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Dutch Women's Perceptions of Childbirth in the Netherlands

Taralyn R. Johnson

Lynn Clark Callister

Brigham Young University - Provo

Donna S. Freeborn

Brigham Young University - Provo

Renea L. Beckstrand

Brigham Young University - Provo, renea@byu.edu

Katinka Huender

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Dutch Women's Perceptions of Childbirth

ABSTRACT

Purpose: To explore the lived experience of childbirth in Dutch women who had given birth at home in the Netherlands.

Methods: Qualitative study using audiotaped interviews with 14 women.

Results: Themes included the advantages of giving birth in the home, where the women felt more in control of their environment; the difficulty and normalcy of the pain associated with giving birth; the feelings of fulfillment and empowerment that come with childbirth and motherhood; and the importance of the supportive role of the midwife-caregiver.

Nursing Implications: Women in a culture different from that of the United States who gave birth at home felt fulfilled and empowered by the experience. These results can help U.S. nurses more fully understand the meaning of childbirth in a different culture and may help identify possible improvements in the design of care for women and newborns in the United States.

Key Words: Childbirth; Dutch; Maternity nursing; Birth; Culture.

in the Netherlands

Taralyn R. Johnson, MSN, RN, Lynn Clark Callister, PhD, RN, FAAN, Donna S. Freeborn, MSN, FNP, CNM, Renea L. Beckstrand, PhD, RN, CCRN, and Katinka Huender, Dutch Midwife

Childbirth in the United States is often seen as an expensive and highly technological process, potentially fraught with complications. This is not so in the Netherlands, where childbirth is generally viewed as a low-risk part of normal family life and is associated with modest costs, excellent maternal and infant outcomes, and a high percentage of home births attended by professional midwives. Many studies have detailed the factors that contribute to this system, but there were no studies found in English about the cultural meaning of childbirth to Dutch women. The purpose of this research study, therefore, was to describe the meaning of childbirth to Dutch women giving birth at home in the Netherlands and identify components of their care that are worthy of inclusion in the United States.

Compared to other modernized nations in the western world, the Netherlands has a very unique approach to healthcare for childbearing women and newborns. The Dutch have a home birth rate of about 30%, whereas other countries with advanced healthcare systems have rates below 3% (DeVries, 2001; Wiegers, Van der Zee, Kerssens, & Keirse, 1998, 2000). However, the common Dutch practice of giving birth at home with a midwife translates into excellent maternal and infant outcomes, including a low infant mortality rate and a low rate of maternal complications and interventions, including cesarean birth. In 2005, the infant mortality rate in the Netherlands was 5.04 per 1,000 live births, whereas in the United States it was 6.5 per 1,000 (United States Central Intelligence Agency, 2005).

The Dutch place a heavy emphasis on prenatal and preventative care, which helps to identify pregnancies with potential complications. Low-risk childbearing women are treated as healthy clients. Many authors note the culture of normalcy that pervades Dutch perspectives of childbirth (DeVries, 2001; Lavender & Baker, 2003; Shirm, Tobi, & De Jong-van den Berg, 2002; Stubbs, 2003). Childbearing is also seen as a healthy, rather than medical, condition by Dutch insurance programs and by the government of the Netherlands. Both private insurance companies and government health funds cover only midwives or family physicians and home birth or short-stay hospital births (where women stay for only a few hours or possibly overnight in the hospital) for low-risk pregnancies (DeVries, 1996, 2001; Jabaaij & Meijer, 1996). Only high-risk pregnancies are referred to obstetricians. Midwives use a strict set of criteria—called an indication list—to screen for probable complications in pregnancy. Women whose pregnancies are determined to be high risk are referred to a specialist. Depending on the severity of the condition and other factors, the midwife may or may not continue to participate in the care of each particular high-risk pregnancy (DeVries, 2004).

Several factors—besides the indication list and government sponsorship—support midwife-directed obstetric care and home birth in the Netherlands. The geography of the Netherlands is such that most women are within 20 minutes of a hospital, which makes for easy transfers from home to hospital should complications arise during the birth (DeVries, 2004). Also of note is the mandatory and consistent education that midwives receive in order to practice: 5 years of secondary school followed by 4 years of midwifery school (DeVries, 2004).

What is unknown is how Dutch women feel about their choices during pregnancy, especially about home births, in which only 2% receive pain medication (Shirm, Tobi, & De Jong-van den Berg, 2002). In the Netherlands, it has been shown that for women with low-risk pregnancies, outcomes of planned home births are as good as or better than the outcomes of hospital births (Wiegers, 1998; Wiegers, Keirse, Van der Zee, & Berghs, 1996). Women who choose to give birth at home have fewer obstetric interventions and referrals to secondary care (Van der Hulst, Van Teijlingen, Bonsel, Eskes, & Bleker, 2004). A woman pays extra (about 240 Euros or \$285 more) to give birth in the hospital (DeVries, 2004). Although these studies may help to explain the high rate of home birth in the Netherlands, there has been little research on how Dutch women view childbirth, and no studies that express the meaning of childbirth to Dutch women in their own words were in English. The purpose of this qualitative descriptive study was to describe the meaning of childbirth to Dutch women giving birth at home. This work built on cross-cultural studies of the meaning of childbirth (Callister et al., 2007; Callister & Vega, 1998; Callister, Lauri, & Vehvilainen-Julkunen, 2001; Kartchner & Callister, 2003; Khalaf & Callister, 1997; Semenic, Callister, & Feldman, 2004).

Methodology

After Institutional Review Board approval, 50 women who had given birth at home in the Netherlands from July 2004 to July 2005 and who had received healthcare services from the Midwife Clinic of Voorburg near The Hague were invited to participate in the study through a flyer mailed to their home by a midwife from the Voorburg clinic. The women were given the contact information of the primary investigator and assured that their personal information would not be given without their permission. The first 13 women who replied were accepted for the study, and another woman joined through the invitation of 1 of the original 13 participants. They were given the choice to be interviewed in Dutch or English, and a bilingual translator joined the interviews of women who wished to be interviewed in Dutch (2 of the 14 women). The consent form was provided in Dutch, and the demographics form was also offered in Dutch, although all of the participants chose to fill out the demographics form in English. This is consistent with national language statistics; nearly 80% of people in the Netherlands are fluent in English (*Overseas Digest*, n.d.). After both forms were signed, appointments were made for 60-minute audiotaped interviews to be held in the participants' homes.

An interview guide was used to obtain information from participants. The principal investigator (and for two Dutch language interviews, a bilingual translator) participated in the interviews, which took place in June and July 2005. Questions were based on Nichols' (1996) meaning of the childbirth experience. Sample questions included "What was your childbirth like?" and "What was most helpful to you as you labored and gave birth?" Participants were also asked, "Were there any cultural practices that were important to you during postpartum?" and "What is important for midwives and nurses caring for childbearing women to know?" Additional clarifying questions were asked as appropriate for qualitative research (Rubin & Rubin, 2005).

Audiotapes were translated and transcribed verbatim. Data included transcripts of the interviews, field notes, member checks, and confirming conversations with the collaborating Dutch midwife. Thematic analysis of the transcripts was conducted as appropriate for descriptive qualitative inquiry, and themes were revealed within the rich narrative data obtained during the interviews (Ayres & Poirier, 1996). The researcher and the women were partners in the sharing of stories, and a naturalistic approach was used to gain an understanding of Dutch childbearing women's perspectives (Lincoln & Guba, 1985).

Trustworthiness of the data was established through member checks, with the principal investigator discussing the data collected with at least 5 study participants to verify that the data accurately described their experiences. The principal investigator established an audit trail by keeping a journal of impressions associated with data collection and analysis (Hesse-Biber & Leavy, 2006). The investigator also worked with the co-investigators in analy-

sis of the data. Data saturation was achieved in each thematic category. To counter the possible outsider bias from the principal investigator, data were provided to the collaborating midwife of the Midwife Clinic of Voorburg, who verified the findings.

Sample Demographics

The final sample consisted of 14 women between the ages of 25 and 38 ($M = 32$) who were interviewed within 1 year of giving birth at home. All were White Dutch women from Voorburg who had vaginal births. Eight women were married, and 6 were in committed relationships. The women had between one and five pregnancies ($M = 2.2$ pregnancies). Nine had experienced previous births, and 5 were first-time mothers. Two women had previous miscarriages (four miscarriages total), and 1 had a previous abortion. None of the women received any analgesia/anesthesia during labor and birth at home, and only 1 woman reported complications (maternal postpartum infection that occurred 3 days after birth). One of the women reported complications with a previous birth, however (i.e., failure to progress), for which she was transferred to the hospital. Two others reported complications with previous hospital births (i.e., placental retention and neonatal hypoglycemia). All of the complications were resolved without long-term consequences.

The women began their prenatal care between 10 and 16 weeks' gestation ($M = 12.5$ weeks' gestation). They had a mean of 10.7 prenatal checkups. Nine women reported attending prenatal childbirth classes, and 4 reported attending childbirth classes during a previous pregnancy. One woman had completed high school, 5 were college graduates, and 8 others had completed graduate school. All 14 women had the baby's father for a support person during labor, and 3 more reported additional support (the attending midwife, a mother, and a friend).

Background on Birth in the Netherlands

A summary of the preparation and process of home birth as described by the participants may help place the findings in context. Many mothers educate themselves by going to yoga or other classes for expectant mothers. These classes commonly teach women and their partners about pregnancy and birth, staying healthy, and navigating the maternal/newborn healthcare system. They also include breathing techniques for pain management in labor and provide a way for pregnant women to get together to talk and express their feelings. Mothers also educate themselves

by reading various books, watching television programs, and asking questions and talking about procedures with the midwives.

To prepare her home for birth, the mother purchases a home birthing kit, which consists mostly of disposable supplies, to be used during the birth. These kits, covered by insurance companies, are a helpful—but not absolutely necessary—part of home birth in the Netherlands. When labor begins, the mother calls the midwife, who stops by the home to check on the woman's progress. Depending on how the woman is doing and how she is progressing, the midwife either stays or returns later. The midwife brings her own medical bag with all the tools necessary to assist a home birth, including a few medications, a small tank of oxygen, resuscitation equipment, a stethoscope, and a few other supplies, all of which fit into a container the size of a large tackle box. She may also bring a birthing chair and a laptop computer.

Only women with high-risk pregnancies are referred to obstetricians in the Netherlands.

"[There] was a big difference with delivery at home. You're only with the midwife. It was very intimate."

Usually the nurse arrives in time to assist the midwife with the birth and, if necessary, with resuscitation. This nurse is another support person for the mother and is instrumental in postpartum monitoring and education. She returns to the home every day for a week to help the new mother and father learn how to take care of the baby and alleviate the mother's load by cooking meals, cleaning, and running errands. She also assesses and records the mother's and baby's progress in a similar manner to that of postpartum nurses in the United States. Postpartum home visits are performed by the midwife to check the medical and emotional condition of the mother and infant and support and assist them in breastfeeding. This preparation and process involved in home birth seems very conducive to the family's needs and comfort.

An interesting sociocultural point brought up by many of the women was the acceptance of their roles as mothers

by the government and employers. Women in the Netherlands are entitled to 16 weeks of full-pay maternity leave, to be taken either before and/or after the birth, according to the wishes and convenience of the mother. The women also may cut their work week down to 3 or 4 days (which many of them did) after the baby is born.

Cultural expressions of the celebration of the birth of the child were evident through various customs expressed by the participants. Nearly all of them handed out biscuits covered with candied anise seeds, called *beschuit met muisjes*, to their friends, family, and colleagues. They also sent out elaborate birth announcements within a few weeks of the birth. Birth was seen as an exciting family event. Shortly after the birth, family and friends were invited to the home to celebrate the arrival of the new family member.

Findings

Themes emerging from the data included the advantages of home birth and the perceptions of childbirth pain. These Dutch women also had common perspectives on the importance of the midwife being a trustworthy and emotionally supportive care provider. Birth was seen as a difficult but natural event, and the idea of motherhood gave feelings of completeness along with increased stress and responsibility. Quotes from the women's narratives are included in the subthemes below to improve understanding of the participants' experiences and perceptions (Ayres & Poirier, 1996).

Advantages of Birth at Home

There were several advantages attributed to giving birth at home. Women reported that at home they could be in control of their environment and do things on their own schedule. As one woman stated, *"Here at home, everything could happen when it needed to happen and that was very comforting to me, very relaxing."* The home was seen as a calm, quiet place—an environment of peace and harmony. *"The environment was quiet and calm and that made me quiet and calm as well."* At home the participants achieved a sense of privacy and intimacy. *"[There] was a big difference with delivery at home. You're only with the midwife. It was very intimate."*

Women who had previously experienced a hospital birth were very positive about giving birth at home within a calm, peaceful environment surrounded by loved ones with a supportive midwife caregiver. One explained, *"I knew that [my husband] was there and I wasn't stuck to any wires or other awful things. So I could just freely move around."*

The home was seen as a comfortable, safe environment for birthing, a place where women could be in control of their bodies and their surroundings. Things could take place on a more natural and peaceful schedule because of the lack of outside influences. Although the participants felt comfortable knowing the hospital was an option if it became necessary, they were grateful for, and preferred, home birth.

Pain Experience

For these Dutch women, the pain of birth was seen as a difficult but surmountable part of the entire experience and not something to be feared. The pain had a natural function and could be accepted. *"It's a very extreme experience. Of course, a very natural biological process and because you're so busy coping with the pain, it's a very introverted experience.... You listen to yourself and concentrate on the pain."* By some women, the pain was even appreciated for its integral function. *"It was a beautiful experience, including the pain."* Labor and the associated pain were not seen as easy by these women but rather were viewed as a difficult experience that they could overcome. *"[Labor was painful and long. What kept me going was] that there was a child at the end. That kept me going. I thought she must come out, one way or the other. She will and it will end."*

The participants spoke of trusting themselves and working with the pain as a normal expected part of the process of laboring and giving birth. Pain was part of the work of labor (Lowe, 2004). As one stated, *"[Labor] is painful but you have to trust in your self confidence.... Try and not fight it."* The pain of childbirth also became a way for these Dutch women to get to know themselves better. *"The way you act, the way you respond to the pain and the whole process. It is quite a mirror in a way."* The women discovered inner power during the extreme experience of giving birth. *"I really went down to my earth.... The deep down feelings. You have a lot of strength.... I didn't know I had it."*

For the women interviewed, the pain associated with labor was real and intense, but it was not something to be feared. Rather it was to be accepted, dealt with, and used constructively. This acceptance of pain as a normal part of childbirth that does not usually need pharmacological intervention has been documented in other cultures (Callister, Khalaf, Semenik, Kartchner, & Vehvilainen-Julkunen, 2003). An element of self-discovery and self-understanding also was achieved through the pain.

Role of Caregiver (Midwife)

The midwives' clinical knowledge was reassuring to the participants and allowed them to trust in the safety of birth at home. As one woman stated, *"When the midwife came...the most important thing to me was that somebody had the knowledge to know what was going to happen."* For these women it was especially important that the midwives inspired confidence and trust. One explained, *"It is important that they assist you in trusting your body to know what has to be done, reassuring you that what is happening is natural and good."* The women described a need for the midwives to provide emotional support and encouragement. *"I expected her to give me courage,"* another mother said.

The midwives who provided healthcare for these women were most appreciated for their ability to relate to the women, give good instruction and labor support, and

inspire feelings of trust and confidence. While acknowledging the importance of the care providers' clinical knowledge and expertise, these Dutch women emphasized the importance of having a care provider they could trust and who would encourage, support, and connect with them.

Meaning of Giving Birth

Childbirth was viewed as a very natural occurrence that should remain as uncomplicated as possible. *"I do not agree that it is so difficult.... Why do we have to do so much for it? It's just something Mother Nature has arranged."* For some women, birth was a fulfillment of the purpose of their bodies. *"Women, that's what we are made for [to bear children]."* Labor and birth was seen as a short period of time with large rewards. As one woman described, *"It was every intense but short. And everything that comes afterwards is so rewarding."*

The women expressed a sense of self-actualization. One mother captured the feeling shared by others: *"I did it! I succeeded! I am capable of doing such a thing and I am capable of being calm during the process. I felt so in touch with myself."* Meaning was articulated as these women recalled the moment of birth. *"Seeing her little face, I'll never forget that. I remember being ecstatic, very happy and very powerful. You feel you are capable of doing almost anything."*

Birth was described as a natural process with immense rewards. It was a joyful event that gave feelings of empowerment. Some women accepted birth as one of the purposes of their bodies. For each of the women, it was a special moment in time, to be remembered and cherished.

Meaning of Motherhood

Becoming a mother changed how the participants viewed

themselves and how they were viewed by others. *"You have changed, you are not the same anymore.... So my life became a hobby. And me? I became [my child] to a certain extent."* Having a child provided feelings of completeness and changed the way they saw the world. *"[It has changed] the way I look at the world. It is so fun to see it through her eyes. Everything is new, and all the things you don't see anymore, you notice again."* A new child became a part of the women's life and a part of themselves. *"She is there always.... She's a part of me and it feels like that."* Priorities shifted as the new member was added to the household. *"It is so special to have a baby. I had to change my priorities. In the past, my career has been very important. It is not that important anymore. Children are so much more important."*

For these women, becoming a mother was a pivotal transition that brought changes in perspectives and priorities. The participants expressed feelings of frustration at the difficulty of the change brought by a new child but focused more on the joy and fulfillment they associated with having a child.

Implications for Clinical Practice

It is unlikely that the Netherlands' entire model of childbirth could be adopted into the United States. Complete healthcare systems cannot be adapted easily from one society to another. As DeVries (2004) argues, in obstetrics, it is societal norms that determine scientific outcomes rather than the other way around. Although it may be impractical to transplant this entire system to another culture, there are several elements of Dutch healthcare for childbearing women and their families that could be implemented for maternal/newborn healthcare in the United States.

One of the most important factors in the Dutch healthcare system is universal access to maternal and newborn care. Although the United States does not have universal healthcare, much could still be done to improve access to care (e.g., insurance incentives for women who attend a certain number of prenatal checkups and extension of government-funded healthcare to more pregnant mothers). Another important factor of the Dutch system worthy of inclusion in the United States is the high percentage of births attended by midwives. The care provided by Dutch midwives can easily be compared to that of Advanced Practice Registered Nurses or Certified Nurse

In the Netherlands, childbirth is generally viewed as a low-risk part of normal family life and is associated with modest costs, excellent maternal and infant outcomes, and a high percentage of home births attended by professional midwives.

Midwives in primary women's healthcare in the United States: cost effective, safe, evidence based, and rated high in patient satisfaction (MacDorman & Singh, 1998, Venning, Durie, Roland, Roberts, & Leese, 2000).

The Dutch view childbearing as a wellness experience, emphasizing health promotion and disease prevention. Childbirth in the United States is often characterized by a focus on control, predictability, efficiency, and calculability rather than quality of the birth experience (Parratt, 2002). Maternal healthcare providers in the United States could adopt the Dutch evidence-based practice of a judicious use of technology and pharmacological pain management. There has been no significant, demonstrated correlation between pharmacological pain management and satisfaction with the childbirth experience (Hodnett, 2002).

Providers in the United States also can implement

be more likely to) have increased satisfaction with their childbirth when there is a decreased amount of technology and an increased amount of emotional support. This research also may help to enhance cultural competence of nurses and other healthcare providers as descriptive data are generated about women's perspectives and beliefs about childbearing.

Limitations and Suggestions for Future Research

This study was conducted from an outside perspective because the primary investigator is not a member of the Dutch healthcare delivery system. To help prevent this factor from influencing the conclusions, findings were confirmed by the collaborating Dutch midwife from the Midwife Clinic of Voorburg. Participants for this study were drawn from a single town and mainly from one midwife practice, so findings may not be reflective of all women giving birth in the Netherlands. The healthcare system is consistent throughout the country, however, and midwives have standardized licensure requirements.

Future research on Dutch childbirth should include studies on pain management and coping in an analgesia-free environment. Also of benefit would be a study comparing Dutch perceptions of family adjustment and bonding with the United States' standard maternity leave of 6 weeks and the Dutch maternity leave of 16 weeks.

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Conclusion

The unique approach to maternal care found in the Netherlands is a product of many factors and is very successful in terms of mortality, morbidity, and patient satisfaction. This study was an attempt to discover the perceptions of Dutch mothers about childbirth within the framework of the Dutch healthcare system. Shared themes extracted from the data include attitudes and perceptions about home birth, the pain experience, the role of the midwife-caregiver, and the meaning of birth and motherhood. Some of the beneficial attributes of the Dutch maternity system, as articulated by these women, can and should be implemented into maternal and newborn healthcare in the United States.

The mothers who participated in this study were very positive about giving birth in a calm, comfortable environment with a supportive caregiver. They appreciated and made use of the extensive prenatal education available to them. They recalled feelings of comfort, joy, and empower-

For the women interviewed, the pain associated with labor was real and intense, but it was not something to be feared. Rather it was to be accepted, dealt with, and used constructively.

changes that would lead to the empowerment of women: giving them the education necessary to share in the decisions about their healthcare, providing emotional support, encouraging self-confidence and a sense of control, and listening to the women's voices. It is feasible to replicate the Dutch environmental characteristics that contribute to feelings of maternal control to hospitals in the United States. These characteristics include freedom of movement, an emphasis on comfort, thorough maternal education, focusing on the woman's desires for her experience, and the use of nonpharmacological pain management strategies.

It is hoped that this research will help increase understanding of healthcare delivery systems outside the United States and help inform policy making and program design (Bradley & Bray, 1996). Increased cultural awareness can contribute to continuous quality improvement in women's healthcare delivery (Hinds et al., 2003). Ideas may be generated about making healthcare in the United States more cost effective, health promoting, and satisfying to women. The findings of this study show that women can (and may

ment in giving birth in a supportive atmosphere where they felt in control of their bodies and their birthing experiences. These positive aspects of Dutch maternity healthcare, as described by these women, should rightfully belong to all women experiencing childbirth. ❖

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Taralyn R. Johnson is a Family Nurse Practitioner, Pediatric Care, Provo, UT.

Lynn Clark Callister is a Professor, College of Nursing, Brigham Young University, Provo, UT, and an Editorial Board Member of MCN. She can be reached via e-mail at lynn_callister@byu.edu

Donna S. Freeborn is an Instructor and Co-Coordinator of the Family Nurse Practitioner Program, Brigham Young University, Provo, UT.

Renea L. Beckstrand is an Associate Professor of Nursing, Brigham Young University, Provo, UT.

Katinka Huender is a Midwife, The Midwife Clinic of Voorburg, the Netherlands.

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www.knov.nl/

Transcultural Nursing Society
www.tcns.org/

National Center for Cultural Competence
www.gucchd.georgetown.edu/nccc

Diversity RX
www.diversityrx.org

Ethnomed
<http://healthlinks.washington.edu/ethnomed/>
World Health Organization
www.who.int/

US Department of Health and Human Services, Office of Minority Health
www.omhrc.gov

US Department of Health and Human Services, Health Resources and Service Administration (HRSA)
www.bphc.hrsa.gov