Expectations and Experiences of Women in Pregnancy, Childbirth, and Infant Feeding: A Qualitative Research Protocol

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Abstract
Maternity and pregnancy involve significant biopsychosocial changes in the lives of women. These changes determine their experience of motherhood and can be a crucial aspect in the choice of parenting style. Women require a source of knowledge and support that goes beyond the technical, clinical environment, led by qualified nurses for holistic and humanized care. The objective of this study is to identify women’s beliefs, expectations, and experiences of their motherhood and its different stages, and their perception of the care they receive, in order to enhance effective management of their new role at a health and social level. A phenomenological qualitative study using thematic analysis will be used, within the theoretical framework provided by the Social Cognitive Theory and the influence of gender. The sample size will be defined by the sampling saturation criterion and should include rural and urban women, with different socioeconomic status. The information will be collected with semi-structured interviews that will be analyzed based on the codification of the texts in three levels and the subsequent triangulation of the results. The biopsychosocial aspects involved in motherhood make it a complex process, with women as the main player. Therefore, mothers’ opinions on the barriers and enablers they encounter in their environment are essential to place them at the center of the process. In addition, knowing the perceptions of women could help improve the work of nurses, having impacts on the humanization of health care and responding to women’s needs during their motherhood.

Keywords
infant feeding, maternity, nursing, pregnancy, qualitative research

Introduction
Maternity and pregnancy involve significant biopsychosocial changes in the lives of women. Pregnant women undergo hormonal changes, such as increased cortisol, the effects of which include fatigue, disruptive sleep, anxiety, and poor memory (Ziomkiewicz et al., 2019). In addition, their self-perception and self-efficacy are influenced by their emotional state, expectations, and idealization of the process (Berlanga et al., 2013; Lou et al., 2017). These physical and psychological aspects, together with their new role as a future mother, determine their experience of motherhood and can be a crucial aspect in the choice of parenting style (Berlanga et al., 2013).

Changes suffered by women vary throughout pregnancy and remain beyond birth. After childbirth, women continue with infant feeding and the upbringing of their offspring. This new role affects many aspects of their life (Berlanga et al., 2013)

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The construct of motherhood is intimately related to the role of women in society (Russo, 1979; Verniers & Vala, 2018). It has been suggested that current fertility ratios, such as those within the European Union, which do not reach replacement levels, could be a reflection of this conception (Eurostat, n.d.-b). Motherhood may have consequences in different social areas, which depend on available resources. These resources, public or private, range from social and health services, such as nursery schools, health centers, or maternity leave, to the social support of family or friends. Additionally, accessibility to these resources is influenced by multidimensional factors (such as distance-time, costs, living in rural or urban settings), and plays an important role in facilitating or hampering the new challenges of maternity (Noguera & Ferrandis, 2014).

Furthermore, the need for intergenerational support to enable work-life balance influences family relationships. Stressful situations can be generated either by the different conceptions of motherhood between generations or the lack of encouragement from the family nucleus. Consequently, women require a source of knowledge and support that goes beyond the technical, clinical environment (Davis-Floyd, 1994; Fairchild, 2017; Foucault, 1990). Health professionals (i.e., nurses, midwives, obstetricians, pediatricians) accompany pregnant women throughout their motherhood, as a source of expert guidance and advice supported by scientific evidence. Specifically, midwives can be a reference figure providing holistic professional support (M. Hollander et al., 2019). In this way, they can also cover the social network deficiencies in health care that are present due to a lack of knowledge or false beliefs.

Therefore, determining the barriers and enablers that women find around the process of motherhood could help to achieve a positive experience. Likewise, assessing the perceived social and health needs is necessary to adapt their expectations to their actual situation. Achieving a healthy environment in the new family structure can be enhanced through nursing care during motherhood (Razurel et al., 2011) as a reliable source of scientific knowledge.

**Background**

**Pregnancy**

Throughout pregnancy, women may encounter a variety of situations, ranging from physical to emotional, which affect both the mother’s and baby’s health (Beales et al., 2016; Ziomekiewicz et al., 2019). Thus, needs and concerns arise related to their bodily sensations, changes in lifestyle and fears about the possibility of miscarriage (Lou et al., 2017). In the psychological field, women’s evaluation of body image affects their self-concept and self-esteem, which appears to be related to perinatal and postnatal depression (Silveira et al., 2015). Their lack of knowledge about their fears or the proximity of childbirth and the care of the baby requires professional and emotional support that provides appropriate information (Lou et al., 2017; Paz Pascual et al., 2016).

Our cultural perspective influences the way we understand and consider the biological concept of pregnancy (Russo, 1979). In many cases, the medicalization produced by the increasing use of technology to avoid possible risks turns the process of motherhood into a pathological-like process, in which the mother is a mere “vessel” (Davis-Floyd, 1994; Fairchild, 2017; Foucault, 1990). However, as Foucault (Foucault, 1990) says, “neither for the subject nor for the physician does it constitute a disease.” In this way, the medical system prioritizes scientific knowledge, relegating the perceptions of pregnant women to a second place. This medicalization reduces the mother’s involvement in decision-making about the course of her pregnancy.

It is essential for pregnant women to be an active part of the process and feel they have greater control over it (Borrelli et al., 2018; M. Hollander et al., 2019). Currently, the World Health Organization (WHO) recommends continued care during motherhood, which should be directed by professionals from different disciplines, and advocates for models of antenatal care directed by midwives. This approach helps women to adjust their expectations and develop care skills, with the ultimate goal of offering women humanized care that provides psychosocial and emotional support through the use of effective and appropriate practices (WHO, 2016).

**Birth**

The moment of birth gives rise to concerns that will be influenced by the mother’s knowledge and expectations. One of the most common feelings found among pregnant women concerning childbirth is fear. This increases the perception of childbirth as a traumatic and painful process (M. H. Hollander et al., 2017) and may be enhanced by false beliefs or negative experiences, generating a state of anxiety linked to possible complications (e.g., cesarean section; Robson et al., 2017). Several studies show how expectations, linked to false myths and fear, influence the decision of whether to have a natural birth. Thus, younger women with less confidence in their knowledge, which is often acquired in an informal environment, are those who tend to prefer a medicalized childbirth (Larsson et al., 2017; Swift et al., 2017). There is a continuum between natural and medicalized birth along which women are placed according to their preferences (Benyamini et al., 2017). Nurses and midwives, through health education, can empower women to make decisions about their pregnancy and type of birth (Borrelli et al., 2018; Paz Pascual et al., 2016).

Acquisition of accurate and realistic knowledge of the process of birth is valued positively by women. Therefore, they need a suitable professional to help them decide a birth plan and the different alternatives, following appropriate guidelines (Borrelli et al., 2018; Van der Garde et al., 2019). Several articles have shown that both the lack of control and communication and the support to face difficulties are related to the experience of a traumatic birth (Borrelli et al., 2018; M. H. Hollander et al., 2017). Taking into account the beliefs and
Infant Feeding

Infant feeding encompasses different feeding models in which breastfeeding is considered the most beneficial from a health perspective. The benefits of breastfeeding are highly documented among the scientific community (Chowdhury et al., 2015). The composition of breast milk adequately provides the nutrients that the infant needs for its development, as well as micronutrients and other bioactive components that are associated with both short- and long-term benefits (e.g., immune system, cognitive disorders). Thus, breast milk improves the baby’s immune system such that prolonged breastfeeding over time prevents conditions such as asthma, atopic dermatitis, or eczema. It also provides benefits to the mother, such as reduced risk of breast and ovarian cancer (Salone et al., 2013). The WHO recommendations advocate exclusive breastfeeding for the first six months and supplementary maintenance for up to 2 years minimum (United Nations International Children’s Emergency Fund [UNICEF] & WHO, 2017). However, dropout rates are higher than desirable, and despite the data for improved breastfeeding having increased in recent years, they are still far from these recommendations (Victora et al., 2016). In addition, formula milk is being increasingly improved and developed, and there are specific ones adapted to the needs of the newborn (Milbrandt, 2017). The aspects involved in the mothers’ choices of the type of food they give their children are not only related to maternal and child health reasons (Takahashi et al., 2017), but social aspects also have an impact on the decisions that mothers make (Colodro-Conde et al., 2015).

Several factors are involved in the cessation of exclusive breastfeeding in high-income countries, such as maternal and child health conditions (due to possible complications such as mastitis, cracked nipples, or low weight gain), factors related to the mother’s environment, such as her insertion in the labor market (Kleven et al., 2019; Odom et al., 2013), or the social expectations of the role of “good mother” (Colodro-Conde et al., 2015; Russo, 1976). Therefore, mothers face changes with implications for their physical and mental health, as well as their work and social status (Morris et al., 2019; Verniers & Vala, 2018). An inadequate approach that idealizes breastfeeding creates expectations far from reality and can become an element of added pressure (Slomian, 2017).

The decision to prolong breastfeeding increases the amount of time dedicated to the care of the baby, entailing an economic impact. What is commonly known as “child penalty” is an indicator that reports how the employment status of women in relation to men is affected by maternity. In different European countries, motherhood has been observed to have an impact on the position of women in the labor world, whereby they suffer a decrease in their income that fails to return to the level they had before the birth of the first child (Kleven et al., 2019). In this sense, prolonging exclusive breastfeeding has an opportunity cost for women. In high-income countries, it has been found that women with higher incomes and higher education continue to breastfeed longer (Victora et al., 2016), suggesting that an increased investment in family policies could reduce this opportunity cost, influencing their decision about their maternity and infant feeding (Kleven et al., 2019; Odom et al., 2013). However, there are differences in spending on family and children benefits, with high variability across Western European countries. In fact, in this regard, Spain invests around half of the European average (Eurostat, n.d.-a).

Therefore, attention to breastfeeding mothers could be improved if we had adequate information on their expectations and experiences. The support that can be generated by health professionals, especially nurses and midwives, is crucial for adequate management of infant feeding, avoiding early dropouts from exclusive breastfeeding (UNICEF & WHO, 2017).

The Study

Objectives

The aim of this study is to identify the beliefs and expectations that women have when considering their motherhood and what their experiences are when confronting the different stages of the process, including pregnancy, childbirth, and infant feeding. We will attempt to determine their perceptions of their self-efficacy in the management of both their own and their babies’ health in order to discover the social and health care needs that women perceive in the situations that arise during this process.

Methodology

This qualitative study follows a phenomenological perspective (Cypress, 2015). Our goal is to determine the expectations of women during their motherhood, and to this end, we deem the theoretical framework of Social Cognitive Theory to be the most appropriate approach (Bandura, 2001). This theory allows us to explain human behavior considering the influence of the social imaginary, the realities found, and the social and personal expectations. These three factors participate in the development of the self-concept, decision making, and conflict
resolution styles that we implement, allowing us to delve into the aspects of the different social and personal agencies of learning, self-concept, and self-efficacy.

Beyond this, the social cognitive theory of the development and functioning of the role of gender is the ideal substrate to observe and understand motherhood and the processes that surround it. These are conditioned by gender-regulated behaviors through social sanctions and self-sanctions, as well as by perceptions of self-efficacy learned through experience and models observed during development (Bussey & Bandura, 1999). Therefore, it is pertinent to approach our research focusing on gender, which explains the perspectives internalized by women as a result of having lived in a particular environment and with a specific social and cultural history.

In order to meet the objectives, a semi-structured interview was considered the best way to collect information. It is common the use of interviews in health research to obtain empirical data that inform us about people’s experiences. The semi-structured interview helps us to understand people’s attitudes about certain processes, and how we can provide them with the necessary health support, or how we can improve the care supplied. Thus, a qualitative design with a thematic analysis approach is considered the appropriate methodology for the development of our research (Braun & Clarke, 2006).

Sample. This qualitative research is nested in the MOVI-da 10! Study (NCT03236363; Sánchez-López et al., 2019). One of the objectives of MOVI-da 10! was to establish the relationship between the type of infant feeding and the duration of breastfeeding, and its influence on cardiovascular health and cognitive performance in schoolchildren (4–6 years). This objective allows us to ask mothers about their interest in participating in the qualitative part of the study. In the present qualitative study, a purposive sampling strategy (Robinson, 2014) will be carried out to recruit a subsample among mothers that showed interest in participating.

Therefore, our sample universe will be defined by mothers who participated in MOVI-da 10! study and who entered labor between 6 months and 3 years before the beginning of the study, after a normal gestation. Thus, we avoid the possibility of wide variations in the way of attending the process, as well as a possible memory bias. The sample selection should include rural and urban women, with different socioeconomic status. Migrant women with sufficient command of the language will also be recruited.

We estimate we will need between 10 and 15 women from each group, rural and urban, 20–30 altogether, considering possible drop-outs or exclusions to finalize at least a sample of 8 women per group, although the sample size will be defined by the sampling saturation criterion (Robinson, 2014).

Settings. The technique used for information gathering will be an interview. An expert in qualitative methodology will conduct the interview face to face. Due to the characteristics of intimacy and privacy that surround an event as personal as motherhood, in order to achieve an agreeable atmosphere that facilitates the expression of women’s experiences, they will be offered the possibility of being interviewed in different places (Robinson, 2014). These locations will be in the research center itself, their home or workplaces, and their health centers.

Data collecting. In order to carry out the semi-structured interviews, a preliminary script has been prepared to determine the most important aspects into which we wish to delve deeper, based on the previous documentation work. The script focuses on three main blocks shown in Figure 1: i) Maternity, ii) Pregnancy, Childbirth, and Postpartum and iii) Infant feeding. We used a field-testing technique to verify the coverage and pertinence of the subject matter of the script and check its implementation (Robinson, 2014). In this sense, we carried out two pilot interviews at a meeting point in the research center.

The interview, which takes 45–60 min, will be carried out face to face, establishing a bond between the researcher and the respondent that helps create a climate of trust. All interviews will be recorded for later transcription and analysis. All this process allows us to assess the aspects that have proven significant in the prior documentation work while it also facilitates the women’s free expression of their expectations and experiences (Mitchell, 2015).

The interviews will end with the sampling saturation criterion, after which the recordings will be transcribed using the F4 software tool. A summary of the main ideas found will be given to the participants for them to give their consent.

Data analysis. For subsequent analysis of the data, we will use the ATLAS.TI 8.3 software. This analysis will be carried out by triangulating the data with three experienced researchers. They will use a thematic analysis (Braun & Clarke, 2006), identifying codes, categories, and themes. The process will thereby allow the information to be organized by groups and integrated according to the theoretical Social Cognitive Theory model and the influence of gender in the issue under consideration.

This coding work will be carried out by establishing relationships between codes that address the same concept to be able to group them within a specific category. The same themes may contain one or several categories in such a way that the content of the interviews is structured and framed in the theoretical model under which our research is conceived (Giacomini & Cook, 2000).

Ethical Aspects

This study has the approval of the Clinical Research Ethics Committee of Virgen de la Luz Hospital (Cuenca, Spain), obtained for the MOVI-da 10! intervention, of which it forms part (approval number: 2008PI0708). Participants will be informed of the estimated duration of the interview, and to ensure the rights of patients regarding confidentiality, they will be informed at the beginning of the interview that it is being recorded. Therefore, for anonymous treatment of the data, we will advise them of the assignment of an identification code that will allow their identity to be disassociated from the content of
Likewise, they will be reminded that they can revoke their consent at any point of the research process.

**Validity and Rigor**

In order to ensure a rigorous analytical approach, several strategies will be used. The sampling technique used will improve the reliability and credibility of the possible findings. This technique will enable us to access a heterogeneous population (i.e., rural and urban environment, different socioeconomic level, migrant or not), but with a shared cultural reality (pregnant women in Western society).

The interviews will be conducted in pleasant, private environments that allow women to express themselves freely. The validity will be reinforced by the systematic use of semi-structured interview techniques performed, in all sessions, by the same researcher. The interviewer will have ample experience in qualitative methodology and communication skills (Mitchell, 2015).

In addition, a summary of the information obtained will be sent back to the women to be checked. After this, the data will be analyzed by three different researchers at three levels of depth (Giacomini & Cook, 2000). This analytical strategy will permit the subsequent discussion of possible discrepancies and their resolution by consensus.

**Discussion**

We will carry out a qualitative study within a phenomenological perspective by means of semi-structured interviews with the

| TOPICS TO DEVELOP |
|-------------------|
| **Maternity**     |
| **Expectations**  | • Imaginary  |
|                   |   ○ Motherhood |
|                   |   ○ Ideal mother characteristic |
|                   | • Future roles  |
|                   |   ○ Self-concept |
|                   |   ○ Environment (couple, close family . . .) |
| **Experiences**   | • Perceptions |
|                   |   ○ Own motherhood |
|                   |   ○ The daily life |
|                   | • Feelings  |
|                   |   ○ Self-efficacy |
|                   |   ○ Need support (asking for help, getting advice . . .) |

| **Pregnancy, Childbirth, and Postpartum** |
|**Expectations**| • Imaginary  |
|                |   ○ Ideal pregnancy, childbirth, and postpartum process (Multiparous) |
| **Experiences**| • Perceptions |
|                |   ○ Process development |
|                |   ○ Sanitary attention |
|                |   ○ Sources of information |
|                | • Feelings  |
|                |   ○ Emotions (happiness, fears, responsibility . . .) |
|                |   ○ Feel heard |
|                |   ○ Possible shortcomings |
|                | • Something to change |

| **Infant Feeding** |
|-------------------|
| **Expectations**  | • Imaginary  |
|                   |   ○ Infant feeding knowledge |
|                   |   ○ Exclusive breastfeeding opinion |
|                   |   ○ Ideal breastfeeding |
| **Experiences**   | • Perceptions |
|                   |   ○ Kind of infant feeding |
|                   |   ○ Establishment and development of breastfeeding |
|                   |   ○ Health problems |
|                   |   ○ Support |
|                   | • Feelings  |
|                   |   ○ Feel heard |
|                   |   ○ Empowerment |
|                   | • Something to change |

**Figure 1.** Script of interviews.
subsequent analysis of the information using a thematic approach. It should be considered that a study of these characteristics is favored by the qualitative approach of the investigation, in such a way that this methodology will provide us with a secure scientific framework that supports our findings and helps us to sustain the social and health care offered to mothers based on scientific evidence.

Work progress to date. Twenty-eight women agreed to participate in the study. Among them, one was excluded because, although she lived within the catchment area of the study, the entire process, pregnancy and childbirth, took place in a different area. In addition, other five women did not attend the meeting. Thus, finally, 22 women were included in the study, belonging to different socioeconomic status. Of these, 11 (50%) came from a rural environment and the remaining 50% from an urban one. Among rural women, three of them were immigrants, one of Arab origin and two of Latin American origin.

The organization of the interviews was especially challenging due to environmental and/or social factors. The main problem was related with the availability of mothers who found difficulties for having the necessary time to carry out the interview, because of their jobs, the caring of their children, or due to obstacles for traveling. Hence, in order to avoid these problems, participation was facilitated as much as possible through the offering of different urban and rural locations, at times that were more favorable for women.

The interviews have already been transcribed with the F4 software and we extracted the most relevant ideas observed using Atlas.ti software, and the work notes. A general summary of these ideas was sent to the participants to inform them about the preliminary main findings and to know if they agreed with them. None of the participants reported any clarification, nor did they transmit not feeling represented in these results.

Currently, we have initiated the coding work using the thematic analysis. As explained above, this coding will be done at three levels of depth, allowing us to generate conclusions about our issue based on the concepts that have been established in the coding work, following the SCT framework.

Strengths and limitations. Some limitations should be pointed out. The realization of the study in a specific environment such as a single province may prevent the generalization of data. However, a purposive sampling strategy will allow us to obtain a heterogeneous sample that is reasonably representative of the female population of reproductive age of Western society, without forgetting that generalization is not one of the objectives of qualitative studies. Besides that, we have not included same-sex couples in our study. We must take this limitation into account because the barriers and enablers that same sex couples encounter can be substantially different (Andresen & Nix, 2019), even though the particular experience of the processes lived during motherhood are encompassed within a social imaginary of similar characteristics for Western women (Power et al., 1999).

The semistructured interview could be a limitation because the information may be filtered through the perspective of the interviewer. Nevertheless, this is an appropriate approach given the intimate nature of the issues. The participation of an experienced member of the team who carries out the semistructured interviews is essential. Furthermore, the recording and transcription process, the checking by participants, as well as the subsequent triangulation in the coding and analysis of the data, will help us overcome this possible methodological stumbling block (Cypress, 2015).

Thus, having defined with sufficient depth the aspects that interact in the maternity process through a comprehensive bibliographic review, the sampling and data collection techniques, as well as the process of their analysis, will provide a robust network to allow the development of our research with guarantees of quality.

Conclusion

The medicalization of care removes women from the center of a process in which they are an essential part. Nurses and midwives can provide support, information, and care that helps the mothers to obtain the best health status for them and their babies. We must, therefore, include women as a central part of the process to improve care so that they are an active part of it, and we can offer advice, support, and quality care with the guarantee of expert knowledge based on the best available evidence.

The complexity of the maternity process from a biopsychosocial perspective and its influence on low birth rates, contributes to population aging in the countries of Western society. It seems necessary to investigate in depth the particular perceptions of women regarding their motherhood and to focus this research from a gender perspective that puts women back at center stage. In this way, we can assess the quality of the assistance received in their social and health needs and identify the aspects that can influence their decision to have further offspring.

Author Contributions

Esther G. Adalia and María Martínez-Andrés have contributed to conception, design, acquisition, analysis, and interpretation of the data for the work and to drafted the manuscript; Montserrat Hernández-Luengo has contributed to acquisition and analysis and interpretation of the data; Raquel Bartolomé-Gutiérrez has contributed to conception, design and analysis and interpretation of the data; Beatriz Rodríguez-Martín has contributed to desing and Estela Jiménez-López contribute to adquisition of the data. All of them have contributed, to critically revised the manuscript; gave the final approval; and agreed to be accountable for all aspects of work ensuring integrity and accuracy.

Declaration of Conflicting Interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.
Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*(1), 77–101. https://doi.org/10.11711/1478088706gp0630a

Bussey, K., & Bandura, A. (1999). Social cognitive theory of gender development and differentiation. *Psychological Review, 106*(4), 676–713. https://doi.org/http://dx.doi.org/10.1037/0033-295X.106.4.676

Chowdhury, R., Sinha, B., Sankar, M. J., Taneja, S., Bhandari, N., Rollins, N., & Martines, J. (2015). Breastfeeding and maternal health outcomes: A systematic review and meta-analysis. *Acta Paediatrica, 104*, 96–113. https://doi.org/10.1111/apa.13102

Colodro-Conde, L., Limiñana-Gras, R. M., Sánchez-López, M. P., & Ordoñana, J. R. (2015). Gender, health, and initiation of breastfeeding. *Women & Health, 55*(1), 22–41. https://doi.org/10.1080/03630242.2014.972015

Cypress, B. S. (2015). Qualitative research. *Dimensions of Critical Care Nursing, 34*(6), 356–361. https://doi.org/10.1097/DCC.0000000000000150

Davis-Floyd, R. (1994). The technocratic body: American childbirth as cultural expression. *Social Science & Medicine, 38*(8), 1125–1140. www.davis-floyd.com/wp-content/uploads/2016/10/Davis-Floyd-1994-The-Technocratic-Body-American-Childbirth-as-Cultural-Expression.pdf

Davis-Floyd, R., & Sargent, C. (1996). The social production of authoritative knowledge in pregnancy and childbirth. *Medical Anthropology Quarterly, 10*(2), 111–120. https://doi.org/10.1525/maq.1996.10.2.02a00010

Eurostat. (n.d.-a). Family and children benefits. Retrieved February 6, 2019, from https://ec.europa.eu/eurostat/statistics-explained/index.php/Social_protection_statistics_-_family_and_children_benefits

Eurostat. (n.d.-b). Fertility rates. Retrieved February 6, 2019, from http://appsso.eurostat.ec.europa.eu/nui/show.do?dataset=demo_hind&

Fairchild, K. (2017). What if? A story of an unwanted medicalized birth. *Narrative Inquiry in Bioethics, 7*(3), 190–192. https://doi.org/10.1015/ni.2017.0059

Foucault, M. (1990). *La Vida de los hombres infames*. In J. Varela & F. Álvarez-Uría (Eds.). La Piqueta.

Giacomini, M. K., & Cook, D. J. (2000). Users’ guides to the medical literature: XXIII. Qualitative research in health care a. Are the results of the study valid? Evidence-based medicine working group. *JAMA, 284*(3), 357–362. http://www.ncbi.nlm.nih.gov/pubmed/10891968

Hollander, M., De Miranda, E., Vandenbussche, F., Van Dillen, J., & Holten, L. (2019). Addressing a need. Holistic midwifery in the Netherlands: A qualitative analysis. *PLOS ONE, 14*(7), 1–22. https://doi.org/10.1371/journal.pone.0202489

Hollander, M. H., van Hastenberg, E., van Dillen, J., van Pampus, M. G., de Miranda, E., & Stramrood, C. A. I. (2017). Preventing traumatic childbirth experiences: 2192 women’s perceptions and views. *Archives of Women’s Mental Health, 20*(4), 515–523. https://doi.org/10.1007/s00737-017-0729-6

Jones, J. C. (2012). Idealized and industrialized labor: Anatomy of a feminist controversy. *Hypatia, 27*(1), 99–117. https://doi.org/10.1111/j.1527-2001.2011.01217.x

Kleven, H., Landais, C., Posch, J., Steinhauer, A., & Zweimüller, J. (2019). Child penalties across countries: Evidence and explanations. *AEA Papers and Proceedings, 109*, 122–126. https://doi.org/10.1257/pandp.20191078

Larsson, B., Karlström, A., Rubertsson, C., Ternström, E., Ekdahl, J., Segebladh, B., & Hildingsson, I. (2017). Birth preference in women undergoing treatment for childbirth fear: A randomised controlled trial. *Women and Birth, 30*(6), 460–467. https://doi.org/10.1016/j.wombi.2017.04.004

Lou, S., Frumer, M., Schlüter, M. M., Petersen, O. B., Vogel, I., & Nielsen, C. P. (2017). Experiences and expectations in the first trimester of pregnancy: A qualitative study. *Health Expectations, 20*(6), 1320–1329. https://doi.org/10.1111/hex.12572

Milbrandt, T. P. (2017). Specialized infant formulas. *Pediatrics in Review, 38*(5), 241–242. https://doi.org/10.1542/pir.2016-0212
Mitchell, G. (2015). Use of interviews in nursing research. *Nursing Standard, 29*(43), 44–48. https://doi.org/10.7748/ns.29.43.44.e8905

Morris, L., Lee, J., & Williams, J. C. (2019). Exposed: Discrimination against breastfeeding workers. https://ssrn.com/abstract=3341649

Noguerá, J., & Ferrandis, A. (2014). Accesibilidad y provisión de Servicios de Interés General en las áreas rurales de la Unión Europea: un análisis a partir del Eurobarómetro [Accessibility and provision of services of general interest in rural areas of the European union: An analysis based on the Eurobarometer]. *Boletín de La Asociación de Geógrafos Españoles, 64*(64), 377–404. https://doi.org/10.21138/bage.1703

Odom, E. C., Lii, R., Scanlon, K. S., Perrine, C. G., & Grummer-Strawn, L. (2013). Reasons for earlier than desired cessation of breastfeeding. *Pediatrics, 131*(3), e726–e732. https://doi.org/10.1542/peds.2012-1295

Paz Pascual, C., Artieta Pinedo, I., Grandes, G., Espinosa Cifuentes, M., Gaminde Inda, I., & Payo Gordon, J. (2016). Necesidades percibidas por las mujeres respecto a su maternidad. Estudio cualitativo para el rediseño de la educación maternal [Perceived needs of women regarding maternity. Qualitative study to redesign maternal education]. *Atención Primaria, 48*(10), 657–664. https://doi.org/10.1016/j.aprim.2015.12.004

Power, M., Bullinger, M., & Harper, A. (1999). The world health organization whqol-100: Tests of the universality of quality of life in 15 different cultural groups worldwide. *Health Psychology, 18*(5), 495–505. https://doi.org/10.1037/0278-6133.18.5.495

Razurel, C., Bruchon-Schweitzer, M., Dupanloup, A., Irion, O., & Epiney, M. (2011). Stressful events, social support and coping strategies of primiparous women during the postpartum period: A qualitative study. *Midwifery, 27*(2), 237–242. https://doi.org/10.1016/j.midw.2010.06.005

Robinson, O. C. (2014). Sampling in interview-based qualitative research: A theoretical and practical guide. *Qualitative Research in Psychology, 11*(1), 25–41. https://doi.org/10.1080/14780887.2013.801543

Robson, S. J., Vally, H., Mohamed, A.-L., Yu, M., & Westrupp, E. M. (2017). Perinatal and social factors predicting caesarean birth in a 2004 Australian birth cohort. *Women and Birth, 30*(6), 506–510. https://doi.org/10.1016/j.wombi.2017.05.002

Rowe, J., Barnes, M., & Sutherns, S. (2013). Supporting maternal transition: Continuity, coaching, and control. *The Journal of Perinatal Education, 22*(3), 145–155. https://doi.org/10.1891/1058-1243.22.3.145

Russo, N. F. (1976). The motherhood mandate. *Journal of Social Issues, 32*(3), 143–153.

Russo, N. F. (1979). Overview: Sex roles, fertility and the motherhood mandate. *Psychology of Women Quarterly, 4*(1), 7–15. https://doi.org/10.1111/j.1471-6402.1979.tb00695.x

Salone, L. R., Vann, W. F., & Dee, D. L. (2013). Breastfeeding: An overview of oral and general health benefits. *The Journal of the American Dental Association, 144*(2), 143–151. https://doi.org/10.14219/jada.archive.2013.0093

Sánchez-López, M., Ruiz-Hermosa, A., Redondo-Tébar, A., Visier-Alfonso, M. E., Jimenez-Lópe, E., Martínez-Andres, M., & Martínez-Vizcaino, V. (2019). Rationale and methods of the MOVI-da10! Study—A cluster-randomized controlled trial of the impact of classroom-based physical activity programs on children’s adiposity, cognition and motor competence. *BMC Public Health, 19*(1), 417. https://doi.org/10.1186/s12889-019-7642-0

Silveira, M. L., Ertel, K. A., Dole, N., & Chasan-Taber, L. (2015). The role of body image in prenatal and postpartum depression: A critical review of the literature. *Archives of Women’s Mental Health, 18*(3), 409–421. https://doi.org/10.1007/s00737-015-0525-0

Slomian, J., Emonts, P., Vigneron, L., Acconcia, A., Glowacz, F., Reginster, J. Y., & Bruyère, O. (2017). Identifying maternal needs following childbirth: A qualitative study among mothers, fathers and professionals. *BMC Pregnancy and Childbirth, 17*(1), 213. https://doi.org/10.1186/s12884-017-1398-1

Swift, E. M., Gottfredsdottir, H., Zoega, H., Gross, M. M., & Stoll, K. (2017). Opting for natural birth: A survey of birth intentions among young Icelandic women. *Sexual & Reproductive Healthcare, 11*, 41–46. https://doi.org/10.1016/j.srhc.2016.09.006

Takahashi, K., Ganchimeg, T., Ota, E., Vogel, J. P., Souza, J. P., Laopaiboon, M., & Mori, R. (2017, March 21). Prevalence of early initiation of breastfeeding and determinants of delayed initiation of breastfeeding: Secondary analysis of the WHO global survey [Scientific Reports]. Nature Publishing Group. https://doi.org/10.1038/srep44868

United Nations International Children’s Emergency Fund, & World Health Organization. (2017). *Tracking progress for breastfeeding policies and programmes: Global breastfeeding scorecard 2017*. World Health Organization.

Van der Garde, M., Hollander, M., Olthuis, G., Vandenbussche, F., & Van Dillen, J. (2019). Women desiring less care than recommended during childbirth: Three years of dedicated clinic. *Birth, 46*(2), 262–269. https://doi.org/10.1111/birt.12419

Verniers, C., & Vala, J. (2018). Justifying gender discrimination in the workplace: The mediating role of motherhood myths. *PLOS ONE, 13*(1), 1–23. https://doi.org/10.1371/journal.pone.0190657

Victora, C. G., Bahl, R., Barros, A. J. D., França, G. V. A., Horton, S., Krasevec, J., & Rollins, N. C. (2016). Breastfeeding in the 21st century: Epidemiology, mechanisms, and lifelong effect. *The Lancet, 387*(10017), 475–490. https://doi.org/10.1016/S0140-6736(15)0024-7

World Health Organization. (2016). WHO recommendations on antenatal care for a positive pregnancy experience. Retrieved March 28, 2019, from www.who.int/reproductivehealth/publications/antenatal_perinatal_health/anc-positive-pregnancy-experience/en/

Ziomekiewicz, A., Wichary, S., & Jasienska, G. (2019). Cognitive costs of reproduction: Life-history trade-offs explain cognitive decline during pregnancy in women. *Biological Reviews, 94*(3), 1105–1115. https://doi.org/10.1111/brv.12494