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Midwifery Care Experiences of Mothers during Labor and Delivery at Orota Maternity National Referral Hospital in Asmara, Eritrea (2011)

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Abstract

In Eritrea normal pregnancy, labor, and postpartum care is mostly managed by nurse midwives. The purpose of this study was to explore midwifery care experiences of women and their families during childbirth at the Orota Maternity National Referral Hospital (OMNRH). The study was a cross sectional descriptive method that utilized both quantitative and qualitative techniques. The study population comprised all women who gave birth at OMNRH at the specified period of time, and their accompanying family member. All 120 women who delivered at the time of data collection were included for maternal interview and 40 family members participated in the study. Data was collected using a predesigned questionnaire and a face to face interview. Data was analyzed using SPSS version 11 for the quantitative data and Leininger's data analysis mode for the qualitative data. Ethical clearance was obtained from the Ministry of Health and the ethical committee of Asmara College of health Science. The Results shows that of the 120 study participants, 41 women were primiparas (giving birth for the first time). Over 90% attended prenatal care (at least one visit). Although prenatal education is crucial to child birth outcome, mothers were not appropriately educated and prepared for labor and delivery. The overall care that mothers received during childbirth was rated as good. However, pain management, food and hydration, support, and personal hygiene were either rated as poor, very poor or non-extent as a practice.

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Midwifery care at OMNRH can be rated as good in various aspects. However, this study identified many gaps in several areas of midwifery care practice, as well as mothers' and their families' satisfaction, which require improvement.

Keywords: Labor and Delivery; Midwifery Care Experiences of Mothers; Eritrea.

1. Introduction

Childbirth takes place within a cultural context and is shaped by the perceptions and practices of that culture [1]. Knowing the care needs of the mother and harmonizing it with professional midwifery model of care improves childbirth outcome and experience Childbirth is also the most significant of all rites of passage, conferring new status of the parents. In most traditional societies, a laboring woman is usually assisted experienced women or birth attendants [2]. Concerted efforts are required by health professionals at the maternity unit and in the community to provide mothers with more adequate support during the childbirth process. In many countries of Africa including Eritrea midwives manage normal prenatal, delivery and postnatal care to mothers and refer abnormal condition. In Eritrea despite midwives' contribution to the national health delivery system, there is no evidence related to midwifery practice. Evidence shows that community-orientated, midwife- led birth is often safer and leads to greater mother's and family's satisfaction, lower caesarean-section rates and fewer admissions to neonatal nurseries [3]. Moreover Midwifery led childbirth is safe and cost effective [4].

The international confederation of midwives [5] has developed standard competencies that a midwife should exercise while caring for the mother and her family during childbirth process. The WHO has adopted Resolution WHA5f4.12 which calls for 'the enhancement of nursing and midwifery services, based on sound scientific and clinical evidence' which will help achieve Millennium Development Goals 4 and 5, related to maternal and child health [6]. In Eritrea, prenatal care attendance is (64% and 41%) at least one and more than one visits respectively. Despite the higher prenatal attendance, professional attended birth is about 33% [7]. It has been reported that delivering place and decision to seek health care in low socio-cultural women is influenced by Supportive friends and family members [8].

Childbirth service load at ONMRH is the highest in the country. Out of the annual 20,940 normal deliveries in Eritrea the 7,031(34%) are carried out at OMNRH [7]. OMNRH has a total of 6 doctors, 41 nurse- midwives, 6 nurses anesthetists, and 44 assistant nurses in 2010[7]. The huge turnover of mothers giving birth puts excessive work load on the care providers and could possibly compromise the quality of health services. In most occasions, mothers come to the hospital in active labor and deliver soon after, that shortens labor follow-up time.

Midwifery practice is influenced by the structure and approach in maternal and child health services including; midwives' knowledge, attitude and skills; parents' knowledge and cultural beliefs and practices [9]. Educational support and favorable and motivating environment for midwives also affect midwifery services [10].

Among factors that influence women's' childbirth experience are; relationship with the care provider, the perception of pain and perceive control, the nature of support received, previous experience, and the process and

outcome of labor, [11]. Women were dissatisfied with their birth experience when, physical environment, interpersonal care and informed decision making were not addressed [12,13]. In contrast, women who participated in their care plan, who were informed, and supported by families and midwives were satisfied. Informed decisions and feeling in control during labor builds women's confidence and increases satisfaction of childbirth experience [14]. The most essential factors for positive childbirth experience include support and quality of midwifery care received [15], on the other hand women who are not supported are not happy, and will always look for other delivery places next time [10].

With regard to mother's and newborn's safety, some studies have shown that early discharge, lack of relevant health information and access in times of problems put the mother and the neonate at risk [16]. Postpartum period is vulnerable, manifested by 10-20% depression association with low income, lack of support and childbirth information. Mothers need more hospital stay for better advice on breastfeeding and newborn for better care [17]. The average hospital stay at the OMNRH for normal postpartum mother is four hours, which gives the midwife little or no time to educate and advice the mother.

The purpose of this study was to explore midwifery care experiences of women and their families during childbirth at OMNRH.

2. Methodology

2.1 Study Design: A cross sectional descriptive study was conducted from December 15-24, 2011. Qualitative data was also collected to have a better understanding of the problem understudy.

2.2 Study site: Orotta Maternity National Referral Hospital (OMNRH) Labor and postpartum ward. OMNRH is the busiest maternity center with high turnover of mothers giving birth. This hospital has about 8000 normal deliveries annually that is 34% of the total national normal deliveries. It a teaching hospital and accommodates, Medical students, nurses, nurse midwives and others.

2.3 Study Population:

1. All women who delivered at OMNRH at the specified period of time.
2. Forty Family members accompanying the delivering women (one out of three)

2.4 Sampling methods:

Total coverage (120); all women who gave normal birth at the time of data. One out of three accompanying family members was selected for interview having a total of 40 family members.

Inclusion criteria: mothers with normal delivery and those who stayed more than one hour in labor ward were included in the study.

2.5 Data collection techniques and tools

Questionnaire with closed and open ended questions was used to collect data from mothers who gave birth in the postpartum period. The questionnaire was developed under the thematic area of demographic data, history of prenatal care for the current pregnancy and care experience on admission, labor, delivery, postpartum and their preference on how they wanted to be cared during childbirth process.

2.6 Data processing and analysis

After preparing three data entry from, the quantitative data was entered using SPSS version 11. Some of the open ended questions were also coded and entered on the same data entry forms.

Data was cleaned for any inconsistencies that occurred during data collection or entry, and then analysis was conducted using the same software.

The qualitative data analysis followed the four Leininger's data analysis model [18], which includes four steps 1) coding and classification; 2) pattern and contextual analysis 3) synthesis and configuration analysis 4) major themes were abstracted

2.7 Ethical consideration:

The research proposal was reviewed by the ethical committees of Asmara College of Health Science and that of the Ministry of Health and ethical clearance was granted. Verbal consent was obtained from the research participants. Participants were told that they could withdraw from the interview whenever they wished, and their privacy would be kept strictly confidential

3. Results

3.1 Results of the experiences of mothers during labor delivery and the postpartum

3.1.1 Demographic back ground of mother

Majority of mothers (32.5%) were 20-24 years old, 25% between 25-29 years old, 21% between 30-34 years old, and 15-19 and over 35 years old groups were (9.2%) each. Most of study participants were from Tigrigna ethnic group who are affiliated to the Coptic Christian denomination as reflected in table 1. Forty one (34.2%) of the respondents were pregnant for the first time (primiparas), 54 of them (45%) had given birth 2 to 4 times. Majority of them (86%) were married and 14% were unmarried.

3.1.2 History of prenatal care during the current pregnancy upon admission

Ninety eight point five (98.5%) of the mothers in labor attended prenatal clinic for their current pregnancy. Majority of them (85%) had more than four prenatal visits. The 35.8% of them started antenatal care (ANC) in the first trimester, while 48.3% and 12.5% started at the second trimester and third trimester respectively. Sixty

three (63%) of them received iron and folic acid supplements once and 37% of them never got any.

Table 1: Socio demographic characteristics of the study population:

	Frequency	*Percent*
Age in Years:		
15-19	*12*	*9.3*
20-24	*41*	*35*
25-29	*30*	*25*
30-34	*25*	*21*
>35	*12*	*9.3*
Religion:		
Muslim	*10*	*8%*
Orthodox	*100*	*84%*
Catholic	*10*	*8%*
Protestant	-	-
Ethnic Group:		
Tigre	*3*	*2%*
Bilen	-	-
Tigrinya	*118*	*98%*
Saho	-	-
Educational level:		
Illiterate	*1*	*0.8%*
Elementary	*30*	*25%*
Junior	*23*	*20%*
Secondary	*65*	*54.1%*
Don't know		
Parity:		
Primipara (first time)	*41*	*34.2%*
Second – fourth times pregnancy	*54*	*45%*
More than four times pregnancy	*24*	*20.8%*
Marital Status:		
Married	103	86%
Unmarried	17	14%

Complete data base was established during their first time visit followed by focused assessment on the subsequent visits. During the first time visit the routine lab (urine, blood, RH, VDRL and voluntary HIV test) investigations were done for them. Health education taught to mothers during their prenatal clinic checkups are shown in table 2. This table shows, majority of the pregnant mothers didn't get the education and the preparation they should get during pregnancy

Table 2: Health education mothers received during prenatal visits.

Topics taught	Frequency	%
Danger signs of pregnancy	51	24.6
Diet during pregnancy	47	22.7
Breastfeeding	30	14.5
Advice on birth plan	17	8.0
Preparation for labor	17	8.0
Exercise during pregnancy	16	7.7
Danger signs of the fetus and neonate	13	6.3
HIV	6	2.9
Care of the newborn	3	1.4
Coping with labor pain	2	1.0
Breast self examination	2	1.0
Vaccination	2	1.0
Pregnancy induced hypertension	1	0.5
hypertension	1	0.5

3.1.3 Care experience of mothers in labor during admission, labor, delivery and the postpartum period:

Admission to the labor ward,

During admission almost all women in labor were accompanied to the OMNRH by a family member, a husband, a mother, sisters or a neighbor. After screening, those in labor were admitted to the labor ward and followed by the midwives on duty. The midwife in labor ward just follows the assessment findings from admission room without establishing her new data base for follow-up. The hospital policy doesn't allow any family member to stay with the mother during labor and delivery, thus all the study participants stayed alone during labor. Moreover the OMNRH is so busy that the health workers do not have much time to spend with the mother in labor.

Care experience during labor (table 3)

The mother in labor is placed in open labor ward together with other mothers in labor. During labor majority of

mothers scream during contractions which frightens the newly admitted mother. In this study all the primipara mothers said “the screaming noise scared us”.

Pain was mentioned as the most scary issue by majority of mothers and they rated their pain experience on the average 8 out of 10(where 0= no pain and 10= worst pain possible). In spite of scary feeling of mothers towards pain, it was among the poorly managed care variables as shown in table 3. Moreover table 3 shows support to laboring mothers, hydration and personal hygiene were poorly rated by mothers

In their open ended answers mothers mentioned the most important care to a laboring mother is *continuous presence of a person* to support and provide them with what they need. Contrary to their preference human presence and support care variables were rated very low as shown in table (table 3). Moreover table 3 shows getting information about the progress of labor and condition of the fetus was rated very low by the laboring mothers.

Table 3: Rates given by mothers to their care during labor.

Description	***Poor***	***fair***	***Good***	***Very good***	***Excellent %***
Food and hydration	63.4	20	5.8	6	4.8
Pain management	59.7	19	9.4	5.5	5.4
Personal hygiene	44.9	11	14.4	21	12.9
Privacy	23.6	32	29.4	10	5
Education (information/advice)	42.8	10	21.8	12	13.4
Support	57.8	15	16.0	7	4.1

Care during delivery and the post-partum period (table 4)

Similar to their experience during labor, pain relief, support, getting information progress of second stage of labor and advice about the postpartum was rated very low by laboring mothers (table 4)

Table 4: Rates given by mothers to their care experiences during, delivery and the postpartum

	Score					
Parameter	5	4	3	2	1	0
Bodily physical care	0	12.2	22.4	14.3	18.4	32.7
human presence and support	2	6.1	6.1	14.3	26.5	44.9
Pain relief	2	4.1	4.1	20.4	22.4	46.9
Information received about labor progress and fetal condition	17.8	12.8	21.3	19.1	8.5	21.3

Discharge care plan

Mothers expressed their experiences on getting proper discharge care plans as shown in table 5 is rated low. Table 6 shows the Health education mothers got upon discharge was inadequate, 21% were informed on child vaccination while majority of them did not receive education they need.

Table 5: Rates given by mothers to their care experiences during of discharge care plan

	Scores					
Parameters	5	4	3	2	1	0
Discharge education plan	0	15.6	31.1	31.1	39.3	0
Follow up care plan	0	0	8.9	4.4	53.3	0
Family planning	0	0	2.2	11.1	66.6	0

Table 6: Health Education given to mothers upon discharge.

Topics taught to mothers during discharge	Frequency	Percent
Child vaccination	26	21.7
Visit the health facility in case problem arises	16	13.3
Personal hygiene	13	10.8
Breast feeding	8	6.7
Frequent urination	5	4.1
Advice on diet/medication	5	4.1
No education	47	39.2

3.1.4. Views of mothers about their preference how to be cared

In general mothers weighed the quality of care they received during childbirth by having alive baby and that baby and mother did not face any complication during labor process. Because of the high maternal mortality mothers are afraid of death during childbirth. Thus About 45% stated that they were happy by the outcome because they delivered safely having live baby and 42.9% expressed their satisfaction. This reflects mothers in Eritrea are not aware what kind of midwifery care they should receive during pregnancy, labor and the postpartum.

3.2 Results of in-depth interview with family members who accompanied mothers during labor to OMNRH.

3.2.1 ***Demography of the family members***

Study participants were 48. Fifteen males and 31 females, their age ranged from 18 to 75 years and their educational level, from illiterate to university graduates.

Table 7: Views of mothers who gave birth on how they should be cared while they are in labor

Care a mother should receive during labor	Frequency	%
The mother needs encouragement and support	42	35%
Follow the condition of the mother and provide care	32	26%
The mother should get nutritious diet and rest	12	11.5
Mothers should be educated using visual aids	36	30%
Meals served in the health facility should be improved and served on time	5	4.1%
The health personnel should receive patients in good manner	3	2.5

3.2 .2 ***Experience of family members while waiting outside the labor ward premises for the mother to give birth, was expressed as.***

Worrisome, Waiting Anxiously:

Majority (85%) said we were just sitting outside without having information about the condition of our sisters in labor and listening to screaming of the mothers in labor disturbed us more. One mother said "whenever I heard the screaming voice of my daughter my whole body was shaking with fears, and never had a chance to see her"

Lack of respect to family members:

Most of the family members (over 90%) said the nurse's approach on arrival was good. Once they take the laboring mother to the labor ward nobody cared about us, especially the cleaners and guards were impolite to us.

Lack of support to our sisters in labor,

All family members expressed their bad feelings about the laboring mother being alone, left to scream. One mother said "If it was at home my daughter could have a lot of support from us. The health workers refused to allow me to see my daughter they didn't either give me adequate information about her condition"

All family members felt that at least one family member should be allowed to stay with the mother in labor.

Happy about birth outcomes

All family members appreciated the obstetric services offered in OMNRH. They said "OMNRH provide better service than the other maternity centers". They said "some health workers are polite while majority are not, they should be trained on how to handle patient and their family members who seek their support and advice"

Family members' views on how a pregnant mother should be cared.

Themes derived from the descriptors: Pregnant mother should get.

"Support and encouragement; follow-up and continued care; advice and education; nutritious food and hydration; adequate rest and sleep; protect mother from hazards."

Descriptors:

- Provide pregnant and laboring mother with the best available food and fluids. One woman from Tigrigna ethnic group said "in our village the milk that is milked on Sunday is given to the poor pregnant women"
- Should get adequate rest and hygiene as culture they said "the neighbors help the pregnant and the newly delivered mother in doing household duties"
- The environment should be very comforting to the pregnant woman, make her happy, avoid sad news, one mother from Kunama ethnic group said "in our ethnic group the culture is all the neighbors tell the pregnant woman jocks to make her laugh and happy".
- Pregnant mothers should be prepared for labor and delivery eg. Prepare cloths to the baby
- Pregnant mothers should receive support, advice and encouragement from health professionals and family members.
- All said "the mother is the nucleus of the family and should be protected and pass through the process of childbirth safely".
- During childbirth process mother should be under the care of a health professional to be protected, guided and advised.

4. Discussion

The discussion follows the sequence of the results that is demographic characteristics, experience of prenatal care for the current pregnancy and care experience during labor postpartum and discharge. It should be noted that in Eritrea, care of normal pregnancy, assisting mother during delivery and postpartum care is provided by nurse midwives.

Hundred twenty (120) mothers who gave birth at OMNRH and 48 family members 15 males and 33 females who accompanied laboring mothers participated in the study. Age group of mothers who gave birth include 35% 20-24 years, 25% 25-29 years, 21%30-34, under 19 and over35 were 9% each. Majority (98%) were from Tigrigna ethnic group, 54% of them had secondary school level education while the rest had elementary and junior level. A large proportion (34%) of them was primipara mothers. Eighty four (84%) were married and 14% were unmarried.

Each woman is a unique individual with her own set of values, cultural beliefs, strengths and fears. Each culture responds to the needs of women during childbirth to meet the biological, emotional and psychological needs of women [19]. Complications during childbirth are unpredictable thus pregnant women should be under culture sensitive quality professional care [20].

In this study over 90% of laboring mothers attended prenatal care. All of them had the basic physical and laboratory examinations. Prenatal care determines birth outcomes and childbirth experiences and it aims to educate pregnant women and her partner/family, screen for signs of abnormality, refer to appropriate levels of care if needed and deal with minor pregnancy associated problems[21]. However in our study the history of prenatal care for the current pregnancy had deficiencies. Though anemia during pregnancy is high in Eritrea [7], provision of iron and folic acid was inadequate, 34% of them never took any and the rest of them were given iron tablets only once. Childbirth education that prepares the mother and her family for childbirth was poor as reflected in table 2. Important topics which should be taught to mothers such as bodily changes during pregnancy, exercise, nutrition, fetal growth and development, preparation for breast feeding, pain coping strategies during labor [22] were not covered. Moreover it is reported that Affectional support , affirmational support and concrete support empower women, builds women's confidence and increases satisfaction and positive childbirth experience [23,14,10]. In this study pregnant mothers and their close family members were not prepared on how to cope with labor pain, what labor is and its progress and were left with their fears to pass through labor process.

In our study mothers in labor were accompanied by a family member to the maternity hospital. Mothers in true labor were admitted to labor ward and join the mothers in labor who were screaming during contraction that worsened their fears of labor pain. The mother in labor stays alone as the hospital policy doesn't allow any presence of a family member. Table 3 shows pain the scariest factor to mothers, human presence and support, provision of information and physical care were among the poorly managed care variables. Labor is a physiologically controlled process through a cascade of hormones. Interfering with the cascade emotionally or chemically disturbs the necessary progression of hormonal regulation that results in a negative consequence [24]. Similar to our findings labor pain was scary factor, primiparous women expressed that they were not happy, childbirth was painful, and uncontrollable more than they expected [10]. Child birth education and support lessens labor pain discomfort. Furthermore a review of 137 studies reported, factors influencing mother's childbirth experience include the amount of support the mother gets, quality of care given, patient relationships and mother's involvement in decision making [15]. Studies on women's care experience reported, women who were not informed and not educated on labor pain and coping strategies were dissatisfied and expressed their wished to be well informed and take active role in their care [25]. Caring with dignity in a supportive and reassuring environment empower mothers, reduce anxiety and shortens the duration of first and second stage of labor [26]. Education and guidance during the second stage of labor lessened pain and fatigue, shortened the pushing time and enhanced the pushing experience [27].

Mothers in our study, similar to their labor experience the care they received during postpartum and discharge was inadequate. Thus pain relief, support, getting information about progress of second stage of labor and advice about the postpartum was rated very low as reflected in table 4. Studies reported that mothers especially first-time mothers' need more support during the postnatal period, such as infant care, breast feeding, emotional coping, and guidance [28]. Consistent with this Go¨zu¨m, reported, because it can never be predicted which postpartum mother will experience postpartum risks all mothers should be well educated before discharge about risks and prevention and actions to be taken (29). Contrary to the evidence in our study the discharge care plan was not standardized and well planned. Mothers were discharged within four hour while they have not

recovered from the labor exhaustion and have no energy and interest to listen to the advice or education they receive. Moreover as discussed above mothers were not educated and prepared during the prenatal care which is the best time to provide advice.

According to [19], during labor the mother and her immediate family members should be well informed, about the labor process and be part of the care plan during the whole labor-delivery and immediate postpartum periods. In the ONMRH there is no proper waiting place for the family members or neither are they allowed to be present with the mother in lab. They just stay outside the maternity ward hearing the screaming voice of the laboring mothers. In addition information about the condition of the woman in labor given to the family members were almost inexistent, 62% didn't receive any information. All family members expressed their bitter feeling about the behavior of the cleaners and guards towards them. During their interview family members expressed waiting outside was worrisome, and expressed their concerns that they didn't get the respect they deserve.

Views of both mothers who gave birth at ONRMH and their families on how a woman should be cared during childbirth process include, rest and good nutrition, protected in a safe environment, support education and advice. Indeed all this views match with the evidenced based midwifery practice presented throughout the manuscript. Mothers also recommended that childbirth education should be enhanced by audiovisual teaching methods.

5. Conclusion

Our research is a small scale study at ONRMH. However as the study site is a teaching hospital providing the major national obstetrics and gynecology services making the study important. Nurse midwives are overloaded in this hospital because they manage all normal deliveries. However the study revealed that there are gaps in preparing pregnant mothers for childbirth that include: lack of close support and provision of information during labor delivery and postpartum, lack of proper discharge care plan. In addition family members are never involved in the care plan of pregnant mothers during pregnancy and childbirth. Thus midwifery practice at OMNRH needs further assessment and improvements

Although women appear to be satisfied with a live healthy baby, the process of 'getting there' has an emotional and psychological dimension that is important to the experience.

6. Recommendation

In-depth assessment of quality of midwifery service is important (prenatal, labor & delivery and postpartum)

There must be continuous in-service training of care providers

Maternity centers including health centers should be able to provide prenatal, intra-labor and postnatal services to decrease the work load at OMNRH

There must be continuous feedback from mothers who consume midwifery services at OMNRH

Family members should be involved in the care plan of the mother.

7. Limitations

The study is a small scale study that may not be a national representative. Because the mother will be discharged soon, data was collected immediately in the postpartum period while the mother has not recovered from her labor exhaustion which may affect the quality of data.

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Reference

[1]P. Liamputtong, S. Yimyam, S. Parisunyakul, C. Baosoung, N. Sansiriphun. "Traditional Beliefs About Pregnancy And Childbirth Among Women From Chiang Mai, Northern Thailand". *Midwifery*, vol. 21. pp, 139–153, 2005.

[2] C. Razurel, M., .Bruchon-Schweitzer, A.,Dupanloup., O., Irion., M., .Epiney . "Stressful Events, Social Support And Coping Strategies of Primiparous Women During The Postpartum Period: A Qualitative Study". *Midwifery* , vol.27, pp. 237–242, 2011

[3] L., Barclay. "Woman and midwives: position, problems and potential". , *Midwifery*, vol.24,pp. 13–21, 2008.

[4] S., Harvey, D., Rach, MC., Stainton, J., Jarrell, R.,Brant. "Evaluation of Satisfaction With Midwifery Care". *Midwifery*, vol.18, pp. 260–267, 2002.

[5] International Confederation of Midwives (ICM). "Essential competencies for Basic Midwifery Practice". ICM 2010.[on line at]. www.internationalmidwives.org. accessed Dec, 2011.

[6].World Health Organization. *Fifty-Sixth World Assembly*. A56 19, Provisional Agenda Item 14112, April 2003.

[7] Ministry of Education Eritrea (MoHE). *Annual Ministry of Education National Activity Report*. Asmera, MoHE, 2013 pp. 30-35.

[8] J. Schooley, C. Mundt, P. Wagner, J. Fullerton, M. O'Donnell. "Factors Influencing Healthcare-Seeking Behaviours Among Mayan Women In Guatemala". *Midwifery*, vol. 25, pp. 411–42, 2007.

[9] I., Waish. *Midwifery Community-Based Care During the Childbearing Years*. 2001 W.B Sounders

Company

[10] I., Lundgren. “Swedish women’s experience of childbirth 2 years after birth”. *Midwifery, vol.* 21, pp., 346–354, 2005.

[11] P., Larkin, CM., Begley., D., Devane. “Women’s experiences of labor and birth: an evolutionary concept analysis”. *Midwifery*, vol., 25,pp. e49–e59, 2009.

[12] KL, Rudman., Khouri., U. Waldesstrom. “Women’s Satisfaction with intra-partum care”. *Jor. of Advanced Nursing*, vol. 59 (5), pp. 474-487, 2007.

[13] U., Waldesstrom. “Experience of labor and birth in 1111 women”. *Journal of Psychosomatic Research*, vol. 47, pp. 471-482. 2007.

[14] J., Gibbons, A., Thomson. “Women’s expectations and experiences of childbirth”. *Midwifery* Vol. 17, pp. 302–313, 2001.

[15] D., Walsh. *Evidence-based Care for Normal Labour and Birth. A Guide for Midwives*. 2007. Routledge, London.

[16] Pillitteri . *Nursing care of the Postnatal Women and Family. Maternal and Child Health Nursing Care of the Child bearing and Child bearing Family*. 2003. Lippincott

[17] S., Kanotra., D., D’Angelo., TM.,. Phares ., B., Morrow., W D., Barfield., A., Lansk. “Challenges Faced by New Mothers in the Early Postpartum Period: An Analysis of Comment Data from the 2000 Pregnancy Risk Assessment Monitoring System (PRAMS) Survey”. *Matern Child Health J*, vol 11, pp :549–558, 2007

[18] M., Leininger. *Transcultural Nursing Concepts, Theories, Research & practice*. Pp93-110, Printer/Binder: Book-mart.Ink .

[19] Varney. *Varney’s Midwifery*. 4th edi. Pp. 304-450. 2004. Jones & Barlet.

[20] World Health Organization.*WHO Report Calls For New Approach to Save Lives of Mothers and Children.*2005. ⟨http://www.who.int/mediacentre/news/ releases/2005/pr16/en/⟩ (accessed2June2012).

[21] World Health Organization . *Effective Prenatal Care Midwfifery/ Obstetric Care*. Pp 9-25. 2010

Publications. WHO Regional Office for Europe Scherfigsvej 8DK-2100 Copenhagen Ø, Denmark

[22]H. Sigurdardottir. “Midwifery care first week after birth. Mothers’ views on the service provided”. *Midwifery*, vol. 82, pp. 19–27, 2004.

[23] AH. Salonen., H. Oommen, M. Kaunonen. "Primiparous And Multiparous Mothers' Perceptions of Social Support From Nursing Professionals In Postnatal Wards". *Midwifery*, vol 30, pp. 476- 487. 2014.

[24] ST. Blackburn. *Maternal, Fetal & Neonatal Physiology: A clinical Perspective*. 2nd ed. Pp 150-200. Saunders.

[25] C. Razurel, M.Bruchon-Schweitzer, A.Dupanloup,, O. Irion,, M.Epiney . "Stressful events, social support and coping strategies of primiparous women during the postpartum period: a qualitative study". *Midwifery* , vol. 27, pp. 237–242, 2011.

[26] D., Lewin., B., Fearon., V.,Hemmings., G.,Johnson. "Women's experiences of vaginal examinations in Labour". *Midwifery*, vol. 21, pp. 267–277, 2005.

[27] S., Chang, , M., Chou., K., Lin, L.,Lin., Y., Lin, , S., Kuo. "Effects of a Pushing Intervention on Pain, Fatigue and Birthing Experiences among Taiwanese Women During the Second Stage of Labor". *Midwifery*, vol. 27, pp 825–831

[28] SF., Ong., WS., Chan., S., Shorey., YS., Chong, P,. Klainin-Yobas, H., Hong-Gu. "Postnatal experiences and support needs of first-time mothers in Singapore: A descriptive qualitative study". *Midwifery*, vol. 30, pp. 772–778, 2014.

[29] S., Go¨zu¨m, D., "Kilic. Health problems related to early discharge of Turkish women". *Midwifery*, vol., pp. 371–378, 2005.