

BEING IN A DILEMMA: EXPERIENCING BIRTH IN ZAMBIA

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ABSTRACT

Numerous publications investigating childbirth in sub-Saharan Africa have overlooked the psychological and emotional elements that women experience, in favour of physical dimensions, such as maternal mortality. The aim of this study was to explore childbirth experiences, in order to better understand how women in Zambia experience and give meaning to the phenomenon. An interpretive phenomenological approach was utilised. Through purposive sampling methods, fifty birthing women, aged between 16 and 38 years, from all the nine provinces of the country were recruited. Unstructured in-depth interviews were conducted. Analysis uncovered six structures. The main focus of this paper is 'Being in a dilemma'. The selection of this structure reflects its general interest and predominance in data analysis. It entailed experiencing the phenomenon without knowledge of whom or what one was going to encounter. The key themes were: 1) choosing where to birth, and 2) choosing the advice to adhere to. The findings illuminated a need for an attitudinal change in maternity care professionals, and a parallel need to build agency and autonomy in women. It is this intrinsic level that is undermining attempts to reduce high maternal mortality in Zambia.

Keywords: childbirth experience, interpretive phenomenology, key themes, structures



INTRODUCTION AND BACKGROUND

Giving birth is a universal physiological process that is perceived by some women either as a traumatic event (Sawyer & Ayers, 2009) or a transformative experience, with short and long-term outcomes (Kennedy, Shannon, Chuahorm and Kravetz, 2004). Yet, the more delicate interrelated psychological and emotional elements that women experience are often overlooked when discussing maternal health in favour of more noticeable elements such as maternal mortality measures (Baker, Choi, Henshaw & Tree, 2005). Given the high maternal mortality ratio (MMR) of 591 per 100 000 live births (CSO et al., 2009) pertaining in Zambia; physical measures are important dimensions for evaluating maternal health. However, they are not adequate to explain the complexity of human experiences such as childbirth. According to Walsh (2007), the emphasis on physical measures alone is such that the impact of other aspects of the experience are underestimated, marginalised or ignored.

According to the Maternal Mortality Estimation Inter-Agency Group (MMEIG), which comprises the World Health Organisation (WHO), the United Nations Children's Fund (UNICEF), the United Nations Population Fund (UNFPA), the United Nations Population Division (UNPD) and The World Bank, an estimated 289 000 women died in 2013 as a result of pregnancy and childbirth (WHO, 2014b). Almost all the deaths (99%) occurred in low-income countries, particularly Africa (WHO, 2006). Most of the deaths occur during childbirth or within the first 24 hours postpartum (Campbell & Graham, 2006). In 2013, MMR in high income countries was 16 per 100 000 live births, versus 230 per 100 000 live births in low-income countries (WHO, 2014a). More than half of these deaths occurred in sub-Saharan Africa. The region has the highest MMR at an average of 510 per 100 000 live births (WHO, 2014a). Out of the 20 countries worldwide with high MMR, only two are outside sub-Saharan Africa (WHO, 2014b). Therefore, there is no question that the risk of maternal death is most acute in sub-Saharan Africa. This makes maternal mortality the most striking health indicator showing the greatest disparity between sub-Saharan Africa and other regions. According to Mushi, Mpembeni and Jahn (2010), the leading causes of the deaths are complications of haemorrhage, sepsis, hypertensive disorders and obstructed labour. This is a tragedy because the health care solutions to prevent or manage these complications are well known and preventable. Emphasis on tackling the high MMR has been on physical aspects with less attention paid to the equally important delicate interrelated psychological and emotional elements that women experience in relation to childbirth. Thus, in the absence of such information, this research of women's childbirth experiences was conducted in Zambia.

Zambia is a landlocked sub-Saharan African country covering an area of 752 612 square kilometres (km²), which is about 2.5% of Africa (Central Statistical Office (CSO), Ministry of Health [MoH], Tropical Diseases Research Centre

[TDRC], University of Zambia [UNZA] and Macro International Inc., 2009). It shares borders with eight other countries and gained political independence from Britain on 24th October 1964. For administrative purposes, the country is divided into nine provinces and 72 districts (CSO et al., 2009). There were some changes in the administrative division purposes of the country at the time of conducting this study. Among the current nine provinces, the Copperbelt and Lusaka provinces are predominantly urban; Central, Eastern, Luapula, North-Western, Northern, Southern and Western, are predominantly rural (CSO et al., 2009). The country has a population of approximately 10 285 631. Compared with the vastness of the country, Zambia is still sparsely populated. Total fertility rates, estimated from the 1969 and 1980 censuses, were 7.4 and 7.2 births per woman, respectively (MoH, 2011). Overall, the population of Zambia is young, with 69% of the population below the age of 25 years, and women of reproductive age represent about 22% of the total population (MoH, 2011).

Demographic factors and emerging issues such as rapid urbanisation, gender inequalities, brain drain to high-income countries, Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS) have constituted major obstacles to ensuring improved quality of life for the Zambian population, particularly women. Maternal health services in Zambia are provided by churches, private practitioners, industries and traditional practitioners, although MoH plays a dominant role (Maimbolwa, Yamba, Diwan & Ransjo-Arvidson, 2003). Provision of public health care services is found at: 1) health posts, 2) rural and urban health centres, 3) zonal health centres, 4) first level hospitals, 5) second level hospitals, and 6) third level or tertiary hospitals. Supplementation of public health provision, especially in rural areas, where health centres are far from where communities reside, is through mobile hospitals that were introduced in 2010 (MoH, 2011). The mobile hospitals have the status of second level hospitals. Maternity care is provided in all public health institutions, irrespective of level.

Prior to the seventeenth century, birthing in most countries was considered within the realm of women. Those who attended the births learned about childbirth from their older female relatives and friends, thus birth stories and knowledge on management of birth were passed down from generation to generation (Savage, 2002). This has not been to the advantage of women in Africa because their status has always been, and still is inferior in comparison to their male counterparts (WHO, 2014). According to Maimbolwa et al. (2003), birthing in Zambia is compounded by secrecy, hence creating a situation where the only people who know what really happens during childbirth are the women themselves and their attendants. Similar to other sub-Saharan African countries, maternity health service provision in Zambia changed from traditional homebirths to institutional births during the eighteenth century, following the 'Scramble for Africa'. As the explorers and missionaries worked with and among indigenous Zambian people, they established and provided

basic modern health services, which included maternity care for themselves and their workers. The introduction of institutional births was accompanied by disapproval and discouragement of homebirths. Institutional births focused much on technology-based interventions and prevention of disease, with less attention being paid to understanding women's social backgrounds, gender issues, historical and the cultural contexts in which childbirth was viewed and provided (AbouZahr & Wardlaw, 2003; Meleis & Im, 2002). Consequently, this led to a loss of knowledge as to how women experience childbirth, and whether maternity services were meeting women's needs, priorities and preferences. The loss of such knowledge could be one of the factors undermining efforts to reduce the country's unacceptably high MMR. This is because without this information, it is difficult to understand how women reason when it comes to birthing issues. Hence, the results of this study have the potential to answer the questions: Why are women in Zambia still dying from pregnancy-related causes? Why have significant investments in resources failed to achieve tangible results? Since the mid twentieth century, perspectives from midwives began influencing the knowledge base of the midwifery profession. This has contributed to the understanding of childbirth as a cultural, social, physiological and psychological phenomenon. Thus, it has become evident that when looking at childbirth, psychological aspects of childbirth are extremely important. They play a significant part alongside physical aspects (Royal College of Midwives, 2000).

STATEMENT OF THE RESEARCH PROBLEM

Personal changes that affect the health and general wellbeing of women make childbirth experience a complex event, as well as an important process with long-term impacts (Whitty-Rogers, 2006; Nelson, 2003). Therefore, the care that each woman receives during this period of time needs to be tailored carefully to suit the needs of the particular woman, if the experience has to have a positive influence on her life. This information is lacking in literature from Zambia. The exclusion of women's subjective experiences from maternity service evaluation has thus rendered an incomplete and unclear depiction of the childbirth phenomenon.

RESEARCH QUESTION

The research question for this study was: 'How do women in Zambia experience and give meaning to childbirth?'

PURPOSE OF THE STUDY

The purpose of this study is to explore childbirth experiences of women giving birth in Zambia in order to gain a better understanding of how women experience and give meaning to the phenomenon.

OBJECTIVES

1. To explore women birthing in Zambia's personal childbirth experiences.
2. To assess how women in Zambia reasoned and perceived the childbirth phenomenon.
3. To explore factors that contributed to women's decisions around the place of birth.

ASSUMPTION

The findings of this study convey knowledge that has potential to aid policy-makers and health care workers to better understand childbirth from women's perspectives, and hence develop, implement and evaluate interventions that will contribute to improvement of experiences and health of birthing women in Zambia. Ultimately, MMR will go down.

Definition of keywords

Childbirth experience is events that happen to women during childbirth together with their personal reactions, feelings and meanings of these events.

Interpretive phenomenology is a qualitative research methodology used when the research question asks for the meaning of the phenomenon and the researcher does not bracket their biases and prior engagement with the question under study. Martin Heidegger (1889–1976) is famous for developing interpretive phenomenology (Ehrich, 2005).

Key themes are patterns of meaning, ideas, thoughts, feelings found throughout the text. They identify and convey something of the meaning of the phenomenon under investigation for the participants. They are most often *in-vivo* quotes from transcripts.

Maternal mortality is the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes.

RESEARCH METHODOLOGY

The qualitative paradigm informed by interpretive phenomenology of Martin Heidegger was found to be most appropriate when posing the research question: 'Could you tell me how you experienced childbirth the last time you gave birth?' The key principle that informed this study was Heidegger's concept of 'Dasein', loosely translated as 'Being-there' (Heidegger, 1927/1998). In order to gain an insider perspective of the world of women birthing in Zambia, I needed to get women who

had given birth to tell me their birthing experience. It was not possible to obtain direct access to participants' worlds. However, my experience as a Zambian woman, mother, wife and midwife educator familiar with birthing in Zambia enabled me to engage with participants' accounts in such a way that I obtained an insider perspective of what birthing meant to the participants. This echoed the Heideggerian interpretive phenomenology view that researchers use their foreknowledge, or preconceptions, to uncover meanings about what it is to be (Greatrex-White, 2007). Therefore, participants were women who had personally lived the experience of birthing in Zambia. According to Smythe (2011), there is no right time from which one can gain a definitive meaning of a woman's experience of birth, since people always live in relation to time and space (Greatrex-White, 2007). The time frame for the birth experiences in this study spanned from 2005 to 2011. This was in cognisance of the fourth in the series of the health sector reforms that the Zambian government had been implementing since 1992 (MoH, 2011). The vision guiding the health reforms was to improve the quality of life for all Zambians through development of health care systems that provided equity of access to cost effective, quality health care as close to the family as possible (MoH, 2011). Unstructured in-depth interviews were conducted in the rural district of Mumbwa and urban district of Lusaka from 25th February to 20th July 2011. Duration of the interviews was between 30 minutes 43 seconds and 1 hour 20 minutes and 30 seconds. Purposive sampling was used to select participants in order to include women who had birthed from all nine provinces of the country. A variety of birth experiences was required in order to better understand how women in Zambia experience and give meaning to childbirth. According to Smythe (2011) and Woodgate (2006), a variety of experiences sparks thinking in a researcher, as well as provides a platform for a deeper understanding of the phenomenon under study. This study was about understanding a lived experience, and so the number of participants was not pre-determined. A total of fifty interviews were conducted with women aged between 16 and 38 years. Information on the purpose of the study was disseminated to the wider communities through talks given in general Out Patients Departments (OPDs). These venues were found appropriate because in Zambia relatives and patients seeking health services pass through OPD in order to access the service they require from health institutions. Care was taken to ensure that the process of accessing care clients came to health institutions for was not in any way disturbed. At the end of each talk the telephone number as well as the physical location where the researcher could be contacted was distributed. The researcher's phone was registered for the 'call collect' service so that potential participants did not bear any financial costs when calling.

Before commencement of data collection, ethical approval was obtained from the University of Zambia Biomedical Research Ethics Committee. Every effort was made to ensure that each participant was not put at risk of being traumatised by sharing her emotional pain if any. A list of names of counsellors was provided in case

the need arose. None of the participants required a counsellor. Each individual who participated made an informed judgement on whether to participate. Comprehensive, plain and clear information regarding participation was provided well in advance of each interview. Participants were informed of their right to withdraw at any time, if they chose. They could stop the interview at any time. All collected data was kept confidential. All identifying materials in the research were given pseudonyms. Where names were mentioned during the interviews, they were omitted in the transcription. Synonyms beginning with the letters L or M were used to identify the participants. Yardley's (2008) four broad principles: 1) sensitivity to context, 2) commitment to rigour, 3) transparency and coherence, and 4) impact and importance were utilised to establish quality of this qualitative research.

ANALYSIS AND DISCUSSION OF RESEARCH RESULTS

According to Patton (2002), phenomenological analysis seeks to grasp and make clear the meaning, structure and essence of a lived experience of a phenomenon for a person or a group of people, and then transforms their data into findings. Each interview was transcribed. The emerging story from the transcription was summarised into a one to two page document and the initial analysis was written before moving on to the next interview. Data analysis also occurred as an explicit step to help conceptually interpret the data as a whole. van Manen's (1990) six steps of analysis: a) turning to a phenomenon of interest, b) investigating experience as we live it, c) reflecting on the essential themes, which characterise the phenomenon, d) describing the phenomenon, e) maintaining a strong and oriented relation to the phenomenon, and f) balancing the research context by considering the parts and the whole were utilised. The steps were a useful guide because they are not absolute or fixed. Socio-demographic characteristics of the participants were diverse. Analysis uncovered six structures that had several key themes. The third structure, 'Being in a dilemma', is presented in this article. The selection of this structure reflects its general interest and predominance in data analysis.

Being in a dilemma

For the participants, 'Being in a dilemma' suggested an uneasiness and uncertainties with maternity care providers' attitudes, labour and delivery process, as well as the outcome of birth, irrespective of the place of birth and who assisted the birth. In participants' view, this was because birthing either at home or health institution exposed a woman to risks that were often fatal. Women in Zambia are encouraged to give birth in health institutions. Homebirths are only permitted in emergencies. Due to the uncertainties of delivery experiences and outcomes in both home and institutional birth delivery settings, Mrs. LL remarked:

I am really in a dilemma when it comes to having children because I know that although I am guaranteed to be taken care of well during labour and delivery at home ... it is risky because the attendants are not skilled...and if a complication arises, anything can happen On the other hand, although there are trained people working in clinics I am not guaranteed to be taken care of well during delivery ... so again anything can happen You might not have visible complications but be emotionally damaged (LL, p.6).

The structure illuminated participants' predicament in choosing where to birth and the advice to adhere to in relation to childbirth.

Choosing where to birth

Dilemma in choosing where to birth was defined by the participants as doubt and disbelief in the benefits of care received within formalised health institutions and homes. It described the difficulty women birthing in Zambia face when deciding whether to birth from home or a health institution. Although men were granted more power, related to decision-making around pregnancy and childbirth, it was the women who experienced the birthing process. Comparing home with health institutional birth experiences, twenty-seven year old Mrs. LH, who gave birth in 2007, said she preferred homebirths in comparison to institutional ones. She narrated being impressed by her mother-in-law's attitude towards her, when she was found giving birth on her own. Her mother-in-law calmly encouraged her to carry on from where she found Mrs. LH, until both mother and baby were safe. She said:

I prefer homebirths in comparison to institutional ones Throughout the whole process of my homebirth, my mother-in-law never raised her voice at me; she was gentle all the way through ... had it been at a hospital either I or my baby would have died because nurses would have concentrated on scolding me instead of assisting In Zambia it is difficult to choose where to birth (LH, p.1).

Birthing at home had its disadvantages. Twenty-three year old Miss LY, who was an accountant at the time of collecting data, gave a horrific account of a birth she experienced in 2006. During the birth, Miss LY was assisted by her mother-in-law and grandmother at home. She narrated:

I was in labour for a long time but for some unknown reasons I was failing to deliver Although I was very young at the time, I noticed something was wrong ... the labour pain I was feeling stopped ... my mother-in-law and grandmother got a mixture of roots and soaked them in water. They forced me to drink one big cup After drinking the traditional medicine the pains resumed and this time they were so severe that I thought I was dying I started crying and begging my grandmother to take me to the hospital because the pain was killing me They kept telling me to just continue pushing because that meant I was about to deliver I delivered the following day to a dead male baby A month after giving birth I noticed that water was dripping from my private part uncontrollable ... after some

time I realised that it was urine not water ... so you see we have a problem when it comes to choosing where to give birth ... at home or health facility ... the question remains! (LY, p.4).

Choosing the advice to adhere to

The second key theme, 'Choosing the advice to adhere to', defined the power that individuals and groups who rendered care and support to birthing women had. Participants mentioned that they got advice on childbirth practices, beliefs and taboos mostly from healthcare providers, relatives, spouses and friends. The dilemma to choosing which advice to adhere to was influenced by the contrast between what healthcare providers said and what relatives, spouses and friends said. For example, Mrs. MC, a 24 year old mother of one, stated that some of the cultural norms she was advised to adhere to were different from what women from other parts of the country were observing. She stated:

I am a Lozi woman and there are some practices pertaining to childbirth that I follow ... when I narrate these to my friend who is Nyanja, she might think I am being ridiculous ... but since I exchange notes with friends from other parts of the country, it is difficult to choose whose advice to follow ... from nurses, from my relatives or from my friends (MC, p.4).

Mrs MC was in a dilemma because the practices, beliefs and taboos were at odds with one another. During the antenatal period, nineteen years old Mrs. LN, who was a primigravida at the time, narrated that she was found with a low haemoglobin count. The midwife attending to her prescribed iron tablets for her to take throughout pregnancy. When she reached home and showed her aunt the iron tablets, her aunt told her not to take them. She instead brought her a traditional drink and instructed her to be drinking a cup every day.

... the nurses gave me tablets for blood I was advised not to take traditional remedies. When I reached home and showed my aunt the tablets, she advised me not to take them My aunt brought me some traditional medicine, which she said helped in boosting blood levels I was confused; I did not know which one to be taking (LN, p.3).

Eighteen years old Mrs. LA was another participant who found herself in a similar situation. At home, her grandmother advised her not to eat eggs during pregnancy. The reason for this was that if she ate eggs her baby would be born bald. Her grandmother's advice was in contrast with the midwives' advice. Mrs. LA was advised by midwives to eat at least an egg daily as a source of nutrition in pregnancy.

"When I was pregnant my grandmother told me that if I ate eggs my baby would be born bald. I was at crossroads because the nurse recommended eggs in my diet ... at least one per day ... she said it was good for my nutrition as well as that of my unborn baby ... I didn't know which advice to follow. But since the nurse was not at home to monitor my eating habits, I ended up not eating eggs the whole pregnancy

because my grandmother was there ... and for sure my baby was not bald at birth (LA, p.5).

‘Being in a dilemma’ was a structure that illustrated factors that influenced participants on where to birth and whose advice to adhere to during the birthing process. The women’s dilemma was supported by the many contrasts between traditional and contemporary childbirth practices, which reinforced real and perceived barriers to accessing maternity care.

One of the three identified key points relating to challenges and barriers that affect provision of quality maternity care is that information from women’s perspectives of how they experience childbirth has not been given attention (UNFPA, 2011). In Zambia the focus of evaluating maternity services has for a long time been through physical indicators, such as maternal mortality rather than a combination of both physical and psychological indicators. Beck (2004), in her phenomenological study on post-traumatic stress with participants from New Zealand, Australia, United States of America (USA) and United Kingdom (UK), found a similar discord. She concluded that the focus for clinicians is often solely related to clinical efficacy, to the exclusion of, and seemingly oblivious to women’s feelings about their birth experience. According to Chen, Wang and Chang (2001), the responsibility of a birth attendant is not only to ensure a safe delivery, but to create a positive and satisfying childbirth experience. One of the core health sector strategies critical for reducing maternal deaths is skilled care for all pregnant women, especially during delivery (Starrs, 2007). It is important to point out that emphasis on skills should not simply be from physical perspectives. In conjunction with improving health care workers skills and health institutions’ infrastructure, emphasis should be on promotion of gender equality and empowerment of women. Hence a study such as this was essential to bridge the knowledge gap that exists in literature.

CONCLUSIONS

Childbirth phenomenon is influenced by many factors that need addressing at local, national and regional level. Understanding how women experience and interpret their childbirth encounters with birth attendants should be one of the factors at the centre of producing workable interventions.

RECOMMENDATIONS

It is recommended that in order to come up with effective interventions to tackle high MMR in Zambia, there needs to be an attitudinal change that involves listening, respecting, being empathetic and kind to women among maternity healthcare providers. There is also a parallel need to build agency and autonomy in women,

which needs to be addressed at an individual and societal level. This should begin with simple things such as assertiveness training, so that women develop economic independence and challenge oppressive practices.

LIMITATIONS OF THE STUDY

This being an interpretive phenomenological study based on reflections of 50 Zambian women whose births occurred between 2005 and 2011, the findings contain cultural and time-specific childbirth experiences. Thus, it is recognised that another researcher could produce different interpretations. Nevertheless, although the results are contextual, they do not imply that they would be inapplicable and have no meaning in other contexts.

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