Pregnancy and childbirth are two of the most common reasons women access the health care system. Patient satisfaction surveys are the dominant method of evaluating health services from the perspective of mothers, focusing primarily on individual expectations of care, yet fail to provide a comprehensive assessment of care from the users’ perspective. Qualitative semi structured interviews followed by thematic analysis were used to explore maternity health care services and understand the personal, social, and institutional experiences of maternity care from the perspective of 11 women. Provider-client relationships, continuity of care, emotional support, time-spent, and control, were identified by all of the women as important components of maternity care. Women’s stories exemplify the need to focus on relationships, continue to question everyday maternity care practices, challenge oppressive practices and structures, work together to build upon the strengths that already exist, and support more empowering experiences for women.

This paper reports the findings of a qualitative study examining responsiveness in maternity care specific to one major theme, that of the relationships between women and their providers. This particular theme is singled out because it predominates participants’ descriptions of their childbirth experiences and because it connected most of the other themes uncovered in the analysis.

**Background**

This study was undertaken in Halifax, Nova Scotia, a city hosting 50% of the province’s nearly one million population and correspondingly, half of the provinces’ births. The study is timely given the rapidly changing context of maternity care in Nova Scotia. There is growing concern over a potential crisis in the capacity to deliver primary maternity care both in Nova Scotia and across Canada (MCP2, 2006). Although maternity care is publicly funded and therefore monetarily accessible to all, there have been many structural and organizational
changes within the Canadian Health Care system since the 1980’s that affect accessibility in other ways. Significant restructuring included the devolution of health care authority from provincial governments to regional health boards (Braunstein et al., 2000). The resulting patchwork effect with regards to health planning has been complicated by increasing centralization of maternity care services. Centralization has been fuelled, in part, by provider shortages, particularly the reduction in the number of Family Physicians willing to provide maternity care services. For example, in Nova Scotia between 1988 and 2004, the number of Family Physicians attending births dropped from 550 to less than 110 (NSDOH, 2005). During that same time period, 16 maternity units in community hospitals across Nova Scotia closed with others left teetering on the brink (RCP, 2004). These closures force many rural women to travel long distances for basic maternity care.

Since funded midwifery services were only introduced in Nova Scotia on April 1st, 2009, the abdication of family doctors from maternity care has meant a shift to obstetrician care for healthy pregnant women (CIHI 2004). Having obstetric specialist provide the bulk of primary maternity care is viewed in many quarters to be less than ideal (ICM, 2005; OMHLTC, 2006). The situation is unlikely to change soon given the measured implementation of only seven midwives divided between three of the provinces’ ten district health authorities (DoH, 2009).

Qualitative Data Missing

Although extensive quantitative information is collected through the Atlee Perinatal Database, providing a broad snapshot of clinical care outcomes and practices including epidural use and c-section rates, there is little data available on women’s views of care except those obtained through patient satisfaction surveys administered by individual hospitals. Despite the limitations and criticisms of quantitative patient satisfaction surveys, they remain the dominant method for evaluating health services from the perspective of users. Specifically, critics suggest that patient satisfaction surveys tend to reflect individual expectations of the available care rather than comprehensively assess perceptions of care quality or individual needs and preferences (Avis, Bond & Arthur, 1997; Sitzia & Wood, 1997; van Teijlingen et al., 2003).

The relationships women have with their maternity care providers are complex. To be understood, they need to be unraveled within the context of care and viewed from multiple vantage points. One overlooked point of view is the woman’s own personal experiences of receiving care. In response to this need, the study set out to explore women’s experiences of maternity health care services. The in-depth analysis included personal, social, and institutional data. This data was collected using a Maternity Care Responsiveness (MCR) interview guide,
developed by combining the World Health Organization conceptual framework for evaluating health system responsiveness (WHO) (2001, 2005) with the National Guidelines on Family-Centered Maternity and Newborn Care (Public Health Agency of Canada, 2002) and the guide for cultural competence in primary health care developed by the IWK Health Centre and the Province of Nova Scotia (2006). The MCR interview guide was then used to conduct semi-structured interviews with eleven women.

The WHO defines responsiveness as the outcome that “can be achieved when institutions and institutional relationships are designed in such a way that they are cognizant and respond appropriately to the universally legitimate expectations of individuals” (deSilva, 2000, p. 3). In essence, responsive care is quality care that meets patients’ reasonable expectations and established community standards. The WHO’s conceptual framework does not specifically mention maternity care. However, the two major components: respect for persons and client orientation and their eight elements listed below, are relevant to maternity care responsiveness. Respect for persons encompasses three key elements: dignity, confidentiality, and autonomy of individuals and families to decide about their own health. Client orientation includes five elements: prompt attention, access to social support networks, quality of facilities, communication, and choice of provider (WHO, 2000). Combined, these provide a complete picture of the four ‘A’ standards of health care services in Canada: accessibility, availability, acceptability, and appropriateness (Health Canada, 2001; Romanow, 2002).

Purpose of Research

The purpose of this research was to explore women’s maternity care experiences as they pertain to maternity care responsiveness in Nova Scotia. The central research question that guided the study was: How do women from diverse backgrounds, experience maternity care responsiveness in Nova Scotia?

METHODOLOGY

Population

Following ethical approval obtained from the IWK Health Center’s research ethics board, eleven women from diverse backgrounds were recruited through purposeful sampling (Patton, 2002), in order to capture different experiences based on age, race, income, education, parity, partner status, and type of delivery. Eligibility criteria included women who spoke English and who had given birth to a single live baby in the past two years in hospital under the care of a physician. Women having unregulated midwifery care were excluded as midwives had not
yet integrated into the public health system when the interviews were conducted. 36% of participants self-identified as visible minority; two were immigrant women, one ‘indigenous’ African Nova Scotian, and one Mi’kmaq. Two women lived below the poverty line with over-all annual incomes ranging from $18,000 to $90,000. Educational attainment varied, with one participant completing grade nine and another, grade 12, while the remaining had some postsecondary education including one PhD student. All but one participant had a spontaneous vaginal birth, including one VBAC (Vaginal Birth After Cesarean), the other had a cesarean section. Five of the participants shared their experiences of giving birth to their first child, five to their second child and one to her third child. Only one of the participants was a single woman. Participants’ ages ranged from 19 to 45, with an average age of 28. Their babies at the time of the interview, were 2 to 23 months old.

We recruited women via advertisements in local papers, as well as flyers distributed to physicians’ offices, hospitals, public libraries, parenting groups, and childcare centers. This was done in partnership with numerous community organizations with whom the researchers had built long term relationships. Staff members were asked to approach potential participants and provide them with the research coordinator’s contact information. They were then given a letter of intent that explained the study. An agreed upon time and place were chosen to conduct the interviews and consent forms were signed before the interviews began.

In order to capture women’s experiences of maternity care in their own words, a semi-structured interview guide was developed, as previously stated, using the WHO conceptual framework for evaluating health system responsiveness, the National Guidelines on Family-Centered Maternity and Newborn Care and the document, Cultural Competence for Primary Health Care in Nova Scotia. The guide was pilot-tested with one woman to assess the length of the interview and whether the questions and style of interviewing supported effective data collection.

Data Collection

The research assistant and two team members conducted face-to-face interviews with eleven women using the semi-structured maternity care responsiveness interview guide. Ten interviews were conducted in the woman’s home and one was conducted in a community organization’s office. The interviews were audio-taped and lasted approximately 30-90 minutes. Participants were assured there was no right or wrong answers and that the dialogue was meant to explore different individual meanings of experience. Participants were encouraged to speak as openly and honestly as they felt comfortable.
Audio-taped interviews were transcribed verbatim. Names were changed to code numbers and all identifying information removed.

**Data Analysis**

Analysis entailed careful readings of the transcripts by the principal applicants, co-applicants and research assistant who each independently coded the first three interviews. They identified emerging themes which were compared within each interview and then between interviews. The research assistant continued the coding herself. The NVivo computer program was used to facilitate data coding, organization and analysis. The research team held regular meetings to discuss the analysis. This thematic analysis entailed close attention to each woman’s experience, “as a means to provide insight into the cultural beliefs and values that instill powerful experiences and motivations” (Luborsky, 1994, p. 190). Thematic Analysis is particularly useful when examining experiences, beliefs and perceptions. Analysis initially focused on the unique experiences of each participant then expanded to consider whether common perceptions and experiences of system responsiveness existed among the women in this study. The differences were also explored. Social and institutional influences were recognized as integral to each woman’s experience. As themes emerged, possible alternate explanations were discussed and accepted or disconfirmed through additional data analysis and an extensive review of the published literature. The end result was an in-depth understanding of participants’ experiences.

The analysis was informed by concepts from feminist social theory (Aston, 2008; Cheek, 2001) which critically connects personal, social, and institutional aspects of care. The analysis was also informed by the concept of empowerment. Empowerment involves active patient participation in the development of his or her own health plan. It has been widely accepted, incorporated into The World Health Organization (1978) policy since the 1970’s and is central to Primary Health Care in Canada (CHNAC, 2003).

Historically, views of the patient-provider relationship assumed that the provider's role was to act in the best interests of the patient, to direct care and make decisions about treatment on the patients’ behalf (Deber, 1994). Unfortunately, this style of practice often led to disempowering relationships. By contrast, when nurses, for instance, begin with the clients’ knowledge and experiences first, this is understood to be part of an empowering strategy that facilitates trust and relationship building (Aston, 2002; 2006; 2008; Anderson, Capuzzi & Hatton, 2001; Jack, DiCenso, & Lohfeld, 2005; Falk-Rafael, 2001; Meagher-Stewart et al, 2004; Schulte, 2000). Empowering patients to actively participate in their care has benefits. They are more likely to
have a sense of control, to accept treatment, and to perceive themselves as healthier (Deber, 1994). However, it can be difficult for clients to negotiate a consensus with their health care so it is important for health care researchers to consider the patient-provider relationship in terms of power differentials and to ask how these unequal relationships affect patient autonomy? Understanding relationships within the personal, social, and institutional landscape of maternity care in Nova Scotia will provide information that may lead to more accessible, available, acceptable, and appropriate care for all women.

Scientific Rigor

Research rigor was ensured through a variety of techniques. Trustworthiness of findings was attained through careful reading, coding, and discussion of each transcript. Readability was attained through regular discussions and confirmation of ongoing analysis. Transferability was achieved with the use of in-depth interviews, dependability and auditability, through documenting the decisions and the research process.

FINDINGS & ANALYSIS

Among the themes that emerged, provider-client relationship was particularly unique and powerful. In fact, all of the women interviewed in the study regardless of their age, citizenship, ethnic origin or economic status, spoke about the relationships they had with nurses, physicians, and other health care professionals as a significant aspect of maternity care responsiveness. Their experiences offered complex in-depth accounts of how provider relationships unfolded, what the relationships meant to them and how they affected care. The theme of provider-client relationship builds and expands upon the WHO’s framework for responsiveness but moves beyond amicable communication style and concrete information exchange to the development of a connection with the provider, to meaningful relationships that were empowering and sensitive to the context of participants’ own life experiences.

Relationships with Nurses

Relationships with nurses left a lasting impression on participants’ maternity care experiences. Generally, the women described their nurses as more supportive than their doctors, perhaps because nurses were able to spend the time needed to develop a relationship: "Nurses for the most part are so fantastic, and they spend so much personal time with you." (Participant 9). Nurses were also more
open to having a personal connection with women in their care, for example:

One nurse I had, had a very similar experience as I did. And so she was really feeling for me and stuff. Which is great because they then started talking to me kind of on a personal level. She was like, ‘Don’t worry I’ve been there, done it.’ (Participant 1)

Supportive relationships with nurses involved a feeling of genuine caring.

And my nurse especially was really hands-on. And she was caring... it really felt like she was concerned about me and worried about me. And they were all very nice from the get-go as soon as I entered the hospital. (Participant 9)

In some instances where women had unfamiliar physicians providing care, they were grateful for the presence of a consistent and supportive nurse.

The second doctor was good. She listened to the nurse because the nurse had been there with me. She had quite a longer shift than the doctor so she was there throughout the whole process. Which was nice to have one person instead of all the... I think I had 3 doctors... it was comforting to have her there because obviously she was paying attention. Because she kept catching the things that the doctors weren’t even on the radar with...She made me feel like I was in better hands...(Participant 8)

Supportive relationships with nurses involved respect for autonomy and establishing a trusting relationship with their nurse, engendered feelings of trust and safety:

I felt like during the labor part, the nurses all treated me with respect. Like they were excited for me, and they let me walk around. They let me do whatever I wanted to do, whatever I felt comfortable doing. And they cared about the fact that I was going through this labor which was brutal. Yes, they were very, very respectful throughout that whole time. The nurses especially. The doctors weren’t necessarily. (Participant 9)

She always seemed to know what I needed. She really seemed to be ahead of what I was thinking. And so that to me made me feel really cared for and respected, and I could sort of trust what was happening. (Participant 10)
One woman described her nurse as a mediator and a translator of medical jargon:

\textit{And she [the labor and delivery nurse] could explain to them so I didn’t feel like I had to be the one to tell them what was happening. Or when they asked her questions, she knew what they were trying to get at. Whereas sometimes I didn’t know what they were trying to ask me.} (Participant 8)

Community based Public Health Nurses were also appreciated for their caring and empathetic continuity of support for breastfeeding. One woman was pleased that her public health nurse was available to come to her home “extra” times if she called (Participant 6).

The women in this study were very forthcoming with their descriptions about their relationships with maternity care nurses. They described the importance of having a personal relationship that was genuine and supportive. They offered many examples of how nurses implemented respectful interactions that supported their autonomy. Clearly, empowerment was an important element of care. Having time to spend with the women during labor and in the home, post partum, as well as having a consistent nurse was greatly appreciated and considered necessary for a positive responsive maternity care experience.

\textbf{Relationships with Physicians}

Within the theme of physician-client relationships, emotional support and genuine caring also came through as important elements.

\textit{...when I went for my check-ups my doctor made sure that everything was o.k. He made sure that I had all my vitamins, he was very caring, asked a lot of questions, how I was feeling and told me to let him know if anything goes wrong, to call him at any time.”} (Participant 2)

I mean I think that is all anyone wants, just a doctor who cares about you. And it’s surprising how hard that is to find. (Participant 9)

Caring support involved listening to women’s experiences:

\textit{He asked me questions, a lot of questions about my first delivery and how I felt about that. Then he told me options of what was available, because with my first delivery, it was done back home in [a developing country]. So it was sort of like he was always listening to my experiences.} (Participant 7)
When the women were genuinely listened to, they expressed feeling a sense of respect. This in turn fostered autonomy and a shared sense of power around decision about their care:

*The doctors that were on-site then totally respected my wishes—what I had to say. They listened to everything I had to say. It was one of the best deliveries I’ve actually had. Even though it was a rocky situation, it was one of the best times that I’ve ever had at the [hospital]. So that was when I would say they definitely respected me then.* (Participant 11)

As in their relationships with nurses, women expected emotional support from their physicians. Support involved not just offering information but also active listening. The most effective listening occurred when the physician was respectful, genuine, and willing to share power within the relationship. For the women in this study, effective listening led to increased autonomy in terms of decision making and to reduced stress. For all of the women, having a positive relationship with their physician was important and a necessary aspect of responsive maternity care.

**Continuity of Care**

Continuity with a known provider was a sub-theme within the descriptions of provider-client relationships. Continuity was clearly valued by participants:

*[My doctor] was my middle. She relayed all the information that came back through the medical [laboratory], what they were finding with baby and whatnot. And so I got to know her even more... She was my knight in shining amour through the whole pregnancy... She was fabulous...* (Participant 1)

Discontinuity of care and having care with multiple unknown providers left women feeling less satisfied with their birth experience although a number of participants acknowledged the reality that one provider could not be available at all times. Several women expressed a desire to have continuity of care with their long time family physician, despite confidence in the care of other physicians. “I’m just lucky because all the doctors in that office are really, really good, but I just wish it was my family doctor because she’s been my doctor since I was three years old.” (Participant 3).

Discontinuity of primary provider can lead to discontinuity of care planning One woman described her prenatal care as, “...all over the
place” (Participant 6) due to a lack of communication between her obstetrician and family practitioner.

Discontinuity of provider also can lead to inconsistent advice which in turn inhibits the development of meaningful relationships as clearly evidenced by these women’s comments:

*I wouldn’t have the same obstetrician... I didn’t feel like the doctors were kind of communicating with each other. Like they would come and they would ask me the same questions that I was asked like two weeks prior... I didn’t feel like anyone was kind of sharing information... And then they would tell me something, and then when my regular obstetrician came back, he would tell me something completely different... I felt a little misinformed sometimes.* (Participant 6)

*Well, I guess just in regards to being referred to so many different doctors [because of a pre-existing medical complication] and just nobody wanting to give me the answer that I guess I felt I needed in order for me to remain calm. Because I was stressed throughout the whole entire pregnancy... And then when they would give me some kind of answers, it would contradict what another doctor told me.* (Participant 11)

Half of the women mentioned instances of problematic collaboration between different care providers. For instance, one mother said she had faith in her family physician but preferred seeing her obstetrician whose routine use of ultrasound technology provided her with a higher level of comfort and reassurance. She described her relationship with these providers as a “personal tug of war” in which she felt “obligated to stay [with] both.” (Participant 1)

Discontinuity created concerns for Participant 5 in terms of judging the quality of care she could expect of an unknown physician:

*I would just hope for a little more comfort level with them as a person.... If something went wrong, I would be even more distressed that I didn’t have the opportunity to get to know that physician at all, to access my comfort level in their competence to deliver that baby... But those little things weight in the back of your mind saying, what if this goes wrong? Am I going to be taken care of the best. Which doctor is this?* (Participant 5)

Discontinuity of care giver left some participants feeling that their provider was impersonal, variously described as “cranky,” “gruff,” and “unfriendly”. Impersonal care was described as “awkward” and
Aston et al. MATERNITY CARE EXPERIENCES OF WOMEN

42

even “scary” because the woman was not being seen as a unique individual, or understood and valued as such:

He didn’t value what I was saying at all. So that was frustrating. And like I said before, scary more than anything. Because you are going through what you think is like the biggest thing. To him, it’s just another delivery. But I think that was part of the problem, he didn’t treat me like a separate individual. He compared me to everybody else that he ever sees and that totally made him misjudge what was going on. (Participant 8)

In terms of nursing care, the intimacy of the relationship participants established with their nurse during labor meant any disconnect in terms of continuity of care was a significant disruption for them:

But I still kind of felt a little abandoned or something because what you are doing- delivering a baby… And it’s a very personal… But it’s just that feeling of okay, so I liked that nurse, she was good and she helped me through this stage of where I was at, and then she is going and somebody else came in. So I had to get comfortable all over again. So that part of the process, I wasn’t very pleased with. (Participant 5)

The discontinuity of postnatal nursing care was also problematic for many participants who were offered “completely different and even opposing advice” especially with regards to breastfeeding, so much so for Participant 10, that she concluded: …it seems that once you give birth, no one is really interested in you. The exception was Participant 1 who stated: "She was good and actually we got her the next day as well. She came back on. She signed herself on as my nurse again so I’m thinking oh, she must have liked me."

Time Spent

A sub-theme of continuity of provider was ‘time spent’ in that the quality of a continuous relationship depended in large part, on having sufficient time to communicate effectively. ‘Time spent’ allowed for the development of two way conversations in which the woman felt she could share her opinions and concerns and was ‘heard’. In speaking about her physician, Participant 3 stated: "...she was very patient with me...I think just because she knew I was worried. She always had time for me." However, the opposite was true for Participant 11 who offered: "[when] you are rushed in and out, that is disrespectful." The same thought was echoed by Participant 10 who could compare her
relationship with nursing staff between a first and second birth. During the latter her nurses “were really busy...they just wouldn’t tell me what was going on and I was really worried...I guess I felt kind of not respected.”

**Demographic Related Differences**

Several demographic variables had an influence on participant’s assessment of the quality of their relationships with providers. The two new comers, both visible minorities from developing nations, were most satisfied overall and described consistently good relationships. This may be related to lower expectations, as highlighted by Participant 2 who noted, “the way they speak to you, they’re so nice, they’re not rude or anything.” The two visible minority Canadians were less happy with their provider relationships as were Caucasian women, especially those who were older, had higher education achievement or previous birth experiences.

**SUMMARY & DISCUSSION**

The quality of the relationships they had with providers was important to participants. Good relationships were identified as ideally, continuous, supportive and caring. They involved time spent discussing concerns and respect for informed autonomy. The most satisfying encounters occurred with a well known provider or with carers who created a personal connection through shared experience. Unresponsive care occurred within disrespectful, rushed and disempowering relationships where providers offered little choice or control.

Although a diverse group of women participated in this study, the theme of provider-client relationship dominated descriptions of their experiences. Continuity of provider, respectful and effective communication, genuine caring and ‘time spent’ emerged as important elements of responsive maternity care. For participants, effective communication depended on establishing responsive relationships which worked best with consistent providers willing to spend the time necessary to build a relationship which in turn fostered feelings of confidence, security, safety, and respect. Alternately, multiple and changing providers meant having to repeatedly explain their care needs and cope with conflicting advice which some women found scary. Put most simply, continuity of provider enabled continuity of care advice and emotionally supportive relationships.

Supportive relationships were described as empowering. Evidence supporting the importance of empowerment to women’s childbirth experiences includes a survey of 2124 women in 44 military hospitals across the USA. Harriott, William and Peterson (2005) found
involvement in decision making to have a significant positive effect on perceptions of care quality and satisfaction. Conversely, Waldenstrom, Rudman and Hildingsson’s (2006) survey of 2686 Swedish women found lack of a supportive client-provider relationship and limited participation to be strong predictors of dissatisfaction with intrapartum care.

The significance pregnant and birthing women place on provider support cannot be overstated. In Hodnett’s (2002) systematic review of pain and women’s childbirth experiences, she found that support as evidenced by the attitudes and behaviors of care providers, exerted the most influence on the experience of giving birth. The longer term benefit are highlighted by Waldstrom (2004) who noted supportive intrapartum care to be an important factor for women who became more positive about their childbirth experiences over time. Provider support is even more relevant to complex childbirth situations as seen by Berg and Dahlberg (1998) who found among ten women having ‘complicated birth’ that the majority of the participants’ narratives focused on their interactions with care givers. This was also true in Robb’s (2007) phenomenological study of Women’s Experiences of Intrapartum Cesarean Delivery in Nova Scotia. She found provider support to be the single most important factor mediating the unplanned cesarean experience. Continuity of care from a supportive provider was associated with the most positive experiences.

The body of evidence on the benefit of continuity of provider is growing (Enang, 1999; Huntley, 2004; SOGC, 2008). Most recently, the Society of Obstetricians and Gynecologists of Canada (2008) conducted two national surveys, one with new mothers and women planning a pregnancy and one with obstetricians and gynecologists. They found that, Canadian women have clear priorities: they want continuity of care throughout their pregnancy by the maternity caregiver of choice; they want an integral role in prenatal and birthing decision-making; and they want to give birth as close to home as possible.

By contrast, the majority of physicians reported their caseload as too heavy, citing long hours at the office and in hospital, followed by extensive on-call, resulting in high levels of stress and burnout. The SOGC (2008) concluded: “This research proves there is a major disconnect between what women expect and what is actually possible,” the assumption being that it is women’s expectations which must be addressed and brought in line to fit the needs of providers. The current debate about how best to organize maternity care services re-enacts long standing patterns of oppression that have no quick fix.

Although empowerment has been identified as central to health care practice (Epp, 1986; Health and Welfare Canada, 1988) maternity professionals continue to be positioned as disproportionately more
powerful than their clients (Cheek, 2001). From their position of power, providers continue to dictate how health care services are run. In moving beyond these historically unequal relationships researchers must question everyday maternity care practices and explore innovation including how empowering strategies are experienced by clients and health professionals alike (Aston et al 2006; Baggens, 2004; Cheek, 2001; Fagerskiold, 2002; Falk-Rafael, 2001; Hardina, 2003). Our research adds to this agenda.

Limitations
The findings are limited with regards to maternity care in rural settings as the study population was drawn exclusively from a large urban centre.

CONCLUSIONS

Provider-client relationships, continuity of care, time spent, and control, are important issues to question and understand with respect to maternity care responsiveness. It is also important to remember that these seemingly personal interactions are part of institutional and social context of care. Quantitative satisfaction surveys have been unable to tap into the complexity of women’s and health care providers’ expectations and experiences of maternity care. Therefore more qualitative research can provide rich in-depth data that moves beyond the surface and explores the multifaceted maternity care experiences of women and health care providers. This research study provided a unique understanding of how relationships between women and their health care providers are integral to maternity care responsiveness and ultimately empowerment for women. With the use of the MCR interview guide, this research was able to provide in-depth maternity care experiences of 11 women and show how responsive health care practices were or were not accessible, available, acceptable, or appropriate. The powerful experiences shared by the women in this study exemplify the need to continue to question everyday maternity care practices, challenge oppressive practices and structures, work together with women, health care professionals, and policy makers to build upon the strengths that already exist, and search for new and creative ways to ensure maternity care is individually, socially, and institutionally responsive.

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Aston et al. MATERNITY CARE EXPERIENCES OF WOMEN


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