NATURAL AND MEDICALISED BIRTH VIA FEMINIST LENS: LITERATURE REVIEW

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Abstract

Overmedicalization of childbirth is in steady increase, and it becomes a public health problem across the number of developing countries by the late 20th century. This approach impact laboring woman negatively, as they feel disempowered and perceived inhumanity through engaging them in unnecessary medical interventions, without taking into consideration their right regarding informed choices and autonomy in decision making. Objective: To perform a literature review on natural and medicalized birth, through the application of feminist approach principles. Methodology: The review includes recent and up-to-date studies, recruited from different databases: The Jordanian database for nursing research, PubMed, Research Gates, Science Direct. Also, a Google Scholar search was used to select additional studies. Data from World Health Organization (WHO) was obtained Jordan Population and Family Health Survey (JPFHS), and books as references. The majority of articles were in full text, and the used language was English. Results and discussion: The studies reviewed within the feminist principles provided evidence that natural childbirth could be achieved when the women perceived empowerment, and autonomy in decision making through the application of midwife led-care care. While in medicalized context, all women reported different types of oppression and disrespectful care. Conclusion: According to the third principle of the feminist approach social and political change is essential. Healthcare professionals should be aware of the need for multidisciplinary efforts. Keywords: Natural childbirth, medicalized childbirth, women’s experiences, feminist approach, and midwife-led care unit.

I. Introduction

Childbirth experience represents a very important event in women’s lives, which marked by the transformation of the woman in her new role of being a mother. The importance of this event is reflected by enhancing maternal and family satisfaction with childbirth experiences, as well as improving mother and fetal health outcomes, such as fast recovery, immediate powerful bonding, and early breastfeeding initiation, and decrease their morbidity and mortality rate (Darsareh, et al., 2018; Semrau, Hirschhorn, Kodkany, et al. 2016). Recently, the actual rates of natural childbirth still remain low (Prosser et al., 2018), and despite that 140 million women given birth worldwide yearly, but less attention is paid to what could be done to enhance positive, safe, and comfortable birth experience, and what is beyond the using of unnecessary clinical interventions, which is refer to a medicalised childbirth (WHO, 2018). This literature review is intended to provide an evaluation of previous studies dealing with the same concerns, and was guided by the principles of feminist theory. The next part will present the search strategies that have been used, philosophical underpinnings, the application of feminism principles on childbirth experience, the perspectives of childbirth in Jordan, and the challenges for natural childbirth.

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II. Search Strategy

This literature review includes recent and up-to-date studies, recruited from different databases: The Jordanian database for nursing research, PubMed, Research Gates, Science Direct. Also, a Google Scholar search was used to select additional studies. Data from World Health Organization (WHO) was obtained Jordan Population and Family Health Survey (JPFHS), and books as references. The majority of articles were in full text, and the used language was English. The main keywords that have been used in searching strategies include natural childbirth, normal childbirth, medicalized childbirth, and women's experiences.

III. Philosophical Underpinnings

Feminism is a philosophical approach that aims to correct both the invisibility and misrepresenting of the female experience (Creswell, 2013). And however, this correction could face many implementation difficulties that approach has always served to initiate a system change. Concerning our study, Feminist researchers have criticized the medicalized model of birth, and claim to use alternatives by including midwifery- models of care, which provide woman-centered care, enhanced by women and midwives partnership (Keedle et al, 2019). Feminist theory can provide deep insight into the experiences of women deciding to give birth naturally in a midwife led-care unit.

Understanding the main values and beliefs, that might promote natural childbirth, requires articulating the theoretical knowledge of the social and cultural attitudes. In regard, Latifnejad, Zakerihamidi, and Merghati (2015) reported that women from the middle class choose medicalized childbirth instead of natural childbirth to overcome pain during delivery, while other women believed in the early recovery, which is the main reason to prefer natural childbirth. Feminist researchers have argued that these attitudes might be different according to the individuals' social culture, social class, and social resources (Behruzi et al., 2013).

Chronologically, Feminist activities passed three waves. The first wave started during the nineteenth and early twentieth centuries, through which, women struggled to have their rights to control the birthing process and to use pain relief drugs. The second wave started in the late 1960s and early 1970s and introduced the concept of natural childbirth and midwifery care. And finally, the third wave of feminist activities, which started after the 1990s, and concerns about women's rights of having technology, and pain-free methods during childbirth (Behruzi et al., 2013).

Each wave of the feminist approach provides a different perspective, regarding women's view of childbirth, and its related care. In this study, we will return to the second wave of feminism, calling for, non-medicalized, women's control, natural childbirth, and women's empowerment. The application of the feministic approach in this study will be based on three principles. According to Hall and Stevens (1991), these principles include (1) valuing women through exploring their experiences; (2); recognizing the oppressed women; (3) and making political and social changes to promote natural childbirth. Each principle and its applicability for the present study will be discussed in the next section.

Viewing the Experiences of Childbirth through Feminist Principles

Principle One: Valuing Women's Experiences of Childbirth

Viewing women's experiences of natural childbirth through a feminist lens will be the first step for policy change (Keedle, Schmied, Burns, et al., 2019). This approach is used to understand and describe women's experiences of natural childbirth, to correct their invisibility through studying women’s issues such as taking positive action, and combat devaluation and powerlessness in their society, particularly during childbirth (Behruzi et al., 2013).

Currently, global consensus has been found regarding the positive outcomes of natural childbirth. For example, a study that used an exploratory design, through conducting in-depth...
interviews with twelve pregnant women age range between 19 to 33 years, to explore the beliefs of pregnant women related to vaginal delivery, and how they perceive the outcomes, in addition to the impact of others perspectives on their decision such as Physicians, midwives, and nurses. The study results illustrated that natural childbirth could aid in fast recovery, immediate powerful bonding, and early breastfeeding initiation.

Therefore, the authors claim to enhance women's attitudes, and awareness regarding natural childbirth, considering the crucial role that nurses and midwives could play in empowering women (Darsareh et al., 2018), such empowerment of women in their journey of natural childbirth, could lead to positive outcomes such as self-confidence, and obtaining uniqueness of birth experience (Olza et al., 2018). Details about the impact of empowerment in enhancing positive childbirth experience are discussed below.

**Women Empowerment in Childbirth.** Empowerment acts as a mechanism to protect women from malpractice during childbirth (Diamond-Smith et al, 2017). Consequently, it is expected to make a difference in a woman's experience, through influencing her readiness to cope with the challenges of childbirth (Nieuwenhuijze, & Leahy-Warren, 2019), This can be achieved by strengthening their belief in their ability to give birth naturally, through providing of physical, emotional and social support (Olza et al, 2018).

**Principle Two: Recognizing the Oppressed Women**

Regarding women's experiences of childbirth and its relation to this theory; Feminist researchers criticize the technocratic obstetric model, by which many women feel disempowered through receiving un-humanized care when engaging them in medicalized childbirth (Cohen, 2016). The un-humanized care was reflected by limited choices, and unnecessary aggressive interventions (Grilo Diniz et al, 2018).

Therefore, the feminist approach aims to help women regain their autonomy during childbirth, and questioned the routine use of unnecessary medical interventions (Reis et al., 2017). The following paragraphs will detail how women's choices in childbirth options may be limited in the medical context, in addition, to clarify the types of medical interventions and their impact on both the women and their newborn outcomes.

**Limiting Women's Choice in Delivery Options.** At the time that policies worldwide advocate for pregnant women to have choices, and autonomy in decision making during childbirth (NHS England, 2016), evidence shows that, in a medical context the health care provider prioritize their professional agenda over the women's needs and choices, and the results reflect women's feeling of pressure to accept medicalized childbirth, in addition to lack of control and autonomy in decision making (Robert, J., & Walsh, D., 2019).

Similarly, Lou, Hvidman, and Uldbjerg et al (2019) conducted a systematic review to obtain evidence about women’s experience of post-term induction, in this study eight qualitative articles were summarized, and the results reflect that women consider that induction of labor is a health care provider recommendation, and it was beyond their own decision, especially that they found themselves following step by step the policy of the hospital in childbirth. Therefore, the authors claim to promote a positive child experience through valuing women's preferences, by providing adequate knowledge, and alternative options, to support informed choice and enhance decision making.

**Using Unnecessary Medical Interventions.** Although the debate is still present about the indications of using intervention during childbirth, several researchers claim to avoid unnecessary interventions and ensure that only necessary interventions should only take place (Maffi, & Gouillhers, 2019). This is consistent with the WHO definition of medicalized childbirth which means: using interventions and procedures even when the mother and fetus are healthy (WHO, 2018).

These interventions that are designed to start, continue, and end labor by routine medical management, could lead to increased risks, rather than allowing the natural, physiological process of birth to be maintained. It includes using either one or more of the following actions: induction of
labor, epidural/spinal/general anesthesia, episiotomy, forceps/vacuum delivery, and cesarean section (Prosser et al., 2018).

More details about medicalized interventions and their outcomes on women and their newborns were presented by a multinational cross-sectional study that aims to explore the variations in childbirth interventions in high-income countries (Seijmonsbergen-Schermers et al., 2018). In this study, data were collected from pregnant women who gave birth to a single child from 37 weeks gestation. The primary outcomes of the study related to medicalized childbirth show that the used interventions include: Using intrapartum antibiotics, epidural and pharmacological pain relief, induction and/or augmentation of labor, episiotomy in vaginal births, instrument-assisted birth, such as vacuum or forceps, cesarean section and finally the use of oxytocin postpartum. While the secondary outcomes were: maternal and perinatal mortality, Apgar score below 7 at 5 min, postpartum hemorrhage, and obstetric anal sphincter injury.

Consequently, women may choose to change their type of delivery to get rid of these aggressive interventions. For more clarification, in a study that aims to understand women's experiences of childbirth in a medicalized context, Pazandeh et al. (2017) were conducted twenty-six in-depth interviews in four public hospitals in Tehran, with women who had a normal vaginal delivery. The results of the study represent two main themes; the first one describes "an ethos of medicalization", this suggests that women's perception of childbirth has been affected by the medical context of childbirth. While the other theme was related to "The reality of fostered medicalization", which illustrates women's childbirth preference change to have Cesarean Section instead of having vaginal delivery with multiple interventions. Authors suggest activating the model of midwifery care that brings together scientific evidence and empathy, to make a change.

**Principle Three: Making Political and Social Changes**

Making change is essential to enhance and maintain natural childbirth worldwide. To achieve the change process it should be implemented at both political and social levels. At the political level, this change aims to establish international guidelines, modify the place of delivery, and activate the role of the midwife. While change at the social level aims to increase public awareness of natural childbirth, including women, family, and the entire community. The next paragraphs firstly presented different approaches to making a change at the political level.

**Natural Childbirth Guidelines.** In response to the rising rate of intervention during birth and delivery, there has been increasing in international interest to promote a natural birth and reduce unnecessary medical interventions, by establishing guidelines and global standards to enhance, promote, and maintain natural childbirth. The next part will identify some agencies and organizations that established natural childbirth guidelines.

Recently, the WHO has established global care standards for healthy pregnant women to reduce unnecessary medical interventions. These standards include: maintaining confidentiality and privacy of the women during childbirth; ensuring good communication and respectful care; having a companion of choice; allowing women to make decisions for childbirth, in addition to highlighting the woman-centered care as a holistic and human rights-based approach (WHO, 2018).

Similar guidelines were established by the Queensland Clinical Guidelines Steering Committee (2017). It includes a consideration that natural childbirth occurs between 37 and 42 weeks gestational age with vertex presentation, in which spontaneous onset and normal labor progress and lead to spontaneous vaginal birth. Throughout the childbirth process, all of the following interventions should be excluded: (1) Induction or augmentation of labor, (2) pharmacological pain relief, (3) infusion of oxytocin, (4) Instrumental birth, such as forceps or vacuum, cesarean section (CS), and episiotomy (Prosser, et al., 2018).

The findings of the previous literature and reports reflect the significant role that international agencies play to promote and maintain natural childbirth. All the agencies claim to apply the international guidelines to achieve the global goal of minimizing the medicalization of childbirth, for the safety of both women, and their children.
Modify the Place of Delivery. Another policy change should be related to the place of delivery that could affect the women's experience of childbirth. In this regard, WHO guideline and recommendations seek to ensure that women give birth in an environment that is safe from a medical perspective (WHO, 2018). Therefore, the midwives wish to promote normal birth in obstetric-led units, as it is considered safer than the units at hospitals, which is characterized by risk-adverse with high rates of intervention and cesarean section (Carolan, Kruger, & Garvey-Graham, 2014).

Moreover, the probability of natural birth was higher for women who deliver in a place that provided continuity of care, freedom of movement, no induction of labor, or continuous fetal monitoring and non-supine position during birth (Prosser et al., 2018). Furthermore, a systematic review of all randomized or quasi-randomized controlled trials, which compared the effects of an alternative institutional maternity care setting, to conventional hospital care was done. The study sample includes 11,795 women who met the inclusion criteria. In this review, the researchers found that the medical interventions during labor and birth were lower in-hospital birth centers, with a high level of satisfaction, without increasing risk to women or newborns, researchers also added that future trials should be conducted to address the factors that affect the continuity of caregiver in the alternative versus conventional birth setting (Hodnett, et al., 2012).

Similar findings were found by a study conducted using a telephone survey with 620 women about six weeks after giving birth at the center. The authors in their study concluded that women who select the birth center care were more likely to attend antenatal classes, less likely to be induced, use non-pharmacological methods of pain relief, more likely to move around in labor, and less likely to have ruptured membranes or continuous CTG. They were more likely to push spontaneously, choose their position for birth and deliver in places other than the bed, in addition, the majority of women who had a spontaneous onset of labor delivered vaginally, less likely to have an episiotomy. A higher proportion of women at the birth center reported skin-to-skin contact with their baby in the first two hours after birth (Macfarlane, et al., 2014).

Midwife-Led Care. Recent policies recommended a woman-centered approach in maternity care and advocates the adoption of Midwife-led care to be one of the important models, for enhancing women's choice, decision making, and continuity of care (Hunter et al, 2017). Midwives play a pivotal role in promoting natural and positive birth experience, they had a great desire to promote normal births with a minimum of intervention, and enhance women have meaningful birth experiences (Aune, et al., 2018; Wong, et al., 2018; Carolan, et al., 2014). This is consistent with the findings of a qualitative study that was conducted by interviewing twelve healthy first-time Norwegian mothers, aged 22-34 years old, and who experienced normal and positive childbirth. The findings reflected that the midwife's attitude and behavior were considered essential to maintain safety, provide care, and promote the women's inner belief and strength in their capability to handle the birth (Dahlberg, et al., 2016).

Similarly, a randomized control trial was conducted in a military hospital in Amman to assess the effects of a childbirth preparation course. A total of 133, low-risk, nulliparous women were recruited, and randomly assigned to either intervention or control groups. The study results revealed that more women in the intervention group (who were exposed to childbirth preparation course), have spontaneous onset of labor, cervical dilation, and earlier initiation of breastfeeding than the control group (Hatamleh, et al., 2019). These findings supported the author's argument related to the significance of the childbirth preparation program that is applied by nurses, and midwives, to enhance spontaneous labor, which will aid in minimizing the medical interventions during the birth process. This study was a randomized controlled trial, which is the most rigorous way to determine the effectiveness of the interventions, but the authors recommended replicating the study using a larger sample size.
The previous literature reflects that midwives play a key role in shaping healthy and positive attitudes of women toward natural childbirth, this could be achieved by providing information and empowering them to make autonomous decisions to make a change (Darsareh, et al., 2018).

Social Change
A woman’s belief that physiological birth can be carried out was based on the sociocultural background (Neerland, 2018). By acknowledging social attitudes toward different delivery methods, societies can be directed towards positive outcomes of natural childbirth, which can contribute to the promotion of maternal and newborn health (Latifnejad Roudsari, 2015).

According to priority, the first step of social change should start at the individual level, beginning with the women. For more clarification, (Preis, 2018) reported that efforts should be collaborated to empower women, especially who had previous experiences of medicalized births, this aid in correcting their belief to trust in their body, and ensure that normal physiological childbirth can happen.

The next step should be to raise family and community awareness about natural childbirth. Database search reflected a lack of evidence that support this important step. Further studies should conduct to investigate these issues.

IV. Perspectives of Childbirth in Jordan

Background
Jordan is an area of about (91,900) square kilometers located in the center of the Middle East. According to Jordan Population and Family Health Survey (JPFHS), the total population in Jordan is 9,456,000. The survey presented that institutional deliveries are almost common in Jordan, with 98% of live births in the 5 years preceding the survey delivered in a health facility. Sixty-five percent of deliveries occurred in public facilities and 33% in private facilities. While Less than 1% of deliveries in the 5 years preceding the survey occurred at home (JPFHS, 2019). All births in the 5 years preceding the survey were delivered by a skilled provider: 89% by a doctor, 11% by a nurse, and 20% by a midwife. Two to thirds 67% of infants had skin-to-skin contact with their mother immediately after birth (JPFHS, 2019).

However, childbirth in Jordan has been viewed as a natural practice (Mrayan and Cornish, 2015). Many factors were integrated to transform the birth journey and impact its outcomes either in the positive or negative direction. Some factors emerged from the social and religious context, which is based on the Jordanian culture, and derived from the Arab-Islamic legacy (Bawadi and ALhamdan 2017; Bawadi, 2015). While the other factors were embedded within the medical context, which recently consider the main concern worldwide. The following paragraphs elaborate on the effect of the medical contexts on the childbirth process in Jordan.

Childbirth in Medical Context
Medicalisation of childbirth in Jordan has been taken place largely after the year of 1946, as cited by Maffi and Gouilhers (2019). Two studies were conducted in Jordan and imply that the rates of labor and birth practices in Jordan differed from WHO guidelines, and not according to the evidence-based recommendations (Khresheh, et al., 2009; Shaban, et al., 2011). The first study was conducted by Khresheh, Homer, and Barclay (2009), which aims to examine data of a new birth record in Jordan from 2004 till 2009, to compare the practices with World Health Organization (WHO) guidelines, and evidence-based recommendations.

The study was conducted in three Ministry of Health hospitals in Jordan, by reviewing the birth records of 1254 mothers and babies. The study results showed that the rates of augmentation of labor (46%) and episiotomy (53%) were particularly high, and seem to be more than the WHO recommendations, which state that neither of these practices should be undertaken routinely (Khresheh, et al., 2009).

After two years, another study was conducted to reflect that, the inappropriate practices during childbirth were not only in a steady increase but also, at a higher rate than the previous study. This study was conducted using an explorative research design, and a non-participant observation approach to collect data from 460 low-risk women during labor and birth. The researchers found that the rate the
augmentation of labor increase to be 95% of the total number of participants, lithotomy position was applied to all of the participants during delivery, and the rate of continuous external fetal monitoring was 77%, more than one-third of the participant 37% had an episiotomy, and 58% of them had various degree of laceration, the researchers concluded that high levels of interventions were observed, many of which may not have been necessary for low risk mothers (Shaban et al., 2011).

The previous results are alarming and indicate either the lack of knowledge among health care professionals or non-adherence to the international guideline, that was established to promote and support natural childbirth. In Jordan, there is a lack of literature that investigates these issues; further work is needed to explore the barrier of why evidence-based practice is not implemented in these hospitals during childbirth.

**Jordanian Women between the Oppression and Recognition**

In Jordan, the birth experiences of women varied across settings and generations. This finding was reported by Hussein, Dahlen, and Ogunsiji (2020), based on a qualitative interpretive study conducted by collecting data using face-to-face semi-structured interviews with 27 Jordanian women. In this study, the author reported that in governmental hospitals in Jordan, women had no support, and were treated disrespectfully.

This finding is consistent with an earlier national study that was conducted at four governmental Maternal and Child Health Centers (MCHCs). Using A retrospective cross-sectional design study, a sample of (n=390) Jordanian women who gave birth within the last one to three months were included in the study. Childbirth Verbal Abuse and Neglect Questionnaire (CVANQ) were developed to collect the data. The main findings of the study revealed that (32.2%) of the women were perceived negligence, and (37.7%) women started being verbally abused. Therefore, authors have recommended identifying the consequences of exposure to neglect and verbal abuse during childbirth on women's psychological, emotional, and physical wellbeing, and conducting educational programs to enhance competent care during childbirth (Alzyoud et al., 2017).

Previously, Hatamleh et al. (2013) presented similar findings, as they reported that women receive poor care during birth, when they are processed as objects, through neglecting their need for independence, and information. The authors related these findings to giving birth in a medicalized model, where the birthing process becomes institutionalized, based on a medical, and managed by the use of birth technology.

On the other side, and based on evidence, women valuing and recognition during the childbirth journey is present whenever the midwife is present (Hawamdeh, 2018; Mensah et al, 2014). For example, a study was conducted by Hawamdeh (2018), using a sample of (n=384) Jordanian women, recruited from the postpartum unit at the department of obstetrics and gynecology at a major public hospital in Amman, Jordan. The main findings of the study illustrate that the majority of women expected their midwife to be a patience, soothing person, who provides reassurance and reflects understanding. These results were not surprising, nor opposing the finding of the previous study of (Alzyoud, et al., 2017) that presents the attitude of general health care providers during childbirth. While this study (Hawamdeh, 2018), was reflected, particularly, the women's perceptions of midwife care, therefore the perceptions were varied.

Unfortunately, this evidence regarding the crucial role that midwives could play in enhancing positive childbirth experiences, was not applicable, because the development of midwifery to be a primary healthcare strategy in Jordan is facing many barriers. To identify these barriers (Shaban et al. 2012) conducted action research, and collected data using workshop discussion and reflections from a convenience sample of 64 midwives and educators. Thematic analysis revealed that the health system in Jordan was medically dominated, and this result creates confusion to the identity and image of midwifery, and therefore it has not yet been seen as a primary health strategy.

**V. Challenges for Natural Childbirth**

Many challenges affect promoting and supporting natural childbirth. Healy, Humphreys, and Kennedy (2017) reported that medicalization affects the provision of maternity care by keeping the midwifery in a peripheral position, with a lack of responsibility for low-risk women and normal birth; it
makes them as a profession reluctant to take action. An integrative literature review was conducted to explore the midwives ’ perceptions of the facilitators and barriers of physiological birth. The findings showed that the main barrier for adopting physiological birth, according to midwives are: Negative perception, lack of knowledge due to inadequate training, the existence of obstetrician-led practices, in addition to time pressures, a risk-averse culture, and women’s negative expectations (Wong et al., 2017).

Moreover, a qualitative study that aims to explore challenges in implementing the Physiologic birth program (PBP) from the perspective of midwives and obstetricians in Iran. Data were collected through focus groups and in-depth interviews with 32 midwives, and six obstetricians, the study results showed that the challenges were related to Firstly; organization factors which include: weakness in implementing (PBP); in inappropriate environmental conditions, and deficiency in implementing the policies, guidelines, and regulations. Secondly; professional factors such as less attention of midwives to PBP, professionals’ resistance to change, and lack of efficient communication. And finally; laboring women factors such as Poor preparation, and women's concerns about normal childbirth.

The researchers of the study concluded that it's important to review policy and regulation regarding natural childbirth, in addition to the importance of enhancing knowledge and attitudes of women, which have been considered the most important factors to promote natural childbirth (Janani et al., 2015). Finally, regarding the role of nurses and midwives to enhance natural childbirth, despite that, they lack autonomy in practice, which makes them prone to biomedical superiority, but they are criticizing the extreme medicalization of birth.

VI. Summary
The summary of the reviewed literature showed that the majority of the studies reflect the importance of natural childbirth, and the positive outcomes that could be gained if natural childbirth has been adopted as a mode of delivery, but most of the studies explored natural childbirth in general, or in comparison to cesarean birth, without emphasizing on the negative impact of medicalized childbirth, and the differences between natural versus medicalized childbirth from the women's perspectives.

In Jordan, several studies were conducted concerning childbirth, but most of the studies highlighted specific issues related to general birth experience without specifying the type of birth whether it is natural or medicalized childbirth. There is still little scientific evidence specifically related to women's role in selecting their preferable mode of birth, and their experiences of having a natural childbirth.

On the other hand, evidence showed that there is a lack of support to influence the experience of positive natural childbirth among women, with many challenges that affect promoting and supporting natural childbirth. There is a lack of national studies using the qualitative feminist approach; to explore the experiences of women who selected natural childbirth as the mode of delivery, after having previous experience of medicalized childbirth. This study will gain more insight into these experiences to deeply understand this phenomenon, and to explore women’s understandings of normal versus risky childbirth. The next chapter will present the methodology of the study.

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Conflicts of interest
The authors have no conflicts of interest to disclose.

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