

# Pregnancy and Childbirth Experiences: A Review of the Care Agencies and the Nature of Care

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**Abstract** It is true that motherhood is often a positive and pleasing experience. However, this is coupled with the pregnancy related complications which if not taken care of can lead to maternal as well as infant mortality. According to World Health Organization (WHO) of all health statistics, the maternal mortality statistics between the developing and developed countries display the greatest difference. Maternal deaths occur mostly in poor countries due to the risk of dying from pregnancy related complications. Inept management of pregnancies and births cause high infant mortality and disability among infants. This situation has remained almost unchanged for many years. This paper makes an assessment of nature of various types of care provided to the pregnant woman and also tries to find out the impact of different types of care on pregnancy and childbirth. Finally this paper makes an attempt to study the scope and limitations of the care provided by medical care providers. On the basis of multiple sources of data, this paper finds that in labor, women feel better when cared for and encouraged by people they know and trust. Family and friends support the laboring women by protecting her privacy, helping her get comfortable, creating an environment that helps her feel safe and protected. Women evaluate their experience of pregnancy and childbirth on the basis of the amount of support from caregivers and the quality of relationships with caregivers, which appear to be so important that they override the influences of age, socioeconomic status, ethnicity, childbirth preparation, the physical birth environment, pain and medical interventions.

**Keywords** Pregnancy Care, Skilled Attendants, Maternity Experiences, Social Support

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## 1. Introduction

According to World Health Organization (WHO) of all health statistics, the maternal mortality statistics between the developing and developed countries display the greatest difference. More than 99% of maternal deaths occur in poor countries; this is due to the risk of dying from pregnancy related complications which are 250 times higher than women in developed countries. Each year 210 million women become pregnant, out of which 30 million develop complications which are deadly in 1.7% cases leading to 529,000 maternal deaths per year. Further, almost 4 million infants do not survive childbirth or the immediate postnatal period and millions more are disabled because of inefficiently managed pregnancies and births. This situation has remained almost unchanged for many years [1, 2].

Pregnancy is marked by various physiological, psychological and emotional changes. A pregnant woman experiences emotional ups and downs. Unbearable and uncontrollable pain, disgust at the sight of blood and other bodily fluids, the horror of cut or torn flesh, and the fear of

her own or her baby's death, coupled with expectations of having to produce a son and heir, can lead to stress and discomfort. Pregnancy related complications get aggravated due to the stress caused by the social factors, psychological and the physiological factors. All these and many other factors can be prevented and managed [3].

Maternal health is a key indicator of women's health and status. The WHO in a report "Women and Health: Today's Evidence Tomorrow's Agenda" defines maternal health as the health of women during pregnancy, childbirth and the postpartum period. While motherhood is often a positive and fulfilling experience, for too many women it is associated with suffering, ill-health and even death. Throughout human history, pregnancy and childbearing have caused death and disability both among women and neonatal. Pregnancy and childbirth are of course not diseases. But, they carry risks because of the varying and embedded complications, practices, processes, beliefs, life conditions and the immediate environment [4].

Governments of different countries of the world have been introducing several policies and programme to improve the health outcomes of the prospective mothers. Interventions are being made at several levels; right from the conception of the pregnancy to childbirth and even during upbringing of the children. An important focus of such programmes is specific care during the pregnancy,

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childbirth and the postpartum as well as postnatal period. Several antenatal and postnatal care programmes are run by the governments to ensure health of the mother and the child.

Institutional deliveries are endorsed by the governments in order to reduce the neonatal as well as the maternal mortality. The women are encouraged to deliver in public or private health facility. Lot of investments is being made and many policies and programmes are being implemented in order to increase the institutional deliveries. However, women often face unequal and indifferent care from institutions which not only create hurdles in pregnancy care and childbirth process but also leave a deep scar on the minds of these women. They may feel dissatisfied with the quality of care and the indifferent and uncaring attitudes of the attendants. This experience might not persuade them to go to such institutions for further delivery or child care. Hence, such situations need a careful understanding and well thought interventions.

There are studies which support that women should be assisted by skilled attendants or professional health carers who are equipped with necessary skills, drugs, equipments and back up [5]. On the other hand, many studies follow that women if assisted by lay persons particularly those who are closer to her like a family member, will show a decline in the pregnancy related complications and the labor pain [6, 7].

It is in this background that the paper intends to fulfill following objectives:

- To have an assessment of nature of various types of care and support provided to the pregnant women.
- To study the scope and limitations of the care provided by medical care providers.
- To find out the impact of different types of care on pregnancy and childbirth.

## 2. Methodology

This paper is analytical in nature and uses critical realism as a method. It has developed its main arguments on the basis of critical review of several empirical works selected through systematic review.

## 3. Results and Discussion

The results of this study are based on the review of various studies giving descriptions of various interventions made by specific agencies or talking about the specific nature of the care provided by these agencies. We will discuss the specific practices, one by one, as appearing in our review work. We will try to reach to some conclusion, toward the end of the paper, by combining some of the best practices.

### 3.1. Agencies of Pregnancy Care and Childbirth

Multiple agencies are involved in providing some kind of

care during pregnancy or childbirth experiences. Sometimes, these agencies work in isolation and sometimes, they are conspicuous because of their complete absence.

#### 3.1.1. Care by Skilled Attendants

Improving maternal and child health and providing the quality health services to a pregnant woman are fundamental to addressing many problems related to pregnancy and childbirth. These quality services include Antenatal Care (ANC), Delivery care and Postnatal Care (PNC). Antenatal care (ANC) refers to pregnancy-related health care, which is usually provided by a doctor, an Auxiliary Nurse Midwife (ANM), or another health professional [8]. Ideally, antenatal care should monitor a pregnancy for signs of complications, detect and treat pre-existing and concurrent problems of pregnancy, and provide advice and counseling on preventive care, diet during pregnancy, delivery care, postnatal care, and related issues. The main purposes of antenatal care are to prevent certain complications, such as anaemia, and identify women with established pregnancy complications for treatment or transfer [9]. In India, the Reproductive and Child Health Programme aims at providing at least three antenatal check-ups which should include a weight and blood pressure check, abdominal examination, immunization against tetanus, iron and folic acid prophylaxis, as well as anaemia management. Further, the postnatal care includes three postnatal visits which should monitor massive vaginal bleeding or high fever—both being symptoms of possible postpartum complications [8].

Skilled care refers to the care provided to a woman and her newborn during pregnancy, childbirth and immediately after birth by an accredited and competent health care provider who has at her/ his disposal the necessary equipment and the support of a functioning health system, including transport and referral facilities for emergency obstetric care [10]. Most maternal and obstetric complications can be prevented or managed if women are attended by skilled attendants like doctors, nurses or midwives during pregnancy and childbirth.

Bernis et al have explored a justification for the need of skilled health care practitioners during pregnancy and childbirth. They strongly believe that instead of an unskilled attendant, a pregnant woman should be cared by a skilled attendant which may include people with midwifery skills such as midwives and doctors and nurses who have been trained enough to tackle the normal pregnancies, childbirth and the immediate postnatal period and to identify, manage and refer complications in the women and newborn. In the absence of such professional assistance, women pay a heavy price—maternal mortality ratio of 1000–2000 per 100,000 births. They support their arguments by locating the experiences of developing and developed countries and how they have managed to reduce the maternal mortality. Countries like Sweden, Norway, the Netherlands and Denmark have not only been able to achieve low maternal mortality with the help of skilled care attendants but also

tried to establish it as a cost effective intervention. They go further by adding that lay carers like the family members or Traditional Birth Attendants (TBAs) whether trained or untrained are not effective for reducing maternal mortality but women do acknowledge the important social and cultural role played by the lay care givers like TBAs, traditional healers and family members who must work in association with other skilled health care providers for effective improvement in care. They conclude that for the care to be appropriate and effective, it should be affordable and accessible to all and should be acceptable to the local population as well. Moreover, the health professionals must take into consideration the local beliefs and customs to help women feel themselves in a friendly and respectful environment [5].

Behruzi et al found that the women participants' major cause of satisfaction during childbirth was related to the presence of a competent or specialist professional who could provide a caring and humane manner of assistance during labor and delivery while still applying medical intervention [11].

However, modern maternal care frequently subjects women to institutional routines, high rates of intervention, unfamiliar personnel, lack of privacy and other conditions that may be experienced as harsh. These conditions may have an adverse effect on the progress of labour and on the development of feelings of competence and confidence; this may in turn increase the risk of depression.

### 3.1.2. Family Support during Pregnancy and Childbirth

Family support has a vital role to play during pregnancy and childbirth. It helps the women to feel relaxed, loved and cared during the stressful period of pregnancy. The quality of support from care providers has an effect on the woman's ability to cope with the stressors of labor. Care and support may help an individual gain, regain, or use personal strength during difficult periods like pregnancy and childbirth, which demand more energy and resource [6]. Women with first order birth or those who have undergone an operative delivery before better recognize the importance of care and support during pregnancy and childbirth. Social support serves as an environmental mediator and has its impact on woman's experiences and the outcome of pregnancy.

Haobijim et al have tried to discover family support and its effect on the outcomes of pregnancy. Their study was conducted on eighty mothers who were selected using purposive sampling and were interviewed as per interview schedule at the postnatal unit of Christian Medical College and hospital, Ludhiana. They have used Roy's adaptation model as the conceptual framework for their study. This study centers on the significance of support during labor in reducing the duration of labor, use of pain relieving drugs and with greater number of normal deliveries. This is related with the reduction of the stress during pregnancy and utilizing the individual potency during labor and childbirth. The study evaluated family support in four different areas

namely emotional, informational, social and financial. This study besides giving the different demographic features of the respondents found that 91.08% of informational support was the highest support of the postnatal mothers during pregnancy as compared to emotional (90.75%), social (73.27%) and financial (87.18%) support. A significant positive relationship was found between family support and outcome of pregnancy. Also the mothers who received low level of support during pregnancy were more likely to have low birth weight, preterm labor, bleeding, low maternal weight gain, infection, and anemia. The women who were accompanied by partners and assigned a midwife during labor received less epidural anesthesia, analgesia and general anesthesia; had fewer episiotomies; and had a greater sense of control during labor compared with women accompanied by partners but not assigned midwives. It was also found that compared with the uncared and unsupported women, the supported and cared women had shorter duration of labor, double the rate of spontaneous vaginal delivery, and half the rates of oxytocin use, cesarean delivery, and forceps use. This study therefore gives a picture of how care by familiar care providers is favorable for pregnancy outcomes and significantly it helps to reduce different problems related to the women during pregnancy, the childbirth and the postnatal period [6].

Similarly, Green and Hotelling found that in labor, women have a better experience when cared for and encouraged by people they know and trust. Family and friends support the laboring women by protecting her privacy, helping her get comfortable, creating an environment that helps her feel safe and protected [7].

From the above reviews one can have an assessment that both social support and skilled attendants play an important role during the pregnancy and childbirth. The pregnant women not only need skilled, professional care during and after the delivery but also it is necessary that familial and social support is provided to her, as both complement each other to decrease the pain and stress that the women undergo during the pregnancy and childbirth.

### 3.2. Nature of Maternity Care

The nature of care plays an important role during the pregnancy and childbirth. If the care and support provided by the skilled attendants in the institutions is not satisfactory for the women, if the women does not feel secure and protected, if she does not develop trust among them then many of the efforts made by the government for increasing the institutional deliveries as well as reducing the pregnancy complications are not going to serve the purpose. Therefore it is very crucial to understand the nature of care in terms of:

- Satisfaction with the care during pregnancy and childbirth.
- Continuity of care and support
- Equal and indiscriminate care
- Women centered care approach

### 3.2.1. Impact of Satisfaction with the Care on Maternity Experiences

In recent decades, the importance of measuring satisfaction with health care has been recognized. Patients' views are being used by health care managers in assessing the quality of care, and by policy makers in making decisions about the organization and provision of health services. Since childbearing is the most common reason for accessing health services, assessments of women's satisfaction with their care during labor and birth are relevant to health care providers, administrators, and policy makers. Satisfaction is a complex concept. It involves both a positive attitude and affective response to an experience, as well as a cognitive evaluation of the emotional response.

E. D. Hodnett has focused on the roles of pain, pain relief and specific pain relief methods and other factors in finding out how satisfied a woman will be and how this satisfaction is related with childbirth outcomes. The author has done a systematic review of 137 reports of factors influencing women's evaluation of their childbirth experiences. In this paper the author after reviewing various survey reports found that women who were cared by the care givers in an unhelpful way were dissatisfied with the care. The studies of childbirth satisfaction showed that there were little or no relationships with demographic characteristics such as age, education, socio-economic status, marital status and attendance of childbirth preparation classes. However, culture and ethnicity were found to play a role only in so far as they affect caregiver's attitudes and behaviors towards women. Further the impact of medical interventions appeared to be weaker than the influences of caregivers' attitudes and behaviors. The author found that women prefer to be cared for by caregivers who are familiar during labor and prefer home like settings for childbirth. The quality of caregivers' support affects the ability of the women to cope with the stressors of labor. Thus these four factors namely personal expectations, the amount of support, the quality of care and the involvement in decision making play a very important role that they will side line the influences of the demographic features as well as ethnicity, physical birth environment, pain, immobility, medical intervention and continuity of care [12].

Yelland *et al* aimed to have an assessment of 308 Filipino, Turkish and Vietnamese women's views about their care during postnatal hospital stay in first six months following birth by using interview schedules. Women were asked about baby feeding practices, aspects of baby or maternal care they required assistance with, the support and sensitivity shown to them by the caregivers, the length of time spent in hospital, their overall rating of care and views about helpful or unhelpful hospital postnatal care.

They found that 29% women were very satisfied overall with the care they received in the hospital after the birth, 48.7% were satisfied, 17.3% rated as mixed and 4.7% were dissatisfied. They found no association between overall rating of care and maternal age, marital status, parity, length

of time in Australia, family income, education, method of delivery and postnatal length of stay. Further, they found 45% of women felt that caregivers had no knowledge of their particular cultural beliefs and practices. They also observed that 41.6% of women reported the delivery of care by midwives in a helpful, empathetic and friendly way. An important finding was that demographic or obstetric factors did not cause any difference on the satisfaction level of care received by the women [13].

Similarly, two Australian studies, Stamp & Crowther (1994) and Zadoroznyj (1996) found that the attitudes of caregivers were one of the main factors associated with women's satisfaction with the postnatal hospital stay [14, 15]. Thus it is very important that women should feel satisfied with the type of care they receive, whether social or medical. The government policies must focus on this critical area in order to make the institutional deliveries a success. The skilled attendants must either provide a homelike setting to the woman or must make attempts to accept the familial care and support along with the medical interventions.

### 3.2.2. Importance of Continuous Care during Labour

Support and care, if continuous during pregnancy, labour and childbirth play a pivotal role in increasing the satisfaction and decreasing the pregnancy related complications.

Hodnett *et al* found that the continuous support was provided either by hospital staff (such as nurses or midwives), women who were not hospital employees and had no personal relationship to the labouring woman (such as doula or women who were provided with a modest amount of guidance), or by companions of the woman's choice from her social network (such as her husband, partner, mother, or friend). Women who received continuous labour support were more likely to give birth 'spontaneously', i.e. give birth with neither caesarean nor vacuum nor forceps. In addition, women were less likely to use pain medications, were more likely to be satisfied, and had slightly shorter labours. Their babies were less likely to have low five-minute Apgar scores. No adverse effects were identified [16].

Continuous support has been viewed by some as a form of pain relief, specifically, as an alternative to epidural analgesia [17], because of concerns about the deleterious effects of epidural analgesia, including on labour progress [18]. If continuous support leads to reduced use of epidural analgesia, it may in turn involve less use of electronic fetal monitoring; intravenous drips, synthetic oxytocin, drugs to combat hypotension, bladder catheterisation, vacuum extraction or forceps, episiotomy and less morbidity associated with these, and may increase mobility during labour and spontaneous birth [19].

### 3.2.3. Women Value Indiscriminate and Equal Care

It has long been understood that health outcomes are strongly shaped not just by biological and medical factors but also by the social, economic and cultural environment,

including people's positions in various social hierarchies. Michael Marmot argues that the environment shaped by social and economic organization is partly responsible for the status of health and factors such as childhood environment, the work environment, unemployment, patterns of social relationships, social exclusion, food, addictive behavior, transport, *etc.*, do account for the differences in disease rates within and between countries [20].

Providing equal and fair care during pregnancy and childbirth is very important social factor that has an influence on the health outcomes of both woman and child. Henderson et al have tried to examine the use of services and perceptions of maternity care among women who belonged to eight specific ethnic groups namely White, Mixed, Indian, Pakistani, Bangladeshi, Black Caribbean, Black African and other ethnicity. They used structured questionnaires to collect information about access, information, communication and choice regarding Antenatal care, delivery mode and neonatal outcomes. Besides this, information regarding demographic indicators was also collected from 50,000 women aged 16 years and above living in England in 2010. They used logistic regression model to calculate the associations between women's experience and ethnic group. A total of 24,319 women however completed the survey. They found that women from minority ethnic groups were significantly less likely to report always being given the help they needed, they could not understand the language they were spoken to, they were also not sufficiently involved in decision. Besides, they were also not able to have a choice about place of birth and rate their antenatal care as good. Bangladeshi and Pakistani women were found to report significantly less confidence and trust in staff. Asian, Black African and women of other ethnicity felt they were being left alone in labor and during immediate post partum period. About the postnatal care, women from all minority ethnic groups were kept in the hospitals for longer lengths as compared to the White women. Also the Asian women and other ethnicity group women felt that they were not always treated with kindness in hospital and were less likely to be seen by a midwife after their discharge as compared to the White women. They also found that there were differences between minority ethnic group women and White women relating to timing of the first contact with health professionals and booking for maternity care. The reasons behind this were the discrimination and stereotyping by health professionals and also the difficulties that were faced on both sides regarding understanding and culture [21].

Yelland et al conducted a deductive study to depict the degree to which women attending different models of maternity describe experiences of perceived discrimination and examine the relationship between maternal social characteristics and perceived discrimination in perinatal care among 200 women of Victoria and South Australia in their study, "Women's experiences of discrimination in Australian perinatal care: the double disadvantage of social

adversity and unequal care". They hypothesized that women going for public maternity care would experience greater perceived discrimination than women receiving private care. The second hypothesis was that women getting greater continuity of caregiver from public models of care would be less likely to report perceived discrimination. The third hypothesis was regarding how the specific maternal social characteristics would be associated with greater likelihood of perceived discrimination. The authors have used perceived discrimination to refer to self reported experiences of unequal treatment based on social and personal characteristics such as age, education, cultural background, weight, sexuality and relationship status. This perceived discrimination may discourage a woman to go for regular checkups and result into adverse maternal, newborn and child health outcomes. It was found that their first and second hypothesis holds true. They found a range of factors associated with perceived discrimination which included being young i.e less than 25 years, being underweight or over weight and smoking during pregnancy [22].

#### 3.2.4. Women Centered Care approach towards Pregnancy and Childbirth

The women centered approach works in a feminist framework. According to the first wave of feminist activists, the women's rights to ease their own sufferings were taken care of. They wanted women to have control over themselves and the birthing process and have choices during childbirth. The first wave of feminists were successful in providing women the right to use pain relief drugs and express their will to use or not use them but they failed to control the process of childbirth and place of delivery which kept to shift from home to hospital. The second wave of feminism advocated for natural birth movement and fought for home birthing as well as midwifery services. The third wave feminists argued about women's choice and their positive experience of obstetric technology at birth [23].

Childbirth which is a natural process gets disrupted due to various socio-economic reasons that lead to release of stress hormone, epinephrine in the blood, which may in turn lead to abnormal fetal heart rate patterns in labor, decreased uterine contractility, a longer labor phase [16]. The humanization of childbirth is arguably an alternative model to the medical and technological models. Humanization of birth is defined as birth without any unnecessary medical intervention.

Behruzi et al have talked about the humanization of birth as being an alternative model of care for women in order to do away with the medicalization of birth which causes adverse effects on the health of a women and her child. Besides, humanized birth care is a women centered approach which helps to keep into consideration women's wishes, values, beliefs, autonomy and control over their bodies. They have tried to establish childbirth patterns as an organizational cultural phenomenon through organizational cultural theory. They have carried a review of literature and found that feminist framework of childbirth supports the humanized care approach. In this paper the authors tried to explore

organizational and cultural dimensions that act as barriers or facilitators in the provision of humanized birth care. Their sample consisted of 17 health professionals in a hospital in Montreal, Canada and 157 women with varying levels of risk, parity and type of delivery. They used semi-structured interviews, field notes, documents, participants' observations of ten births and a self administered questionnaire. They used descriptive and qualitative deductive content analysis on the collected data. The findings revealed that the participants did not consider the use of technology and medical intervention as opposing the concept of humanized birth care. The women were satisfied with the medical interventions because it was combined with the presence of competent professionals who cared and assisted in a compassionate manner. Using their conceptual framework one can understand the barriers and facilitating factors encountered in the humanization of birth practices [23].

Simkin et al have attempted to review the non pharmacologic methods as means of reducing pain, increasing maternal satisfaction and improving the birth outcomes. These methods help the women to have control over the management of their pain, to have support from loved ones and caregivers etc. These methods although are simple and effective means of reducing pain without serious side effects or high economic costs yet they have not received much attention in the medical literature and are not commonly used in North America. They have tried to evaluate the effectiveness of the non pharmacologic measures in reducing the labor pain and limitations of these methods. They have taken the studies of continuous non medical labor support by an experienced nurse, midwife or doula into their review. They found that women who were supported by trained lay people had reduced epidural rates and also there were no changes in the epidural rates when nurses were the labor support providers. They also found from some of the studies that these non pharmacologic methods reduced the cesarean section and other obstetric interventions and increased the satisfaction level of women in their post partum period [24].

#### 4. Conclusions

Different agencies of care must come together to reduce the burden of increasing maternal and infant mortalities caused due to pregnancy related complications which are left uncared and unmanaged. Personalized care and support from family along with skilled attendants can improvise the increasing risks of maternal deaths and hence improve the maternal health. Besides their joint association it is essential that the care provided by these agencies must satisfy the pregnant woman that will help her to cope with the stress leading to pregnancy and childbirth complications. Continuous support by medical care providers during labor should not be the only standard; rather it should be supplemented by appropriate social and family care. The

family should care for the women in all the possible ways and should not add to their stress and anxiety. Within the institutional framework, the care should reflect a combination of medical knowledge and personal concern. Moreover, it is necessary that care should be equal and indiscriminate. The maternal care services should be available, accessible, affordable and acceptable to all the women. Policy makers, administrators and health care providers must recognize the importance of skilled, supportive, trust worthy and caring attendants for having a satisfactory response from women. Humanization of birth and use of non pharmacologic methods must gain attention in order to reduce the unnecessary medical interventions and enhance better pregnancy and childbirth outcomes.

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