latter two on the active role of the birth-giver and a holistic approach trying to avoid medical interventions in birth. The research material used is the stories written by birthing women (N = 123) collected by the Battles over birth -research project, which are analysed using narrative analysis.

According to our results, different birth-givers approach childbirth from very different values and meanings. What feels like a good, desirable and safe birth to one person may feel the opposite to another. The wishes, experiences and interpretations of birth-giver largely arise from their own personal life-worlds. While one woman feels safe in the presence of strong medical pain relief and control, another person feels safe because the process of birth and her own body are not medically interfered with unless it is necessary. However, those who rely on medical control also consider important the key elements of other care paradigms, such as the care relationship and a good atmosphere during birth. Similarly, in the stories of those who wish for the birth to be as natural as possible, may still appreciate a needed medical intervention and positive interaction, much like others. The need for good connection with professionals emerged in fact in every single narrative, which reflects the basic need for social bonding and a sense of belonging in a vulnerable situation.

Based on our results, birth care that acknowledges different life-worlds in birth can only be developed by allowing and encountering people's diverse life-worlds from their own starting points with appreciation. Only then can disputes related to different wishes and approaches melt away and create space for diverse experiences. Based on our analysis, different modes of delivery, birth place or paradigms do not have to be set against each other. Our results confirm the findings of previous research on how elements arising from different life-worlds or care paradigms often come together without problems, but sometimes also tensions and ambivalences arise.

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## Chapter 5. Negotiating a Planned Caesarean Section in Finnish Maternity Care

*Eeva Itkonen*

In Finland, women and birthing people cannot choose a caesarean section themselves; the decision about mode of delivery is made by an obstetrician. Within the healthcare system, a request for a caesarean section is typically interpreted as fear of childbirth, which is addressed through information and psychological support. A caesarean section is considered medically indicated only if fear persists and prevents vaginal birth despite treatment. In recent years, however, people requesting a caesarean section have increasingly questioned professionals' authority to define risks and make decisions about birth. Previous research indicates that requests for caesarean section are based on diverse reasons, often intertwined with earlier life experiences and personal values. Yet little research has examined the experiences of women and birthing people negotiating a caesarean request and their encounters with professionals, particularly in the Finnish healthcare system, where vaginal birth holds a strong normative position as the primary mode of delivery.

Drawing on interviews, written narratives, and social media discussions, this chapter analyses experiences of requesting a caesarean section within Finnish maternity care. The analysis focuses on short-lived but meaningful intimate moments in which the distance between people narrows and which can either support or undermine well-being in vulnerable situations. Lived well-being is approached through Self-Determination Theory, with particular attention to the role of autonomy, competence, and relatedness as they appear in the narrative accounts.

The chapter shows that encounters with healthcare professionals shape well-being, not only the final decision about mode of delivery. In these encounters, alongside autonomy, the experience of relatedness emerges as central. The data reveal three recurring dynamics that disrupt relatedness in encounters with professionals: shame associated with deviating from the norm, fear of losing autonomy, and lack of recognition. Shame emerges from the experience of being seen as the “wrong kind” of mother. Fear of losing autonomy relates especially to uncertainty about the mode of delivery if labour begins before a decision on caesarean section has been made. Lack of recognition refers to situations in which the request is accepted, but the decision is not experienced as validated or affirmed. In supportive encounters, relatedness is strengthened when individual perspectives are recognised and there is a shared understanding of the goals of care. However, relatedness is fragile and may also be sustained outside the healthcare system through close relationships and peer communities.

The experiences of requesting a caesarean section suggest that the healthcare system may, at times, intensify the fear and suffering it seeks to alleviate.

At the same time, respect for self-determination can be strengthened without shifting full responsibility onto the individual or withdrawing professional support. This requires a consistent and transparent care process and opportunities to discuss mode of delivery when the need for such discussions arises. Professionals should provide balanced and evidence-based information on the benefits and risks of different modes of delivery. Decision-making should also be supported in ways that ensure individual needs, concerns, and values are taken into account. Offering perinatal mental health support is important when fear or traumatic experiences underlie a caesarean request. Nevertheless, it is necessary to critically assess whether a diagnosis of fear of childbirth and its treatment should always be a prerequisite for approving a caesarean section.

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## Chapter 6. Normative Expectations and Tensions Surrounding Childbirth: Gender, Sexuality, and Diverse Families in Childbirth

*Kaisa Kuurne, Mirjam Raudasoja & Tuuli Paajanen*

In this chapter, we examine normative expectations and tensions surrounding childbirth from the perspective of gender, sexuality, and diverse family forms, drawing on critical social science and psychological literature as well as empirical birth narratives. The focus is on the regulatory influence of gender in childbirth as reflected in the narratives of both women and non-binary birthing people, as well as the manifestation of the heterosexual nuclear family norm in the birth stories of single mothers and female couples.

In birth narratives, gender manifests as a lived experience, a guiding norm, and an object of control. In these stories, gender is constructed, emphasized—and also struggled against. Childbirth and (female) gender are intertwined both in social discourse and in the practices that guide action. Institutional power is evident in who is allowed to give birth and who is encouraged to do so, as well as in how those giving birth are treated. The heterosexual nuclear family is the dominant norm against which other family forms are measured.

In the accounts of some women who give birth, the internalized “good girl” model manifests as experiences of powerlessness and an inability to resist the authority of professionals. Some women in labor, on the other hand, draw strength from their femininity, while others hope not to be gendered as women. For gender minorities, being misgendered is often a wounding experience, but similar feelings on normative guidance can also be expressed

by women in labor. In the narratives of female couples and single mothers, family structure does not particularly come to the fore, but in the narratives of non-birthing mothers in female couples, their status as mothers often goes unrecognized in healthcare. The uncertainty surrounding the status of rainbow families and non-biological parents is highlighted in one-time services, where rigid service structures do not recognize anything other than the heteronormative nuclear family model. Single mothers, on the other hand, may be left without adequate support as the healthcare system relies so heavily on the two-parent model.

Gender, as a norm guiding behavior, permeates the reproductive field regardless of the birth-giver's gender and family form. Birthing people belonging to gender and sexual minorities may be overlooked by misidentifying their gender, sexuality, or family form and by directing them into a mold that does not suit them. The issue of inclusive language highlights a broader phenomenon: the system and professionals should be open to all groups of birthing people and families. On the other hand, completely gender-neutral language can lose meaningful and, for some, empowering experiences of being a woman and make it harder to recognize gender-related vulnerabilities and power relations.

Gender thus presents a kind of dilemma within the system. In general contexts, it is best to avoid gender-normative language, and in Finnish, one can naturally speak of "birth-giver" and "expectant parents." The most important thing is that diverse birthing people are heard without making normative assumptions from the outset. Birth care requires a gender-sensitive approach: critical sensitivity to recognize the diversity of gender and family forms and to identify the associated meanings and vulnerabilities. A dialogue is needed that respects the uniqueness of every person giving birth and every family.

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## Chapter 7. "Somehow present, but not in anyone's way": Moral dilemmas of childbirth in fathers' narratives

*Tuuli Paajanen & Katri Komulainen*

In contemporary society gender-equal parenting and the importance of fathers' presence during childbirth are increasingly emphasized. However, previous research shows that fathers often experience feelings of marginalization in birthing situations. Cultural master narratives shaping fatherhood embed behavioral norms and complex, often contradictory expectations. Fathers' participation in childbirth has been less frequently examined from the perspective of interaction research. In this study, we analyze the construction of fatherhood during childbirth and in the early stages of parenthood drawing on the small stories approach and positioning analysis.

This chapter examines how childbirth culture shapes fatherhood and the conflicting expectations directed at them, and how fathers respond to these expectations by positioning themselves as fathers and partners. The analysis is based on narrative interviews with 13 fathers about the birth of their child. From these interviews, we examined the types of stories fathers told about the birth, the master narratives that emerged regarding the father's role, and how fathers positioned themselves in relation to these narratives.

In fathers' accounts, childbirth appeared as a morally demanding situation. In stories describing the pregnancy period and preparations for the birth, fathers positioned themselves as active and engaged agents who were nevertheless unsure and insecure. The birth itself was constructed as an event bound to medical practices and the mother's body, challenging the ideal of shared parenting. For the fathers, being a "good father" during childbirth meant acting as a good partner, such as advocating for the birthing mother's rights. Stories about caring for an older child indicated that equal parenting became possible in the home environment and in later stages of parenthood.

From the perspective of professional practices, especially the first childbirth experiences appear as situations requiring particular attention. Early fatherhood is shaped by multiple simultaneous (moral) ideals, such as the obligation to respect the mother's bodily integrity while also safeguarding the child's best interests and the birthing mother's rights. The father's position during childbirth is significantly more ambiguous and contradictory than the prevailing master narrative of shared parenting suggests. Framing fathers primarily as support person doesn't make visible the expectations and practices that shape the childbirth situation.

Although fathers reported having access to medical information of childbirth, they felt they needed another type of knowledge: an understanding of the complexity of the situation, and guidance on what issues should be discussed with their partner beforehand.

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## Chapter 8. Experiences of unplanned out-of-hospital deliveries in the Finnish Maternity Care Service System

*Jussi Hänninen*

As maternity hospital services become more centralised, an increasing number of birth-givers may give birth outside their planned settings, for example, at home, en route to the hospital, or in an ambulance. Any birth-giver or family in Finland may be affected by an unplanned out-of-hospital birth. In the context of Finnish maternity care services, unplanned births involve coordination between multiple professional activity systems and actors, including labour units, the Emergency Response Centre Administration and prehospital care organisations.

Previous research on unplanned out-of-hospital births has largely focused on the associated risks. The objective of this study is to develop collaboration between the expertise and activity systems of actors in maternity care. This necessitates studying the experiences of birthing women. The results of this study are based on interviews with women who experienced unplanned out-of-hospital births (N=25).

An unplanned out-of-hospital birth can result in an overall positive birth experience, which may be empowering for the mother. Addressing contradictions within and between maternity care activity systems may lead to qualitative improvements in these systems and enhance the expertise of actors involved in maternity care. The involvement of a midwife at any stage of unplanned out-of-hospital birth facilitates smooth delivery. To promote active agency, mothers experiencing unplanned out-of-hospital birth should be supported in developing a sense of control, trusting their own bodies and the natural process of childbirth, and making autonomous decisions.

The results of the study benefit both those who may give birth outside the hospital setting against their plans in the future, as well as society, for example by addressing inequalities between different delivery models perceived by women and families. Inequalities within the Finnish maternity care service system are evident in that women admitted to hospital benefit from world-class childbirth safety systems, whereas those giving birth outside the hospital are subjected to a less secure environment, with likely reduced access to professional expertise and increased exposure to risks. Professional expertise

and interoperability between activity systems must be developed to ensure that mothers can trust the strengthened system to ensure that women giving birth can trust the competence of the professional actors involved during critical and unexpected birth events. This supports a positive experience of unplanned out-of-hospital delivery.

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## Chapter 9. Lived experiences of women and birthing people with fear of childbirth and encounters with maternity care professionals

*Laura Sandström*

In the Nordic countries, fear of childbirth is becoming more common. Fear can have a wide range of consequences: it casts a shadow over the pregnancy period, increases the risk of bad childbirth experiences, and is associated with a smaller number of children than desired. Fear of childbirth has received a lot of attention in research and the media in recent years, but health science research often focuses on individual risk factors related to the individual giving birth.

In this chapter, I examine the experiences of first-time and multiparous women and people with fear of childbirth on the basis of 187 written descriptions. With the help of reflexive thematic analysis, I examine their lived experiences, thoughts and needs in the context of maternity care.

According to the results, the experiences of women and birthing people are placed in a tense relationship with the medical power, which is represented by professionals. Individuals who gave birth described that they had been left without sufficient support, their experiences and feelings were belittled, their choices were judged and they felt that they were being subjected to procedures where their personal space had been invaded without asking permission. However, the women and birthing people also had positive fear-reducing encounters with professionals, where their previous experiences and feelings were validated, the individual situation was taken into account, and decisions related to treatment were respected.

Good treatment that prevents fears requires comprehensive attention to the woman and birthing person. Caring, individual and respectful relationships are important, as well as ensuring trust, presence and the birthing woman's and person's right to self-determination.

From time to time, the system itself produces fear of childbirth, which, based on my analysis, is partly justified. The structures of maternity care, the maternity and child health clinic system and the resulting operating methods are hardly questioned, apart from the speeches of the women and people giving birth. Based on my data, it can even be argued that it is a risk to the good care of individuals giving birth. In order to achieve sustainable change, attention should be focused on the rationality of care, i.e. the ways of thinking, principles and values behind nursing that guide their actions, rather than on individual professionals.

In order for comprehensive care to be genuinely possible, the structures of maternity care must be changed from a divided maternity and child health clinic model to an evidence-based model of continuity of midwifery care, in which the same midwife takes care of the family from early pregnancy to childbirth and for a few weeks after childbirth. This model strengthens the woman's and person's right to self-determination, builds trust and distributes responsibilities more evenly. It improves the flow of information and is cost-effective, as treatment outcomes are better than with fragmented models.

Finland is facing an unprecedented birth crisis. Instead of constantly improving efficiency and saving, maternity care professionals should be guaranteed good working conditions and peace of mind, where they have the opportunity to stop and think about the miracle of birth and the unique experience of a birthing family. Women and birthing people, on the other hand, deserve evidence-based comprehensive continuity of midwifery care.

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## Chapter 10. Vulnerable situations and relationships: Psychological and social vulnerability in the lives of birth-givers, newborns and families

*Anna Leppo, Kaisa Kuurne, Sanna Isosävi & Reija Klemetti*

During pregnancy, childbirth, and the early infant period (the perinatal period), fundamental interconnectedness between people, corporeality and the need for care come necessarily to the fore. The newborn is dependent on parental care and psychological support. Challenges during the perinatal period can threaten the physical and psychological well-being of the birthing parent and activate previous traumatic experiences. Additionally, social vulnerability caused e.g. by financial difficulties or intimate partner violence, can undermine the well-being of families with infants.

In this chapter we examine the perinatal period from the perspectives of psychological and social vulnerability, drawing from literature from the social sciences, health sciences, and trauma psychology. The research data consists of birthing narratives (N = 123) and the FinLapset survey data aimed at parents of small infants (N = 14,820).

Our findings indicate that the vulnerable situations of expectant parents, birth-givers, and families with infants in Finland are multifaceted, encompassing both psychological and social factors. Nearly a quarter of all respondents and almost a third of first-time mothers reported in the FinLapset survey that their childbirth experience was worse than expected.

The narrative data reveals numerous experiences described as traumatic. Our analysis reinforces the view that the perinatal period can activate previous trauma experiences as well as produce new ones. The social vulnerability of families with infants in our data ranges from poverty and a lack of social support networks to intimate partner violence. For example, a lack of social support can have far-reaching negative effects on family well-being. Social stressors often produce psychological burdens and vice versa.

The results indicate that the Finnish welfare state system does not always meet the needs of families with infants living in vulnerable positions. A significant challenge is the lack of continuity of care and professionals' heavy workload, which can hinder the establishment of trust and psychological safety. To ensure adequate support, care, and assistance, there is a need for responsive and personalized care, which requires sufficient resources.

Further, current care practices lack a holistic, trauma-informed understanding of and approach to the perinatal period. There is a need for trauma-informed encounters and structures, where building trust and safety, ensuring continuity of care and supporting the families' agency are a priority. Structured care pathways are needed to enable professionals to timely direct traumatized parents in need of assistance to the appropriate services.

Reducing parental burden is one of the key support measures for child well-being. Families burdened by severe traumatic experiences and social vulnerabilities require multidisciplinary support that takes into account the parent's social situation, mental health, early interactions with the infant, and the practical reduction of daily burdens through childcare assistance and home support.

Providing insufficient financial resources for the care and support of expectant parents, birth-givers, and families with infants is shortsighted and, despite its objectives, does not reduce overall public costs. The inadequacy of public healthcare services also exacerbates inequality among children and families.

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Chapter 11. "I have dropped the sun from inside  
me": Challenging the Cultural Silence around  
Miscarriage through Literary Narratives

*Nanny Jolma*

In Finnish culture, pregnancy loss has traditionally been met with silence, even though it touches the lives of most women and their partners. The topic is culturally entangled with shame, feelings of failure, and pressures rooted in the ideal of the nuclear family and public debates on declining birth rates. However, contemporary discursive practices indicate a shift: miscarriages are discussed in traditional and social media more openly than ever before, and literature addressing the topic has become increasingly common since the early 2000s. This study arises from that cultural transformation and from a need to understand how fiction contributes to challenging social norms and culturally available narratives.

In this chapter, I examine Finnish miscarriage narratives from the perspective of literary studies. The primary material consists of novels that explicitly depict pregnancy loss, complemented by examples from other media. I analyze how contemporary narratives contest the "from adversity to triumph" master plot, in which miscarriage is reduced to a temporary setback on the path to a happy family life. A particular focus is on how literary works portray the embodiedness, shame, and complexity of loss with metaphors and other narrative techniques.

The findings indicate that fiction serves as a significant cultural arena where the silence surrounding pregnancy loss can be dismantled and where new modes of representation and storytelling can emerge. Literary fiction has the potential to articulate societal blind spots and to challenge widely circulated narratives that often oversimplify complex phenomena. Works such as Eve Hietamies's *Puolinainen*, Leena Paasio's *Melkein äiti*, and Katja Kettu's *Erään kissan tutkimuksia* expand the means to narrate miscarriage through figurative language and by questioning the ideal of the nuclear family. These texts foreground individual grief and embodied experience while simultaneously commenting on the societal structures that shape cultural understandings of womanhood and motherhood.

Analyzing miscarriage narratives highlights why diverse perspectives and narrative means are essential for breaking the loneliness and shame that often surround those who have experienced pregnancy loss. Fiction offers tools for critically examining societal norms and can function as a mirror and resource in efforts to foster a more sensitive culture of dialogue and professional encounter.

*Nanny Jolma, PhD, is a senior researcher specializing in Finnish literature and narrative studies at Tampere University.*

## Chapter 12. "There Have Been Lovely Nurses as Well": Care Experiences of Parents Who Lost Their Child During Pregnancy and in Early Infancy in the Finnish Healthcare System

*Helena Krohn*

The article examines the institutionalized care experiences of parents who have lost a child within the Finnish healthcare system. The analysis focuses on the ethical, emotional, and societal dimensions of institutional care. The study is motivated by a need to better understand the experiences of bereaved parents and to develop care practices that would support them in a more holistic manner. The data consist of an online survey conducted in 2020 by Käpy (Käpy Lapsikuolemaperheet ry), among parents whose child died during pregnancy, at birth, or shortly after birth. The study employs qualitative content analysis, identifying recurring themes in parents' experiences.

The results indicate that the core of a positive care experience lies in an empathetic encounter in which the parent's grief, the child, and parenthood are genuinely acknowledged. The language and gestures used by professionals, such as preserving mementos or providing support from a hospital chaplain, reinforce the experience of being seen and valued. Conversely, mechanical or rushed care increases feelings that the deceased child and the parents' parenthood are being devalued or ignored. The study also highlights structural inequality within healthcare, where one parent is often left without adequate support.

A key emphasis of the article is the need to place care ethics and humane encounters at the center of healthcare alongside medical efficiency. It challenges the Finnish healthcare system to consider care also as a matter of power, language, and justice. The findings can be applied in social and healthcare education, in the development of care cultures, and in guidelines concerning support following the early death of a child. Questions of life and death carry an inherent responsibility and value that cannot be overlooked. Central to this is strengthening healthcare professionals' capacities for compassionate

encounters, for providing ritual and spiritual support, and for recognizing both parents as integral members of the family.

*Helena Krohn is a Doctoral Researcher in Theology at the University of Helsinki.*

### Chapter 13. Care recommendation: Perspectives to professionals treating fear of childbirth

*Hanna Rouhe*

I examine fear of childbirth and its treatment, drawing on research on fear of childbirth as well as my clinical experience as an obstetrician specializing in its care. My aim is to offer professionals perspectives on treating patients with fear of childbirth.

Fear of childbirth has increased markedly in the 2000s: according to diagnosis-related statistics, fear of childbirth was present in Finland in 2007 in 1.9% of those giving birth and in 2023 in 11.7%. Fear of childbirth can significantly hinder pregnancy and birth, and therefore its treatment is important. Anxiety during pregnancy affects the pregnant person, but also the fetus, influencing brain development and increasing the risk of mental health disorders. Fear of childbirth also affects wishes regarding starting a family and also the number of children. The increase in fear of childbirth is due to many different factors: people have a greater need than before to control life, negative birth stories appear in the public discourse, birth preparation education and orientation visits offered by birth hospitals have been reduced, and many maternity hospitals have been closed. First-time birth-givers mainly fear an unknown and uncontrollable birth situation, and those giving birth again fear the recurrence of a poor birth experience.

For all first-timers—and, when needed, also for those giving birth again—it would be important to provide childbirth preparation education offered by labor ward midwives. Often, good childbirth education is sufficient to treat mild fear of childbirth and improves the birth experience. Traditionally, fear of childbirth has been treated in specialist health care at appointments with a midwife and physician specializing in fear of childbirth. In Finland, group interventions for the treatment of fear of childbirth have also been implemented. The more severe the fear of childbirth, the more multiprofessional care is needed, with greater specialization in perinatal mental health. For a pregnant person suffering from fear of childbirth, a doula, i.e., a birth support person, can be recommended to provide support during pregnancy and birth.

In the care of a patient with fear of childbirth, personalised care and humane encounters are important, as is the pregnant person's experience of being heard and an understanding of the nature of the fear and its underlying factors. Digital solutions cannot replace a therapeutic human relationship. Every encounter with a professional during pregnancy can alleviate fear and increase trust. It is important to create for the pregnant person an experience that the care team and the birthing family are "on the same side," aiming for a safe birth and a good birth experience regardless of the mode of delivery.

Some pregnant people have an absolute preference for cesarean section, which may feel like a more controllable mode of delivery. Under no circumstances should anyone be pressured into vaginal birth. For a person requesting a cesarean section, it is important to promise that they will receive a cesarean if they still wish for it in late pregnancy. This promise, and the knowledge that moving to cesarean section from vaginal birth can be done when needed as a low-threshold "back door," can increase the pregnant person's sense of safety. During care, it is advisable to develop a birth plan together with the pregnant person regarding birth preferences, which can reduce fear. It is extremely important that everyone involved in care adheres to what has been agreed in advance. A fearful birthing person should be listened to with an open mind and helped to consider vaginal birth as an option. With good care, most people with fear of childbirth ultimately give birth vaginally. For the chosen mode of delivery—whether, after care, vaginal birth or cesarean section—it is important to obtain a physician's approval.

*Hanna Rouhe, PhD, is an Obstetrician specialized in fear of childbirth.*

## Chapter 14. Toward Trauma-Informed Maternity Care

*Ria Malva*

The systematic application of trauma-informed care in maternity services is still in its early stages, even though many situations encountered during pregnancy and childbirth can remind patients of past traumatic experiences and cause psychological distress. This article sheds light on the effects of trauma on birthing individuals, identifies situations in maternity care that can activate traumatic memories, and presents concrete approaches for implementing trauma-informed care. Birthing individuals experience power imbalances, loss of agency, and inadequate support in maternity care settings, which at worst can lead to re-traumatization.

Interaction in healthcare settings should be grounded in collaboration, where the patient's sense of safety emerges through a strengthened sense of control. Increasing agency is especially important for patients who have

traumatic experiences of things happening to them without their consent or choice. For those who have experienced sexual violence, the right to self-determination is paramount. Asking for consent has not traditionally been standard practice for healthcare professionals, but in trauma-informed care it is central. Patients should be informed of the progression and duration of procedures and examinations, and the professional should continuously talk through what they are doing.

In healthcare, it is also essential to recognize power dynamics and their impact on the care situation. Even the act of seeking care can bring up feelings of shame, fear, and powerlessness for individuals with a trauma background. The professional's sensitivity, continuity of the care relationship, and sufficient time for each encounter are key to creating adequate psychological safety.

Professionals cannot know which of the maternity care patients they encounter have experienced trauma, so trauma-informed care should be a universal practice in all patient interactions. Approximately half of Finnish women of fertile age have experienced sexual violence involving physical contact, and a third have experienced intimate partner violence. Traumatic experiences are therefore not a marginal phenomenon — they are a regular presence in healthcare encounters.

Implementing trauma-informed care requires a broader cultural shift in healthcare. Leadership support, adequate training, and clinical supervision are essential. The birthing individual's sense of safety must be seen as a care priority, sufficient time must be allocated for patient work, and the importance of consent must be recognized. Trauma-informed care reduces health disparities and improves care outcomes, particularly for more vulnerable population groups. It lays the foundation not only for a positive birth experience but also for the long-term wellbeing of the mother-infant pair, while simultaneously strengthening professionals' ability to do meaningful and ethically sustainable work.

*Ria Malva is a midwife specialised in trauma-informed care*

## Chapter 15. Maternity and Child Health Clinics—The Crown Jewel of Health Care? Mothers' Experiences of Pregnancy, Childbirth, and Maternity and Child Health Services in the FinLapset Survey

*Reija Klemetti*

Finland's maternity and child health clinic system (*neuvola*) has been regarded as “the crown jewel” of the nation's health care for over a century, providing support to pregnant women and families with children. The introduction of these services and their accessibility as so-called low-threshold services have contributed to reductions in maternal and infant mortality as well as improvements in vaccination coverage.

In recent years, however, questions have arisen as to whether maternity and child health services continue to meet the needs of all families in a changing society. Data from the FinLapset survey indicate that most women who have given birth are satisfied with the professional expertise of the clinics and with pregnancy monitoring. Nevertheless, many report insufficient support, particularly in preparing for childbirth, addressing fear of childbirth, supporting parenthood, and considering the needs of the whole family. Among first-time mothers, as many as one third rate their childbirth experience as worse than expected.

Dissatisfaction is pronounced both among women of lower socioeconomic status and among highly educated urban mothers. Mothers with a migrant background often evaluate services more positively than native Finnish mothers; however, they report more symptoms of exhaustion and have less information about available services.

Efforts to tailor services to individual needs have not been fully successful. The reduction of antenatal classes and its shift to remote formats have weakened experiences, especially among first-time mothers. Continuity of care and the provision of home visits are important but not consistently realized. In addition, a family's perceived poor financial situation is associated with nearly all services experienced as insufficient.

Societal changes—including rising maternal age, declining birth rates, parental exhaustion, and an increasingly diverse clientele—pose challenges for the maternity and child health clinic system and call for reform. In the future, service integration, individualized tailoring, and the development of family centers will be key to ensuring that the system retains its status as the crown jewel of Finnish health care.

The maternity and child health clinic system must evolve to better address the needs of diverse families and to utilize digital services alongside face-to-face encounters. Increased investment in antenatal classes and in the identification of fear of childbirth is also needed to improve childbirth experiences and strengthen support for parenthood. Through these measures, the clinic

system can remain a central component of services for families with children in Finland in the years to come.

*Reija Klemetti, PhD in public health, currently works at the Ministry of Health.*

## Chapter 16. In need of a safe haven: A sense of psychological security during pregnancy, childbirth, and early parenthood

*Mirjam Raudasoja*

In Finland, it is physically very safe to be pregnant and give birth, but pregnancy, childbirth, and transition to parenthood challenge every parent's sense of psychological security. This is due to physical vulnerability and the uncontrollable nature of the transition, as well as the feelings of uncertainty and fear from previous relationship experiences that are often reactivated. The transition to parenthood is a psychologically challenging developmental task, especially for those who have had challenging relationship experiences in the past.

Psychological security refers to an emotional state characterized by the absence of threats or dangers and an internal experience of safety, acceptance, and freedom to act. Although psychological theories emphasize the essential importance of a sense of security for parental well-being, very little direct research has been done on the subject. In Finland, maternity care systems focus mainly on physical safety, and their emphasis on efficiency and medical control suggests that the importance of psychological security is not sufficiently understood. For this literature review, I reviewed academic literature on psychological security in pregnancy, childbirth, and early parenthood considering my doctoral dissertation and supplementary literature.

A sufficient sense of security is a prerequisite for positive experiences of pregnancy and childbirth, as well as for the psychological well-being of parents transitioning into parenthood. Research suggests that childbirth experiences are not so much determined by specific events as by the feelings and interpretations associated with them. Although physical safety is the most important prerequisite for maintaining a sense of security, traumatic birth memories are most often associated with experiences of inadequate and psychologically damaging interaction with professionals.

Psychological security is created primarily through interaction, which is why it is important for the healthcare system to support the best possible encounters between professionals and parents. The responsibility for building security lies with professionals, and they need sufficient understanding, skills, and opportunities to support the sense of security of all types of parents. Based on research evidence, a model of continuity of care would be

the most important step in enabling the healthcare system to support the building of psychological security in the transition to parenthood. In this case, families would have a familiar, designated midwife who would take care of pregnancy monitoring, assist in childbirth, and provide postnatal healthcare. This model has been studied quite extensively, but it has not yet been implemented in Finland. Particularly people in a vulnerable position giving birth would benefit from the secure care contact enabled by continuity of care, which has also been shown to reduce various complications and have a positive impact on the birth experience. The continuous presence of a midwife throughout the birth provides somewhat similar benefits.

Insecure experiences cause psychological distress and traumatic symptoms, challenge parenthood, and may affect the number of children, while secure experiences can help to work through previously unfinished developmental tasks, which increases well-being. Taking psychological safety into account as much as possible shows that people giving birth are respected as valuable individuals, not just as tools for the renewal of the nation.

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## Chapter 17. The significance of the perinatal period for parental and child mental health

*Tiina Riekkö*

The concept of perinatal mental health refers to the wide range of mental health challenges related to pregnancy, childbirth and the postpartum period. Although the term is still relatively new and not widely known in Finland, the phenomena it refers to are better recognised. Perinatal mental health challenges include mental health problems related to pregnancy, childbirth and early infancy; psychological challenges associated with infertility and traumatic perinatal experiences; difficulties in early parent–infant interaction; and mental health symptoms in infants and toddlers.

I have examined perinatal mental health through my work as a general practitioner, specialist in psychiatry, researcher, and as Chair of the board in the Finnish Perinatal Mental Health Association. In this chapter, I consider the significance of the perinatal period for parental and child mental health in light of medical and psychological research, as well as professional experience. I also discuss challenges and opportunities within the Finnish healthcare system from the perspective of perinatal mental health.

Perinatal mental health involves both physical and psychological responses to the normative events, medical procedures and complications

of pregnancy, childbirth and early infancy. At the same time, the perinatal period—with its substantial changes and adaptation demands—may increase parents' vulnerability to mental health symptoms and the onset of psychiatric disorders. Parental wellbeing, caregiving capacity and interaction skills form the foundation for a child's mental health development. Many genetic, physiological, psychological and life circumstance factors contribute to a child's susceptibility to mental health problems, but parental perinatal mental health difficulties are among the most significant risk factors. Because of Finland's comprehensive maternity and child welfare -system and birth care, the perinatal period offers an excellent opportunity to identify families in difficulty and to intervene in negative developmental trajectories. This makes it possible to prevent the prolongation of parental mental health problems as well as the emergence of mental health difficulties in children.

The Finnish social and healthcare system provides many opportunities for addressing perinatal mental health problems, but there is currently no clearly established structure responsible for their care. At present, services are fragmented across multiple sectors of social and health care. A perinatal psychiatric service system could include multidisciplinary teams at both primary and specialist levels that focus on treating perinatal mental health problems and supporting both parental mental health and early interaction. Such a system would enhance family wellbeing, reduce the burden on professionals encountering families in crisis, and improve the efficiency of the service system. Building a highquality perinatal mental health service structure requires multidisciplinary collaboration and commitment, the use of research evidence, skilled professionals, adequate societal resources, and attention to parents' experiences and needs.

This chapter provides foundational knowledge on perinatal mental health from the perspectives of both parents and children. Understanding perinatal mental health and the needs and shortcomings of its service system is essential not only for social and healthcare professionals working with families with infants, bereaved parents and those experiencing involuntary childlessness, but also for decision-makers responsible for planning and developing services for families with children.

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## Chapter 18. Preparing for childbirth in maternity clinics

*Elina Jääoja-Virtanen*

This chapter brings together research findings on the significance of preparing for childbirth, as well as the expectations of pregnant persons and their partners regarding family work related to childbirth preparation. One of the key tasks of maternity clinics is to support expectant persons and their partners in preparing for childbirth and parenthood, as normal and low-risk pregnancies are monitored solely in maternity clinics, apart from fetal screenings.

According to a government decree, all first-time parents must be offered prenatal education that includes childbirth preparation. Prenatal classes are usually organized at maternity clinics, though childbirth classes may also be held in hospitals. Since maternity clinics and maternity hospitals in Finland operate as separate entities, it is particularly important to strengthen cooperation between them to ensure continuity of care.

Expectant parents hope that these classes provide not only information about childbirth but also practical exercises, peer support, opportunities to become familiar with the maternity hospital, and sufficient time and space for discussion. They wish instructors would acknowledge participants' individual needs and the role of birth partners. The classes are expected to increase confidence and a sense of competence as a birthing person, support person, and parent, as well as to foster a positive attitude toward childbirth. In addition, they are hoped to reduce fear and anxiety related to childbirth and strengthen trust in healthcare professionals.

Childbirth education is changing rapidly, with a growing shift toward digital formats. While online materials and online classes are cost-effective and easily accessible, they may not fully meet the expectations and needs of expectant parents.

Preparation for childbirth should also be taken into consideration during regular maternity clinic visits. Above all, pregnant persons value being treated with respect, feeling heard, and having their possible fear of childbirth taken seriously. It is also important to consider individual needs. Maternity visits should allow enough time and space for in-depth discussion. The topic of childbirth preparation and its significance should be raised early enough, for example during the maternity clinic visit at weeks 13–18 of pregnancy, when the family's resources are also assessed.

In maternity clinics, it is essential to encourage expectant persons and their partners to prepare for childbirth, to reflect on their thoughts and expectations, and to write down them for the midwife who will be assisting with the birth. In addition, support for fear of childbirth or mental health challenges should be readily available and easily accessible.

*Elina Jääoja-Virtanen is a midwife and a public health nurse who holds a Master's degree in Public Health and has studied birth education in her master's thesis.*

## Chapter 19. Nervous system downregulation and relaxation techniques in pregnancy and labour

*Tuisku Koskela*

In my chapter, I examine the use of relaxation methods in pregnancy and labour care. My perspective draws both on existing evidence and on my experience as a midwife and childbirth educator specialized in relaxation techniques. Various relaxation methods have been applied and studied in the context of childbirth, including breathing techniques, audio analgesia, vocalization, progressive muscle relaxation, hypnosis and selfhypnosis, visualization, mindfulness, and yoga. Among these, breathing is the most commonly used method during labour. According to current evidence, the World Health Organization recommends relaxation techniques for healthy parturients who request pain relief during labour, depending on their preferences.

Most parturients hope to experience a physiological, lowintervention birth. Relaxation methods can support this by facilitating physiological birth processes, helping manage pain, and reinforcing a positive birth experience. Their use during pregnancy and childbirth may also have positive effects on the postpartum period, early parenting, and longterm child health outcomes. These benefits are grounded in physiological mechanisms, hormonal pathways, and in addressing the psychophysiological and social needs of the birthing person.

Relaxation is a learnable skill, and regular practice during pregnancy is advisable. Childbirth preparation classes should incorporate relaxation techniques, at minimum deep breathing strategies. It is essential that all information and counselling provided are realistic and aligned with clinical practice. Pregnant persons who have a fear of childbirth benefit particularly from practising relaxation methods. During maternity clinic visits, personal skills, preferences, and intentions related to relaxation should be considered and also communicated to the professionals involved in intrapartum care.

Professionals, birth companions, and labour support persons play a central role in promoting relaxation during labour, and they require appropriate knowledge and skills to apply these techniques effectively. Supportive measures to promote relaxation may include optimizing the environment, using touch and massage, breathing and vocalizing together with the labouring person, assisting with comfortable positioning, and supporting free

movement. Relaxation techniques should also be incorporated into care when medical interventions are used.

For many parturients, it is easiest to adopt relaxation guidance during early labour, when pain intensity remains moderate. In the Finnish health-care system, where a parturient typically does not meet the midwife until active labour has begun, opportunities to provide such guidance early are limited. Nevertheless, within the existing system, relaxation can still be supported through maternity assessment units, birth preparation classes, and telephone counselling during labour.

Consideration of relaxation should also inform the design of birth environments. Increasing opportunities for midwives and support persons to assist parturients during early labour could enhance relaxation, promote physiological birth, and contribute to more positive birth experiences. Professionals working in pregnancy and labour care would benefit from education on the neurophysiology of birth and on the practical use of relaxation methods, ideally integrated already during their professional training and later reinforced through continuing education.

*Tuisku Koskela is a midwife and a relaxation and stress-management specialist*

## Chapter 20. The rhythms of midwives' work in an efficiency-driven maternity ward

*Johanna Sarlio-Nieminen*

Maternity hospitals in Finland have decreased sharply in number. While there were 41 at the turn of the millennium, by 2025 only 21 remained. Increased centralisation of care has brought efficiency measures and practices of operational management into childbirth care, which has influenced the routines and rhythms of midwives' work. This chapter examines the daily midwifery work and its rhythms in two maternity hospitals of different size, one of university hospital and that of a central-level smaller hospital as described by the midwives who work in them. The research data was collected using the memory-work method. It consists of written memories of two groups of midwives of five midwives and the researcher in each group. The data was later analysed by the researcher using the rhythm analysis developed by Henri Lefebvre.

Examining the narratives on midwives' daily work in groups brought to light perspectives through which increased busyness or responses to changes during childbirth were identified and verbalised. Maternity wards appeared as multi-rhythmic spaces, where different rhythms occur simultaneously. These include the organisational rhythms of the hospital, rhythms related

to the midwife's work and shift, as well as the embodied rhythms associated with the expectant mother's pregnancy and childbirth. The rhythms are often repetitive but differ in their nature. Organisational practices linked to efficiency have shaped the work of midwives. A central idea that emerged in the groups' analysis concerns the identification of so-called "waste" time, as referenced in lean thinking, and the effective use of resources.

In the language of maternity hospitals, these ideas are encapsulated in the term "throughput time," which refers to the length of the mother's hospital stay that is aimed to be shortened. The pace of midwives' work has accelerated, especially in large, efficiency-driven hospitals, where the mechanical rhythms of the organization shape midwifery work to adapt to them rather than to the rhythms of the birthing mothers. The friction between the embodied rhythms of childbirth and the mechanical rhythms of the organization burdens midwives, who strive to shield mothers from the tensions between these different rhythms. The hospital organization's time constraints and practices often limit midwives' opportunities to provide present and unhurried support during childbirth.

The results of this chapter show that intensified organizational rhythms allow midwives less presence with mothers in labour and increase the burden on midwives. They highlight how challenging it is to work under the pressure of conflicting rhythms, where one feels more like a factory worker than a companion at birth, when mothers are in need of the midwife's presence. According to the midwives, there is an urgent need for better resources and for calming the rhythms that support positive birth experiences and help retain midwives in their work.

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## Chapter 21. Cultural diversity and encounter during childbirth - an address by a midwife and a researcher

*Outi Kaasinen & Anita Wikberg*

Our chapter discusses the importance of cultural diversity in obstetric care and midwifery. Giving birth in a foreign environment and in a foreign language or without a common language at all requires a great deal of trust between the birthing person and the midwife. Trust serves as the basis for the person giving birth to feel safe, receive high-quality care and have a positive birth experience. The person giving birth comes with their entire life situation and history, and each encounter with healthcare professionals can either

strengthen or weaken trust. Legislation requires that the patient's language, culture and individual needs be taken into account.

Midwives working in Finland increasingly encounter people giving birth from diverse cultures. Cultural background can affect the birth experience, expectations for childbirth and ultimately health. Differences in birth outcomes have been observed between the indigenous population and people from other cultures, for example, caesarean sections, vacuum extractions and Apgar scores. Refugees are at higher risk of poor birth outcomes, and traumatic experiences such as war, previous violence or genital mutilation can make birth difficult, impairing the ability of the woman in labour to feel confident and interpret her own body's sensations.

Cultural and linguistic understanding is the foundation of good care. The availability of interpretation, the gender of the interpreter and the clarity of communication are key factors, as the level of knowledge and health literacy of the women in labour vary. Linguistic barriers can increase fear and the experience of pain. The sensitivity of the midwife, her unhurried presence and non-verbal communication are emphasized in the absence of a common language. The wishes of the woman in labour, especially in connection with intimate procedures, must be respected. Cultural expectations also affect the behaviour of the woman in labour and the expression of the need for pain relief.

Successful intercultural encounters reduce misunderstandings, support the woman in labour and improve the birth experience. Open interaction, cultural sensitivity, and respect for the wishes of the woman in labour are essential to multicultural childbirth care.

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*Anita Wikberg is a Doctor in Health Sciences and a midwife*

## Chapter 22. Bioethics of Ghosts: A Call for Reproductive Justice in Finnish Healthcare

*Tiia Sudenkaarne*

In this chapter, I discuss birthing in the framework of reproductive justice, not limited to reproductive rights. In the field of applied ethics, I map out needs and vulnerabilities of people of gender and sexual variance (LGBTQI+) and racialized people to bridge a lacuna for further research.

There is little data on birthing experiences of queer, trans and/or Black and Brown people in Finland. By thinking with philosophical concept analysis, my chapter seeks to shed light on ghosts as sociologist Avery Gordon

defines them: elusive and eerie everyday situations and specters that hark back and forth to various forms of structural and direct violence that marginalized bodyminds are subjected to. Essentially philosophical in nature, this chapter does not deliver the data but seeks to offer a theoretical framework in which such data could be analyzed to alleviate injustice.

What I suggest is a reproductive justice framework for Finnish healthcare. This approach, originating from US Black feminist activism and applied to Finland by my colleagues Mwenza Blell and Riikka Homanen and myself, seeks to focus on intersectional possibilities to have children, not to have children and to parent the children one has in a safe and sustainable environment, and to refuse focus of liberal feminism choice talk. In an application of the framework to Finnish healthcare in terms of birthing, I discuss ghosts in the Machine, those marginalized in the historic makings of the welfare state. I analyze how normative reproduction politics, including rhetoric of so-called birthing crisis in Finland, is focused on white, middleclass cis- and heteronormative people's reproduction.

Activism around birthing, with a specific focus on obstetric violence that has been unheard of in Finland, has created a political and ethical discourse that now needs to give platform to marginalized voices. I conclude that based on further research on marginalized birthing experiences in a reproductive justice framework, healthcare professionals and the system needs to learn to recognize the ghosts in the machine, for example, by developing antiracist practices, subscribing to trans-affirmative treatment and understanding specific queer vulnerabilities.

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### Chapter 23. Centralisation of Hospital Births and the Threat of "Cheapening" Birth Care: An Intervention in Defence of a Good Birth and a Good Beginning of Life

*Sirpa Wrede*

This chapter examines the trend towards the centralisation of childbirth services in Finland from sociological and historical perspectives. It is presented as an expert commentary grounded in long-term research on maternity care. The discussion arises from a situation in which childbirth care in Finland has become increasingly politicised in recent decades, and health policy decision-making has come to emphasise economic efficiency at the expense of humane and socially oriented care. Underlying this trend is a belief in the

superiority and efficiency of large maternity hospitals—an assumption that is not supported by unambiguous research evidence.

The need for a critical examination of childbirth policy stems from cultural and institutional changes in childbirth care, in which the experiences of birthing women, the expertise of midwifery, and continuity of care have been sidelined. This text analyses the process of the “cheapening” of childbirth care: how the logic of efficiency, doctrines of industrial production, and the technocratic rationalisation of hospital administration reshape the human meaning of childbirth.

The essay draws on extensive international and comparative research on maternity care. Through this lens, childbirth policy appears as part of a historical continuum in which the autonomy of midwifery has been progressively narrowed and childbirth has become increasingly medicalised. The analysis shows that the centralisation of birth care has been justified in the name of safety, while overlooking the fact that birthing women experience insecurity related to long travel distances and the discontinuity of care.

The chapter’s key critical contribution is the concept of the cheapening of childbirth care, which describes the diminishing recognition of the human and cultural value of care in the name of efficiency. It highlights that childbirth policy is also a question of values and human rights: birth is not only a medical event but also a societal one.

This critical perspective can inform decision-making and the development of service systems by incorporating a broader understanding of safety and wellbeing into childbirth policy—one that respects the birthing person’s experience and the expertise of midwifery as much as considerations of efficiency and economics.

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## Epilogue: The powers of life and death and the enchantment of birth

*Kaisa Kuurne & Anna Leppo*

In the final chapter of the book, we reflect on how enchanting the birth of a new human being is. In modern Finland, childbirth is so closely linked to the medical understanding of pregnancy and birth safety that even the majority of birth-givers’ own stories are drawing on a medical perspective and vocabulary. Some birth stories are however different connecting birth to the great forces of life, vulnerability, and the experience of bringing a new, unique human being into the world.

Some birth narratives are life-altering and their language escapes the clinical hospital setting and its medical worldview and vocabulary. As an lived experience, birth can be deeply meaningful, even an extreme or mystical experience that can be difficult to accommodate in the way we perceive life in our culture. These stories often describe the powerful presence of death in birth in ways that are meaningful. Birth stories may feature a significant transition, deceased ancestors, a “memento mori” experience in which one’s own mortality becomes a vivid reality, or a stillborn child whose beautiful and powerful birth may even after death strengthen the parental bond.

Birth may be surrounded by an almost mythical beauty, which can carry an otherwise difficult birth experience and invite the parent into connection with the child even after a procedural birth that has been experienced as ugly. In this final epilogue, we reflect on stories and literature to consider how important it is in the understanding and care of childbirth to create space for a possibility of enchantment, beauty, and deeply meaningful experiences. Such experiences can give strength and meaning to many, but will especially help carry through difficult and rough experiences that some have to go through.

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