

## ORIGINAL PAPER

## WOMEN'S CONTROL AND PARTICIPATION IN DECISION-MAKING DURING CHILDBIRTH IN RELATION TO SATISFACTION

Lucia Mazúchová<sup>1</sup>, Simona Kelčíková<sup>1</sup>, Linda Štofániková<sup>2</sup>, Nora Malinovská<sup>3</sup><sup>1</sup>Department of Midwifery, Jessenius Faculty of Medicine in Martin, Comenius University in Bratislava, Slovakia<sup>2</sup>Department of Midwifery, Jessenius Faculty of Medicine in Martin, Comenius University in Bratislava, Slovakia (student)<sup>3</sup>Department of Foreign Languages, Jessenius Faculty of Medicine in Martin, Comenius University in Bratislava, Slovakia

Received June 23, 2020; Accepted August 24, 2020. Copyright: This is an open access article under the CC BY-NC-4.0 license.

## Abstract

**Aim:** The objective of the study was to determine the satisfaction of women with their control and participation in decision-making during childbirth. **Design:** A quantitative cross-sectional study. **Methods:** The KLI-P questionnaire measuring psychosocial climate in maternity hospitals by evaluating six factors was used to collect the relevant data. This article presents the results of assessing the satisfaction of women with the factor woman's control and participation in decision-making during childbirth. The study sample consisted of 360 women within one year after natural birth (the mean time from childbirth:  $6.22 \pm 3.64$  months). The obtained data were analyzed using univariate descriptive statistics, ANOVA and Student's t-test. **Results:** The satisfaction with the factor woman's control and participation in decision-making during childbirth was 61.50%. The lowest satisfaction (20.28%) was associated with the women's possibility of choosing the position for giving birth. Statistically significant differences were found with respect to the age group ( $p = 0.009$ ), subjective perception of the course of childbirth ( $p = 0.001$ ) and skin-to-skin contact support after childbirth ( $p = 0.001$ ). **Conclusion:** The results indicate the necessity to respect the principles of women's autonomy during childbirth, with the emphasis on providing care focused on the needs of mothers, their rights as well as their active participation during childbirth, constituting an important complement to the current evidence-based approach to obstetrics.

**Keywords:** obstetric care, participation in decision-making, women's autonomy, women's control in labour, women's satisfaction.

## Introduction

A woman's control and participation in decision-making during childbirth is an important psychosocial aspect of obstetric care. The key to global health care reform is the shift towards more people-centred care, including their involvement in decision-making. Participation in decision-making is considered to be fundamental in human-centred care and is associated with better health outcomes (Barry & Edgman-Levitan, 2012). An important aspect of care during childbirth is respect for women's autonomy, that is, respect for their needs (Chigbu & Onyeka, 2011). Involving women in decision-making during childbirth has an impact on a positive childbirth experience (Gärtner et al., 2014) and is a key aspect of the quality of care (Attanasio et al., 2018). The need for relevant information is a major component of participation in the decision-making process (Coulter & Collins, 2011).

Control and awareness are important factors enhancing the active role of women during childbirth (Larkin et al., 2009). Control during childbirth consists of internal and external processes. Internal control refers to a woman's ability to control her feelings and pain expressions to make decisions concerning her body such as changing position freely during childbirth. External control is related to a woman's ability to participate in decisions concerning the childbirth such as medical interventions, sources and types of support (Cook & Loomis, 2012). A woman can outline her preferences and expectations during labour and delivery in a birth plan that opens communication between her and health care providers. At the same time, it provides useful information and knowledge for women before childbirth (Doherty, 2010). The birth plan is essential for the woman's control in labour, supports her proactive approach, enables her to participate in decision-making and provides important details about these decisions to health care providers (DeBaets, 2017). However, the use of the birth plan sometimes provokes hostile opposition from some health professionals. This may be due to the fact

Corresponding author: Simona Kelčíková, Department of Midwifery, Jessenius Faculty of Medicine in Martin, Comenius University, Malá Hora 5, Martin, Slovakia; email: kelcikova@jfmed.uniba.sk

that women put too much emphasis on less important issues they expect from health professionals. Consultation of birth plans in advance can be a suitable alternative to their use. Meeting and discussing the woman's demands offer an opportunity for effective communication and building mutual trust which could serve as a preventive measure to avoid possible conflicts that may arise during childbirth.

## Aim

The objective of the study was to determine the satisfaction of women with control and participation in decision-making during childbirth.

## Methods

### Design

A quantitative cross-sectional study was performed.

### Sample

The sample group consisted of 360 women approached to participate in the study in five paediatric centres in five Slovak cities (Martin, Žilina, Prešov, Sabinov and Lipany) during regular medical check-ups between November 2016 and January 2018. The centres were selected to suit our capabilities upon obtaining consent from the paediatricians.

Purposeful sampling was used to select the respondents. The inclusion criteria were being a woman within one year after natural delivery of a healthy baby, willing to participate and signing a consent form. The mean time from childbirth was  $6.22 \pm 3.64$  months. Most women were aged 21–30 years (68.9%), followed by age groups 31–40 years (27.78%), 20 years or younger (2.22%) and 41–50 years (1.11%). The majority of participants (49.44%) completed secondary education with a diploma, 39.72% completed tertiary education, 8.89% completed their apprenticeship and only 1.94% achieved primary education. The majority of women (75.83%) subjectively perceived their last birth as uncomplicated; the remaining 24.17% of births were considered complicated. Postpartum skin-to-skin contact (SSC) support according to the recommended procedures (i.e. allowed immediate, uninterrupted SSC between the mother and her newly born infant lasting at least 3/4 of an hour, possibly with a short interruption during the first assessment of the newborn) was given to 47.78% of women, while most women (52.22%) stated they had not received proper postpartum SSC support. The sample characteristics with respect to the categorical variables (age, education, subjective perception of the

course of childbirth and SSC support) are presented in Table 1.

**Table 1** Basic characteristics of participants

Characteristic (n = 360)	n	%
<b>Age</b>		
20 years or younger	8	2.20
21–30 years	248	69.00
31–40 years	100	27.80
41–50 years	4	1.10
<b>Education</b>		
primary	7	1.94
secondary without a diploma	32	8.89
secondary with a diploma	178	49.44
tertiary	143	39.72
<b>Perception of the course of childbirth</b>		
complicated	87	24.20
uncomplicated	273	75.80
<b>SSC support</b>		
yes	172	47.90
no	188	52.20

### Data collection

The KLI-P questionnaire measuring psychosocial climate in maternity hospitals was used for data collection. It focuses on diagnosing women's satisfaction, with respect to psychosocial aspects of care provided such as *helpfulness and empathy of midwives, helpfulness and empathy of physicians, superiority and lack of interest, physical comfort and services, woman's control and participation in decision-making during childbirth and providing information and availability of health professionals*. To record and measure the responses, a 4-point Likert scale was chosen, where 4 represented the highest satisfaction and 1 the lowest satisfaction. In the article we present the partial results of evaluating one of the studied aspects – the factor *woman's control and participation in decision-making during childbirth*. The questionnaire was supplemented with categorical variables (age, education, subjective perception of the course of childbirth and SSC support), which helped to characterize the research group and also to determine their relationship to assessing women's satisfaction with individual factors.

The questionnaire was validated in the Czech Republic (Takács et al., 2013). The original Czech version of the questionnaire was translated into Slovak following cooperation between several Slovak language experts. To maintain the equivalence of the questionnaire in the target Slovak language, the method of back translation was applied and the translated questionnaire was then translated back into Czech by a team of Czech language

experts. The clarity of the questionnaire was verified by a pilot study with five women after childbirth. Based on the pilot study, some items were reformulated. A combined method of questionnaire administration was chosen (in person, electronically). The mothers who agreed to take part in the research project and signed the consent form filled in the questionnaire either in a printed form during their visits to the paediatric centres or in an electronic form sent to their e-mail addresses. Out of 70 personally distributed questionnaires, 55 questionnaires were completed, giving a response rate of 78.57%. Out of 400 questionnaires sent electronically to e-mail addresses, 341 questionnaires were returned completed, that is a response rate of 85.25%. Out of a total of 396 completed questionnaires, 36 were excluded due to incorrect or incomplete answers or due to non-compliance with the inclusion criteria.

### Data analysis

Data were analyzed using statistical software PSPP, version 22.0 and Microsoft Office Excel 2007. Statistical testing was performed using univariate descriptive statistics. Analysis of variance (ANOVA)

and Student's t-test for independent samples were used to test the statistical significance of differences between groups of respondents. A result with p-value < 0.05 was considered statistically significant.

### Results

Analysis of the factor *woman's control and participation in decision-making during childbirth* showed that the lowest mean scale score of the responses was found for the questionnaire item concerning the possibility of choosing the position for giving birth ( $1.79 \pm 0.96$ ), with 79.72% of women expressing their dissatisfaction and only 20.28% satisfaction. Further, 53.05% of women expressed their satisfaction in the questionnaire item concerning health professionals' respect for refusal of any interventions or examinations by patients ( $2.56 \pm 1.03$ ). The mean scale score of the responses was the highest for the question whether the patient felt that health professionals had respected her own pace of the birth ( $3.03 \pm 0.97$ ), with 73.33% of women being satisfied (Table 2).

**Table 2** Descriptive characteristics of satisfaction with the factor *woman's control and participation in decision-making during childbirth*

Items	4 n (%)	3 n (%)	2 n (%)	1 n (%)	X	SD	median
I felt that I could refuse any intervention or examination during the childbirth and that the health professionals would respect it.	79 (21.94)	112 (31.11)	102 (28.33)	67 (18.61)	2.56	1.03	3
I felt that the health professionals respected my own pace of the birth.	140 (38.89)	124 (34.44)	62 (17.22)	34 (9.44)	3.03	0.97	3
I could choose the birth position.	31 (8.61)	42 (11.67)	107 (29.72)	180 (50)	1.79	0.96	1

4 – strongly agree; 3 – somewhat agree; 2 – somewhat disagree; 1 – strongly disagree; X – mean scale score; SD – standard deviation

The maximum raw score of the factor *woman's control and participation in decision-making during childbirth* was 12 and the mean raw score of this factor was 2.46 ( $\pm 1.11$ ). The overall satisfaction for the examined factor was 61.50% (Table 3).

In terms of age, the highest mean score in the evaluation of the examined factor was in the 41–50 age group and the lowest in the group of women aged 20 years or younger. Statistically significant differences were found between the age groups ( $p = 0.009$ ).

In terms of education, the highest mean score in the evaluation of the examined factor was shown in women with primary education, the lowest in women with tertiary education. No statistically

significant differences were found between the education groups ( $p = 0.288$ ).

The mean score in the evaluation of the examined factor in terms of subjective perception of the course of childbirth was shown to be higher in women who gave birth naturally without complications compared to those with complicated childbirth. Statistically significant differences were found between the groups classified by the course of childbirth ( $p = 0.001$ ).

The mean score in the evaluation of the examined factor in terms of SSC support was higher in women with postpartum SSC support than in those without it. Statistically significant differences ( $p = 0.001$ ) were found between the groups classified by SSC support (Table 4).

**Table 3** Evaluation of satisfaction with the factor *woman's control and participation in decision-making during childbirth*

Factor	Number of items	Max raw score	Mean raw score	SD	Satisfaction (%)
Woman's control and participation in decision-making during childbirth	3	12	2.46	1.11	61.50

SD – standard deviation

**Table 4** Relationship between variables (age, education, perception of the course of childbirth, SSC support) and the factor *woman's control and participation in decision-making during childbirth*

Variables	n (%)	mean (SD)	p-value*
<b>Age</b>			
20 years or younger	8 (2.22)	6.75 (± 2.19)	0.009 <sup>a</sup>
21–30 years	248 (68.89)	7.16 (± 2.27)	
31–40 years	100 (27.78)	7.90 (± 2.27)	
41–50 years	4 (1.11)	9.50 (± 2.38)	
<b>Education</b>			
primary	7 (1.94)	9.00 (± 3.11)	0.288 <sup>a</sup>
secondary without a diploma	32 (8.89)	7.47 (± 2.16)	
secondary with a diploma	178 (49.44)	7.38 (± 2.32)	
tertiary	143 (39.72)	7.29 (± 2.25)	
<b>Perception of the course of childbirth</b>			
complicated	273 (75.83)	7.68 (± 2.29)	0.001 <sup>b</sup>
uncomplicated	87 (24.17)	6.43 (± 2.07)	
<b>SSC support</b>			
yes	172 (47.78)	7.97 (± 2.26)	0.001 <sup>b</sup>
no	188 (52.22)	6.85 (± 2.20)	

mean – mean scale score; SD – standard deviation; <sup>a</sup>ANOVA; <sup>b</sup>Student's *t*-test for independent samples; \**p* < 0.05

## Discussion

The factor *woman's control and participation in decision-making during childbirth* monitored the degree of involvement of women in decision-making processes concerning the course of childbirth and care of the child. This issue included health professionals' respect for the needs of women during childbirth and for their notions of how to manage childbirth. It also evaluated women's awareness of the planned steps (interventions, examinations, etc.), the possibility to refuse routine interventions (shaving, enema, medication in uncomplicated childbirth), the degree of health professionals' respect for the natural pace of childbirth, the ability of women to choose the birth position (in uncomplicated childbirth) as well as to decide on postpartum contact with their child (Takács et al., 2012). According to the present study, half of women felt that they could refuse any interventions or examinations during childbirth and that health professionals would respect it. Only 20.28% of women could choose their birth position; most women felt that health professionals respected their own pace during childbirth (Table 2). In a 2013 Czech study (Takács & Seidlerová, 2013), 35% of women reported the possibility to refuse

interventions or examinations, 24% of women could choose their birth position and almost 42% of women mentioned that health professionals respected their own pace in the course of childbirth. Iravani et al. (2015) claim that demonstrating respect, trust and competence helps to maintain respectful maternity care during childbirth. Mothers emphasize that they want to participate in decision-making and various aspects of maternal care. Nilsson & Lundgren (2009) state that once women feel secure, they obtain a sense of control and empowerment. Women who feel they have control over birth show much more strength and ability to concentrate on contractions, while loss of control is perceived as worse than pain by some. Women need a sense of security and a feeling of being involved in the decisions directly affecting them during childbirth (Nilsson et al., 2013). The abilities to maintain a certain level of autonomy and to mobilize and change positions during childbirth are important predictors of female satisfaction. Upright positions and mobility are beneficial to spontaneous delivery. Women should be encouraged to give birth in a position they deem comfortable (Nieuwenhuijze et al., 2013).

Overall, the factor *woman's control and participation in decision-making during childbirth* was assessed at a satisfaction level of 61.50%. The 2013 Czech



study showed very low satisfaction (34%) with this factor (Takács & Seidlerová, 2013). In a study by Kabakian-Khasholian et al. (2017), a high level of satisfaction with childbirth and an average level of control perception were demonstrated. Similarly, maternal control was identified as the most important predictor of birth satisfaction in the study by Nilsson et al. (2013). A Slovak study revealed that women lose their sense of dignity during childbirth, have little control over the decision-making process, do not have enough information about various options and receive interventions against their preferences (Mazúchová et al., 2014). Insufficient information provision and a sense of loss of control can be successfully handled by improving communication between health professionals and women in labour. Midwives play an important role here by promoting communication that respects an individual approach to each woman as an exceptional human being, not just one from a group of women giving birth. Sufficient time, patience, sincerity, trust, helpfulness, kindness, empathy and especially attentive, active listening are essential for any successful conversation with every single woman (Bánovčinová & Bubeníková, 2011). Evidence-based care, the expertise of midwives and respect for women's opinions and preferences form the basis of safe care, bringing satisfaction to those receiving it (Štomerová, 2010). The care procedures negatively affecting female autonomy are authoritarian or routine practices that also have a negative impact on the perception of childbirth. Relationships with health professionals, quality of communication, availability of information and the chance to participate in decision-making are crucial for the overall assessment of perinatal care (Ford et al., 2009). A lack of respect and disrespect for women's decisions contribute to their apathy and inability to make further decisions (Maputle, 2018).

Statistical significance was demonstrated for satisfaction with the factor *woman's control and participation in decision-making during childbirth* in terms of age, with younger women expressing greater dissatisfaction than older women. We assume that this fact may be influenced by differences in digital literacy, in younger women manifested by greater awareness and the need to exercise their rights with an emphasis on the course of childbirth. Therefore, younger women also have higher expectations which are not always met, increasing their dissatisfaction. In the past, women giving birth were in the hands of health professionals during childbirth. Over time, however, they have increasingly been claiming their rights. Takács & Seidlerová (2013) state that the number of women

preferring an active approach to childbirth is likely to increase in the future and this should be reflected in the attitude of health professionals towards them. In the present study, significant differences were also found with respect to women's perception of the course of childbirth. According to results of a Cochrane systematic review, supportive care during childbirth can increase physiological birth processes as well as women's feelings of control and competence, thus reducing the need for obstetric intervention (Hodnett et al., 2012). Respect for women's autonomy should also be demonstrated by promoting postpartum bonding in the form of SSC. Unfortunately, this was not supported in more than half of women in the present study. There were significant differences in satisfaction concerning postpartum SSC support. Women who could bond with their babies expressed greater satisfaction with the factor *woman's control and participation in decision-making during childbirth* than those who could not. Given the existing scientific evidence of the importance of SSC emphasizing its irreplaceable benefits for both children and mothers (Bergman & Bergman, 2013; Moore et al., 2012), it is highly unsatisfactory that less than half of women in our study were not given SSC support according to the recommendations. This is consistent with another study in Slovakia (Mazúchová et al., 2016). According to a systematic review, higher levels of SSC support are reported in some countries such as Croatia (98%), Denmark (96%), Switzerland (95%), Finland (89%), Canada (81%) or Italy (80%). By contrast, lower levels of SSC support were found in Brazil (34%), Mexico (10%) or Ethiopia (8%) (Abdulghani et al., 2018). The child belongs to the mother and she has the right to be with her baby right after birth. Except for serious medical reasons, preventing mother-child separation is a basic, safe and sound, evidence-based practice that improves short-term and long-term health outcomes for mothers and children (Mazúchová et al., 2016). The importance of early mother-child contact for maternal satisfaction during childbirth has also been reported in other studies (Conesa Ferrer et al., 2016; Stevens et al., 2014). Midwives play an important role in respecting women's dignity and shaping their experience of childbirth (MirzaeeRabor et al., 2016). The importance of midwives' professional support, together with a sensitive approach to women in labour was also demonstrated in a study by Maskálová et al. (2020).

### Limitations of study

Certain limitations were inherent to the nature of our research. One of the weaknesses of the study is

purposeful sampling of respondents, as a result of which it is possible to interpret and generalize the conclusions only to the selected research sample. The study may be considered as partial. Despite the above limitations, we believe that the study has yielded inspiring results.

## Conclusion

The study results have revealed dissatisfaction with control and participation in decision-making during childbirth in more than a third of women. This finding calls for special attention in the context of midwifery services in Slovakia, with emphasis on the needs and rights of mothers as well as on respecting their demands for more active involvement in childbirth, allowing them to have better control over themselves and to participate in decision-making. Respecting the principles of women's autonomy during childbirth should constitute an important complement to the current evidence-based approach to obstetrics. Thus, the attitude of health professionals towards women in labour should reflect this trend.

## Ethical aspects and conflict of interest

The study was approved by the Ethics Committee of the Žilina (Number EC: 05404/2016/OZ-06) and Prešov (Number EC: 02227/2016/OZa HF-49) Self-Governing Regions (Slovak Republic). All participants received full information about the nature and goals of the research, as well as about the details connected with their involvement in the study. The data collection was anonymous; all participants expressed their willingness to be included in the study and provided their informed consent. The authors declare and confirm that there are no known conflicts of interest associated with this publication.

## Acknowledgements

This study was supported by project VEGA (research grant agency of the Ministry of Education, Science, Research and Sport of the Slovak Republic) under contract no. VEGA-1/0211/19.

## Author contributions

The concept and study design (LM, LH), data analysis and interpretations (LM, LH), processing the draft of the manuscript (LM, SK), critical revision of the manuscript (LM, SK, NM), article finalization (LM, SK, NM).

## References

- Abdulghani, N., Edvardsson, K., Amir, L. H. (2018). Worldwide prevalence of mother-infant skin-to-skin contact after vaginal birth: A systematic review. *PLoS One*, 13(10), e0205696. <https://doi.org/10.1371/journal.pone.0205696>
- Attanasio, L. B., Kozhimannil, K. B., & Kjerulff, K. H. (2018). Factors influencing women's perceptions of shared decision making during labor and delivery: Results from a large-scale cohort study of first childbirth. *Patient Education and Counselling*, 101(6), 1130–1136. <https://doi.org/10.1016/j.pec.2018.01.002>
- Bánovčinová, E., Bubeníková, M. (2011). Empatia v ošetrovatelstve. *Ošetrovatelství a porodní asistence* 2(1), 165–170. (in Slovak)
- Barry, M. J., & Edgman-Levitan, S. (2012). Shared decision making – the pinnacle of patient-centered care. *The New England Journal of Medicine*, 366(9), 780–781. <https://doi.org/10.1056/NEJMp1109283>
- Bergman, J., & Bergman, N. (2013). Whose choice? Advocating birthing practices according to baby's biological needs. *The Journal of Perinatal Education*, 22(1), 8–13. <https://doi.org/10.1891/1058-1243.22.1.8>
- Chigbu, C. O., & Onyeka, T. C. (2011). Denial of pain relief during labor to parturients in southeast Nigeria. *International Journal of Gynecology & Obstetrics*, 114(3), 226–228. <https://doi.org/10.1016/j.ijgo.2011.04.006>
- Conesa Ferrer, M. B., Canteras Jordana, M., Ballesteros Meseguer, C., Carrillo García, C., & Martínez Roche, M. E. (2016). Comparative study analysing women's childbirth satisfaction and obstetric outcomes across two different models of maternity care. *BMJ Open*, 6, e011362. <https://doi.org/10.1136/bmjopen-2016-011362>
- Cook, K., & Loomis, C. (2012). The impact of choice and control on women's childbirth experiences. *The Journal of Perinatal Education*, 21(3), 158–168. <https://doi.org/10.1891/1058-1243.21.3.158>
- Coulter, A., & Collins, A. (2011). *Making shared decision-making a reality. No decision about me, without me*. London: King's Fund. [https://www.kingsfund.org.uk/sites/default/files/Making-shared-decision-making-a-reality-paper-Angela-Coulter-Alf-Collins-July-2011\\_0.pdf](https://www.kingsfund.org.uk/sites/default/files/Making-shared-decision-making-a-reality-paper-Angela-Coulter-Alf-Collins-July-2011_0.pdf)
- DeBaets, A. M. (2017). From birth plan to birth partnership: enhancing communication in childbirth. *American Journal of Obstetrics and Gynecology*, 216(1), 31.E1–31.E4. <https://doi.org/10.1016/j.ajog.2016.09.087>
- Doherty, M. E. (2010). Midwifery care: reflections of midwifery clients. *Journal of Perinatal Education*, 19(4), 41–51. <https://doi.org/10.1624/105812410X530929>
- Ford, E., Ayers, S., & Wright, D. B. (2009). Measurement of Maternal Perceptions of Support and Control in Birth (SCIB). *Journal of Women's Health*, 18(2), 245–252. <https://doi.org/10.1089/jwh.2008.0882>
- Gärtner, F. R., Freeman, L. M., Rijnders, M. E., Middeldorp, J. M., Bloemenkamp, K. W. M., Stiggelbout, A. M., & van den Akker-van Marle M. E. (2014). A comprehensive representation of the birth-experience: identification and prioritization of birth-specific domains based on a mixed-method design. *BMC Pregnancy Childbirth*, 14, 147. <https://doi.org/10.1186/1471-2393-14-147>
- Hodnett, E. D., Gates, S., Hofmeyr, G. J., Sakala, C. & Weston, J. (2012). Continuous support for women during childbirth. *Cochrane Database of Systematic Reviews*, (2),

- CD003766  
<https://doi.org/10.1002/14651858.CD003766.pub3>
- Iravani, M., Zarean, E., Janghorbani, M., & Bahrami, M. (2015). Women's needs and expectations during normal labor and delivery. *Journal of Education and Health Promotion*, 4, 6.
- Kabakian-Khasholian, T., Bashour, H., El-Nemer, A., Kharouf, M., Sheikha, S., El Lakany, N., Barakat, R., Elsheikh, O., Nameh, N., Chahine, R., & Portela, A. (2017). Women's satisfaction and perception of control in childbirth in three Arab countries. *Reproductive Health Matters*, 25(sup1), 16–26.  
<https://doi.org/10.1080/09688080.2017.1381533>
- Larkin, P., Begley, C. M., & Devane, D. (2009). Women's experiences of labour and birth: an evolutionary concept analysis. *Midwifery*, 25(2), e49–e59.  
<https://doi.org/10.1016/j.midw.2007.07.010>
- Maputle, M. S. (2018). Support provided by midwives to women during labour in a public hospital, Limpopo Province, South Africa: a participant observation study. *BMC Pregnancy Childbirth*, 18, 210.  
<https://doi.org/10.1186/s12884-018-1860-8>
- Maskálová, E., Samselyová, J., Urbanová, E. (2020). Skúsenosti žien s pôrodom – profesionálna podpora pôrodnej asistentky počas pôrodu. *Florence*, 16(1), 1–7. (in Slovak)
- Mazúchová, L., Kelčíková, S., & Paráková, D. (2014, September 26). *Identification of negative experience and risk factors post-traumatic stress disorder of women in relation to childbirth* [Conference session] International symposium: Science and Research in Nursing, Brno, Czech Republic.  
[http://www2.med.muni.cz/nursing/dokumenty/pdf/sbornik\\_09\\_14\\_en\\_2.pdf](http://www2.med.muni.cz/nursing/dokumenty/pdf/sbornik_09_14_en_2.pdf)
- Mazúchová, L., Kelčíková, S., Vasilková, P., & Buchanec, J. (2016). Podpora bondingu po pôrode. *Česko-Slovenská Pediatrie*, 71(4), 196–201. (in Slovak)
- MirzaeeRabor, F., Mirzaee, F., MirzaeiNajmabadi, K., & Taghipour, A. (2016). Respect for woman's decision-making in spontaneous birth: A thematic synthesis study. *Iranian Journal of Nursing and Midwifery Research*, 21(5), 449–457. <https://doi.org/10.4103/1735-9066.193389>
- Moore, E. R., Anderson, G. C., Bergman, N., & Dowswell, T. (2012). Early skin to skin contact for mothers and their healthy newborn infants. *Cochrane Database of Systematic Reviews*, 5, CD003519.  
<https://doi.org/10.1002/14651858.CD003519.pub3>
- Nieuwenhuijze, M. J., de Jonge, A., Korstjens, I., Budé, L., & Lagro-Janssen, T. L. (2013). Influence on birthing positions affects women's sense of control in second stage of labour. *Midwifery*, 29(11), e107–e114.  
<https://doi.org/10.1016/j.midw.2012.12.007>
- Nilsson, C., & Lundgren, I. (2009). Women's lived experience of fear of childbirth. *Midwifery*, 25(2), e1–e9.  
<https://doi.org/10.1016/j.midw.2007.01.017>
- Nilsson, L., Thorsell, T., Hertfelt Wahn, E., & Ekström, A. (2013). Factors influencing positive birth experiences of first-time mothers. *Nursing Research and Practice*, 2013, Article ID 349124. <https://doi.org/10.1155/2013/349124>
- Stevens, J., Schmied, V., Burns, E., & Dahlen, H. (2014). Immediate or early skin-to-skin contact after a Caesarean section: a review of the literature. *Maternal and Child Nutrition*, 10(4), 456–473.  
<https://doi.org/10.1111/mcn.12128>
- Štromerová, Z. (2010). *Porodní asistentkou krok za krokem*. Praha: Argo. (in Czech)
- Takács, L., Kodyšová, E., & Seidlerová, J. (2012). Souvislost psychosociálních aspektů perinatální péče s některými zákroky a zdravotními komplikacemi v průběhu porodu. *Česká Gynekologie*, 77(3), 195–204. (in Czech)
- Takács, L., Smolík, F., Sněhotová, J., & Horáková Hoskovcová, S. (2013). Diagnostika psychosociálního klimatu porodnice – konstrukce a psychometrická evaluace dotazníku KLI- P. *Československá Psychologie*, 57(1), 73–91. (in Czech)
- Takács, L., & Seidlerová, J. (2013). Psychosociální klima porodnice očima rodiček II. Prediktory spokojenosti s perinatální péčí v České republice. *Česká Gynekologie*, 78(3), 269–275. (in Czech)