How are Women's Experiences of Childbirth Represented in the Literature? A Critical Review of Qualitative Health Research Set in the Global South

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As maternal mortality continues to be an important part of the global health agenda, more qualitative researchers are exploring maternity services from the perspective of women in the global South. Here, I review recent journal articles about women's hospital or clinic-based birth experiences to investigate how the stories of these women are represented in qualitative health literature. I argue that the ways in which research participants' experiences are represented have wide-ranging implications. Conceptualizing health inequalities solely in terms of healthcare enables 'solutions' to be framed technologically rather than toward the redistribution of resources. In representing women's experiences, researchers frequently engage in colonial representation that simultaneously homogenizes and 'Others' the experiences of women in resource-poor contexts. To avoid silencing research participants, it is crucial to engage in a reflexive process before embarking on exploring and interpreting women's experiences.

As maternal mortality, and its intractability, have become an important part of the global health agenda, more qualitative researchers are exploring women's experiences of delivering their babies in health facilities in the global South. This research is often undertaken to clarify

the value of, and impediments to, hospital/clinic delivery as a means to improving maternal healthcare from the perspective of women. Within this genre of qualitative health research, elicited experiences of research participants are frequently used as evidence of the 'truth' about a given phenomenon or practice. This use of language as a mirror of women's 'reality' has been problematized by some commentators, who have called for examination of these data as co-constructed by researcher and subject (see Allen & Cloyes, 2004). While these differences in opinion are mired in diverging epistemological orientations, it is questionable whether qualitative research is sufficiently able to give voice to participant experiences. Together with existing power relations, tensions between the voice of the researcher and that of the participant place the latter at risk of being drowned out by the former (MacLure, 2009). This is of particular concern when researchers seek to explore the experiences of communities or individuals who have less leverage in setting the research agenda (Schnarch, 2004).

Maternal health, given its contemporary alliance with international development and sexual and reproductive rights (Lane, 1994), is an ideal area of health research within which to examine the representation of women's experiences. It is vitally important to do so because misrepresentation of women's experiences could ultimately lead to flawed policymaking. I accessed and reviewed recent qualitative research using three online databases to investigate how women's hospital or clinic-based birth experiences are represented in qualitative research set in the global South. I approached this review from a post-colonial feminist perspective, drawing on the work of Chandra Talpade Mohanty (1988), Uma Narayan (1997), and Gayatri Chakravorty Spivak (1994;1996).

METHODOLOGY

Levander and Mignolo define the 'global South' as "an entity that has been invented in the struggle and conflicts between imperial global domination and emancipatory and decolonial forces that do not acquiesce with global designs" (2011, p. 3). The term is commonly used to refer to a geopolitical concept replacing 'Third World' after the collapse of the Soviet Union. For some, the 'global South' refers to under-developed and emerging nations that need the 'support' of the global North; for others it refers to areas where new visions of the future are emerging, and where global, political, and de-colonial societies are connected (Levander & Mignolo, 2011). In this paper, I use the terms 'global South' and 'Third World' interchangeably instead of the term 'developing countries,' given the latter's association with modernization and development discourses (Escobar, 1995).

Post-colonial feminists have attempted to critique the construction of the 'Third-World woman' within Third World discourses (Mohanty, 1988). This kind of critique generally refers to textual strategies used by writers, which 'Other' Third-World women, constructing them as oppressed and powerless. These strategies simultaneously construct the West as normative and Western women as liberated. Mohanty (1988) and Narayan (1997) have both argued that middle-class urban feminists in Third-World contexts frequently normalize urban middle-class culture in a similar way.

From this perspective, Narayan offers her conception of 'colonial representation' as "[replication of] problematic aspects of Western representations of Third-World nations and communities, aspects that have their roots in the history of colonization" (1997, p. 45). She argues that such representations erase the histories of colonization in Third-World contexts and often construct these regions as "uniform and monolithic spaces, with no important internal cultural differentiations, complexities and variations" (1997, p. 50) where the problems of Third-World women are attributed to "Traditional Patriarchal Cultural Practices" (p. 59).

Narayan (1997) has been criticized for her "[lack of engagement] with the metropolitan political economy of the production of "Third-World" identity, difference and representation" (Hussain, 2000, p. 145-146). Spivak's (1994) essay *Can the subaltern speak?* provides a useful entry point to such an engagement: Spivak argues that "the clearest available example of … epistemic violence is the remotely orchestrated, far-flung, and heterogeneous project to constitute the colonial subject as Other" (1994, p. 76) by intellectuals who homogenize identity and difference in the Third World. According to Spivak, what a subaltern woman says frequently goes unheard, because she is misrepresented even by those who seek to make space for her:

> *In [the subaltern's] case, the denial and withholding of consumerism and the structure of exploitation is compounded by social relations. On the other side of the international division of labor, the subject of exploitation cannot know and speak the text of female exploitation* even if the absurdity of the nonrepresenting intellectual making space for her to speak is achieved. (Spivak, 1994, p. 84, emphasis mine)

Spivak extends this idea to the global alliance politics of feminism, a politics that is increasingly gaining popularity in the field of global women's health (see e.g., Global Alliance for Women's Health, n.d.).

Colonial representation is very relevant to any analysis of health or healthcare in the global South given the historical relations between medicine and colonialism (Doyal, 1979; Birn, Pillay & Holtz, 2009). It is particularly relevant today because health agendas for women are so closely linked with international health and development (Birn, 1999; Birn et al., 2009; Kapoor, 2004). From the perspective of the World Bank, for example, improving maternal health is a means to poverty alleviation and is essential for the maintenance of a healthy workforce (see World Bank, 2011). While this instrumental view is in itself problematic, it suggests that health necessarily leads to 'economic well-being', although whose 'well-being' is open to question. Meanwhile, the sexual and reproductive health and rights agenda, spearheaded by transnational feminist networks, sees maternal health as a human right (see Roseman, 2009). From this perspective, women dying from childbirth is indefensible, and all the more so because it aligns with the interests of cultural feminism (Grewal, 1999).

As a potential alternative, the social determinants of health approach views 'the conditions in which people are born, grow, live, work and age' or the social determinants of health to be shaped by 'the distribution of money, power and resources at global, national and local levels' and thus crucial to health (World Health Organization (WHO), 2013). Although this approach gained global attention after the publication of the report of the WHO Commission on the Social Determinants of Health (CSDH, 2008), its philosophy remains conspicuously absent in global health policymaking. Predictably, it has received scant attention from the World Bank. Neither has it been adopted as an advocacy tool by global women's health advocacy groups. On the other hand, the report of the WHO Commission on the Social Determinants of Health has been criticized for being 'profoundly apolitical' in its neglect of class and other axes of power (Navarro, 2009).

Depending on the researcher's social location, disciplinary training and a host of other factors, women's experiences of healthcare may be explored from a variety of angles. In doing so, researchers could engage in colonial representation in at least two ways: First, by focusing on proximal determinants of health, such as access to healthcare, without giving due consideration to distal factors such as poverty and economic exploitation on a global and/or national scale. Second, by constituting women in resource-poor contexts as a 'coherent group with identical interests and desires, regardless of class, ethnic or racial location' (Mohanty, 1988, 64), thereby overlooking intersecting axes of difference that may impact women's health in equally problematic ways.

Before I begin exploring how researchers represent women's birth experiences, it is essential that I clarify my own position. This paper stems from my frustrations with the representation of Third-World

women's experiences within health research. As a graduate student in public health in North America, my own professional experiences as a physician in Sri Lanka contradict the representations of women within such research. These frustrations have led me to explore ways to contest these representations; this review is part of this effort. As I write this paper, I am acutely aware of my own role as Spivak's "nonrepresenting intellectual" (1994, p. 84).

Search Strategy

I searched the MEDLINE, CINAHL, and Web of Science databases for recent research on women's experiences of healthcare during childbirth in the global South. I limited my search to English-language papers published between January 1990 and June 2012. Search terms were: [childbirth OR obstetrics OR parturition OR labour OR delivery] AND [women's experiences]. In the MEDLINE and CINAHL searches, subject headings as well as key words were included; in Web of Science, only key words were included. The search recovered 199, 201, and 320 papers about women's birth experiences from the MEDLINE, CINAHL, and Web of Science databases, respectively.

I reviewed the abstracts to identify papers that used qualitative research methodologies to explore women's experiences of hospital- or clinic-based healthcare during childbirth in the global South. As the 'global South' is not a concrete definition with existing territorial boundaries, and at the risk of reinforcing the agenda of international finance institutions, I limited my review to research conducted in low- and middle-income countries (World Bank, 2012). I excluded any studies that used only survey techniques or other quantitative methods of data collection, and any research focusing on immigrant women or other marginalized groups of women residing in the global North.

Based on these criteria, I selected 24, 26, and 28 papers from the MEDLINE, CINAHL, and Web of Science databases respectively. To include unindexed publications, I also searched Google Scholar and traced a few publications by 'berry-picking' reference lists. After removing duplicates and reading all papers in their entirety, I eventually retrieved a total of 20 publications from all sources for analysis; see Table 1 for the geographic distribution of study locations. As a result of my search criteria, this review is by no means comprehensive – and importantly it does not include any research that has not found its way into Western modes of knowledge production (Mohanty, 1988).

My analysis focused on how researchers approached the research problem, whether they made explicit their theoretical orientation, whether they made references to their own positionality and how women's experiences were represented more broadly.

Table I: Regions & Countries/Territories Represented in the Review

Regions & Countries/Territories	Number of papers
Asia: Bangladesh, China, Thailand (2)	4
Africa*: Benin, Egypt, Ghana, South Africa (2), Tanzania, Uganda (2), Zambia	8
Middle East: Lebanon, Palestine, Turkey	3
Latin America: Bolivia, Brazil (3), Jamaica	5
Total	20

*The number of papers in the left-hand column is not identical to the total in the right-hand column because one paper included study samples from two countries.

ANALYSIS

Framing, Theoretical Orientation & Aims of Research

After reviewing the introductory sections of all the papers, I divided the studies into three broad subsets: those that framed the research question from the perspective of maternal mortality (7), those that sought to critique the medicalization of childbirth (6) and a subset of studies (7) that did not fit into either of these categories.

Addressing Maternal Mortality: The underlying assumption in this group of papers (Bangser et al., 2011; Grossman-Kendall et al., 2001; Kyomuhendo, 2003; Otis & Brett, 2008; Parkhurst & Rahman, 2007; Stekelenburg et al., 2004; Yakong et al., 2010) was that exploring women's experiences in obstetric care could contribute to achieving reductions in maternal mortality by improving access to or delivery of healthcare.

Much of this work assumed a normative biomedical paradigm. Three studies used the 'three delays model' as a framework for analysis (Otis & Brett, 2008; Parkhurst & Rahman, 2007; Stekelenburg et al., 2004). The 'three delays model' is an explanatory model that conceptualizes maternal mortality in terms of delays in seeking or receiving healthcare (Freedman & Maine, 1993). Another three papers attributed rising maternal mortality to such delays without explicit reference to the 'three delays model' (Bangser et al., 2011; Yakong et al., 2010; Kyomuhendo, 2003). Only Otis and Brett (2008) explicitly stated the importance of considering the global political and economic forces that shape access to healthcare and argued that the 'three delays model' was too narrow in its conceptualization.

Extant health disparities, dire poverty, and the absence of basic

health and other infrastructure in the global South were invoked to justify this research. Although maternal mortality was widely recognized as a marker of social inequality, there was an uncritical acceptance of the social conditions, such as poverty and the unequal distribution of resources, that give rise to these health disparities. These researchers drew upon the biomedical and technocratic model of healthcare, arguing for the need to combat maternal mortality through improving *access* to emergency obstetric care. By constructing maternal mortality as a problem engendered by lacking access to healthcare facilitates conceptualizing social problems as having technological solutions; thus the structural causes of the problem are effectively erased. In other words, the 'structural violence' (Farmer, 2009) inflicted on rural and marginalized communities by the global elite remained unchallenged. This kind of narrow technological definition of the problem and its solution makes it possible to overlook the more contentious issue of resource redistribution, which will necessarily be required to achieve longer-term improvements in health and healthcare.

The intertwining of childbirth with international health and development efforts may help explain this focus on access to healthcare. The 5th Millennium Development Goal (*improving maternal health*) has become a war cry in international development efforts, spawning global partnerships and strategies throughout the global South to achieve the stipulated reductions in maternal mortality by *improving access to healthcare* (see AbouZahr, 2003; Berer, 2007; Lalonde, 2010). For the most part, the global health agenda aligns with the neoliberal agendas of international development agencies and their colluding partners (see Stuckler, Basu & McKee, 2011; Benatar, Gill & Bakker, 2009). It is, therefore, not surprising that much of this research would narrowly conceptualize health problems in the global South. Despite Otis and Brett's (2008) reference to the political economy of health, none of these studies located maternal mortality within the context of globalization and economic exploitation, important structural influences that perpetuate social inequalities in Third-World countries (Birn et al., 2009). By overlooking the histories of colonialism and imperialism that engendered these inequalities, as well as the contemporary neoliberal forces that perpetuate them, health researchers engage in colonial representation.

The Critique of Medicalization: This group had their theoretical grounding in critiques of medicalization[4] (Cheung et al., 2011; Cindoglu

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4 Zola (1983) offers a useful definition of medicalization: "a process whereby more and more of everyday life [comes] under medical dominion, influence and supervision" (as cited in Conrad, 1992, p. 210).

& Sayan-Cengiz, 2010; du Plessis, 2005; Jamas, Hoga & Tanaka, 2011; Kabakian-Khasholian et al., 2000; Liamputtong, 2004). Specifically, they applied Western feminist scholarship to critique the medicalization of childbirth. This kind of critique emerged with the historical expansion of obstetrics as a recognized field within Western medicine and the concomitant marginalization of midwifery in Western contexts (Annandale, 2009). While this critique may perhaps be meaningfully applied in these contexts, its universal application is questionable. First, the critique of medicalization is based on the assumption that women have access to healthcare and thus normalizes the experiences and expectations of a privileged class of women (Johnson, 2008). According to Johnson, a preference for midwifery and home births among privileged women in the West is "a rejection of privilege that simultaneously confirms it" (2008, p. 897). Second, this kind of critique homogenizes midwifery by invoking a normative standard of midwifery, one that is drawn from the West. Modern midwifery was imposed on colonized settings as an extension of colonial medicine (see Jones, 2002), undermining indigenous modes of birthing. The imposition of modern midwifery in post-colonial contexts continues today in the efforts to integrate indigenous midwifery to medical services (see Torri, 2012). Thus, modern midwifery and midwife-led birth care in the global South may well have different socially situated meanings depending on historical context. Here I do not mean to essentialize 'third world difference' (Mohanty, 1988), but rather to highlight the tendency to normalize particular ways of thinking in research.

Other Approaches: The remaining papers approached the research question in various ways. Behague (2002) approached her study by problematizing the uncritical acceptance of concepts like medical domination and medicalization, drawing on Foucault's and Gramsci's work to offer an alternative view of medicalization. Developing on her previous work, Liamputtong (2005) provided a class-based analysis of medicalization using a Bourdieusian framework. El-Nemer, Downe and Small (2006) called for an analysis that bridges ideologies of birth care to better serve women's needs. Hassan-Bitar and Wick (2007) and Founds (2007) recognized the importance of studying the influence of context on birth practices; the former based their analysis on specific tools designed to assess maternity services in a conflict setting. Souza, Cecatti, Parpinelli, Krupa and Osis (2009) approached the problem from a psychosocial perspective, to better understand how women make sense of childbirth complications. And Tebid, du Plessis, Beukes, Van Niekerk and Jooste (2011) framed their research within the context of the rights of immigrant women within healthcare.

Stated Aims: The common objective in all reviewed papers was to explore women's experiences in hospital or clinic-based healthcare

during childbirth, but the specific aims of research varied considerably. These aims included 1) to clarify the prevailing state of 'under-utilization' of maternity services (Otis & Brett, 2008; Parkhurst & Rahman, 2007; Stekelenburg et al., 2004; Yakong et al., 2010); 2) to improve the quality of maternity services (Bangser et al., 2011; Hassan-Bitar & Wick, 2007); 3) to explore women's experiences in midwife-led birth care (Cheung et al., 2011; du Plessis, 2005; Jamas et al. 2011); 4) to explore women's experiences in obstetric care (El-Nemer et al., 2006; Grossman-Kendall et al. 2001; Kyomuhendo, 2003; Kabakian-Khasholian et al., 2000; Liamputtong 2004;2005; Souza et al., 2009; Tebid et al., 2011); and 5) to examine a particular phenomenon in a specific context, i.e., rising rates of Caesarean section in Brazil (Behague, 2002), breech delivery in rural Jamaica (Founds, 2007), and medicalization of childbirth in Turkey (Cindoglu & Sayan-Cengiz, 2010).

Positionality & Reflexivity

In my analysis, I looked for explanations for the seemingly arbitrary and divergent approaches taken to studying women's experiences by focusing on positionality (including disciplinary training and funding) and other demonstrations of reflexivity.

In only seven publications did the author(s) refer to researcher positionality in the main text of the article. Five author(s) mentioned their own clinical experience as nurses or midwives (El-Nemer, 2006; Founds, 2007; Hassan-Bitar & Wick, 2007; Tebid et al., 2011; Yakong, 2010). Souza et al. (2009) specified 'clinical experience' as a motivation for research, and Cheung et al. (2011) alluded to their own research affiliations in the introductory remarks. Most authors seemed to invoke their clinical experience to demonstrate their 'insider' status (Narayan, 1993). In most instances when professional aspects of the authors' social location were not disclosed in the main text, it was possible to gauge disciplinary training and background from the stated author affiliations. The influence of training or professional experience became clear in my analysis: more than half of the papers critiquing medicalization were authored by researchers with disciplinary backgrounds in nursing and midwifery (Cheung et al., 2011; du Plessis, 2005; Hassan-Bitar & Wick, 2007; Jamas et al., 2011).The others had backgrounds in public health or social sciences (Cindoglu & Sayan-Cengiz, 2010; Kabakian-Khasholian et al., 2000; Liamputtong, 2004 & 2005). Not surprisingly, critiques were not offered by researchers with physician training. None of the authors discussed or divulged any non-professional aspects of social location or other non-financial motivations for conducting research.

Funding is an important motivation for research, and geographical location influences the availability of funding. Eight studies were authored by researchers affiliated with local institutions (Cindoglu

& Sayan-Cengiz, 2010; du Plessis, 2005; Founds, 2007; Hassan-Bitar & Wick, 2007; Jamas et al., 2011; Kyomuhendo, 2003; Souza et al., 2009; Tebid et al., 2011), while five were collaborations between authors based in local and foreign institutions (Bangser et al., 2011; Cheung et al., 2011; ; El-Nemer et al., 2006; Kabakian-Khasholian et al., 2000; Stekelenburg, 2004). The remainder were either authored by researchers affiliated with foreign institutions where local institutional collaboration was unspecified (Liamputtong, 2004;2005; Otis & Brett, 2008; Parkhurst & Rahman, 2007; Yakong et al., 2005), or the paper did not include information about the geographical location of authorship (Behague, 2002; Grossman-Kendall et al., 2001). Only two studies were funded by institutions based in the global South (El-Nemer et al., 2006; Souza et al., 2009). This may reflect the general lack of research funding in the global South and the extent to which indigenous researchers are involved in setting the health research agenda.

Significantly, four of the seven studies that explored women's experiences from the perspective of maternal mortality were funded by international health and development agencies. Grossman-Kendall et al. (2001) and Parkhurst and Rahman (2007) were funded by the United Kingdom Department for International Development (DFID), while Kyomuhendo (2003) and Stekenlenburg et al. (2004) were supported by the Rockefeller Foundation and the Dutch Society of Tropical Medicine and International Health, respectively. The availability of support from organizations in the global North that are ideologically driven by development discourses (see Escobar, 1995) and the simultaneous lack of funding for health research in the global South perpetuates a system that identifies and addresses health problems within a very narrow framework. Importantly, such a framework would not question or challenge the unequal distribution of resources within Southern contexts or between Northern and Southern contexts. Addressing deficiencies in healthcare provides a more convenient and less contentious alternative.

Women's 'experiences' were explored as a means to elicit 'truths' about women's health or healthcare (see Allen & Cloyes, 2005). However, by not paying attention to positionality, researchers frequently overlooked their own role in co-constructing data, with grave implications for representation. How researchers represent participants has much to do with their own social location and disciplinary training (Bourdieu & Wacquant, 1992); it is important to address this issue—especially when research participants have less leverage in setting the research agenda (Schnarch, 2004). For example, drawing on a theoretical framework that does not take into account prevailing social and political conditions may signal both a lack of meaningful engagement with research participants in the design stage of the study, as well as unfamiliarity with the research context on the part of the researcher.

Reflexivity or "the process of reflecting critically on the self as researcher" (Guba & Lincoln, 2005, p. 210) has been explored as one way to deal with issues of representation (Finlay, 2002). Reflexivity involves analyzing how "the production of …knowledge is shaped by the shifting, contextual, and relational contours of the researcher's social *identity* and her social situatedness or *positionality*, (in terms of gender, race, class, sexuality and other axes of social difference), with respect to her subjects" (Nagar & Geiger, 2007, p. 2, emphasis in original), and requires the researcher to interrogate her/his research interests, choice of research question, design and methodology, as well as the ultimate purpose of the research. As a key element of ethics-in-practice, addressing reflexivity would improve the credibility of qualitative research (Guillemin & Gillam, 2004; Schwartz-Shea, 2009).

Representation of Women's Experiences

My analysis revealed that maternal mortality tends to be explored as a problem of poorer women. Five of the seven studies focused on this topic were set in Africa, and all in sub-Saharan Africa. The authors of this sub-set of papers justified their examination of women's experiences based on the high rates of maternal mortality in these regions. While it may be taken for granted that these populations would be at more 'risk' for complications of childbirth and maternal mortality, research itself can contribute to stereotyping: by continuously studying specific problems in marginalized communities in Third-World contexts, researchers constitute peoples in specific geographical locations as disease-ridden and poor. Studying such groups of peoples without making significant changes in their lives is ethically problematic; these endeavours also run the risk of conflating structural violence and cultural difference (Farmer, 2009).

The selection of research samples within contexts can also contribute towards constructing specific communities in problematic ways. Six studies limited recruitment to rural populations (Otis & Brett, 2008; Founds, 2007; Kyomuhendo, 2003; Parkhurst & Rahman, 2007; Stekelenburg et al., 2004; Yakong, 2010). The remainder either studied urban groups of women (Behague, 2002; Cheung et al., 2011; du Plessis, 2005; Jamas et al., 2011; Tebid et al., 2011) or recruited participants from urban hospitals ensuring the inclusion of rural women in the sample (Cindoglu & Sayan-Cengiz, 2010; El-Nemer, 2006; Hassan-Bitar & Wick, 2007; Kabakian-Khasholian et al., 2000; Liamputtong, 2004 & 2005) or did not specify urban/rural sector (Bangser et al., 2011; Grossman-Kendall et al., 2001; Souza et al., 2009). Interestingly, all studies of rural populations with the exception of Founds (2007), who examined breech delivery, approached women's experiences from the perspective of maternal mortality. In contrast, the three studies that explored women's

experiences in midwife-led birth care studied urban groups of women. In this way, researchers constructed mortality and medicalization as rural problems and urban problems, respectively.

Decisions on the selection of issues for analysis and interpretation are frequently made by researchers without consultation with research participants. Such a research design poses challenges for representation as issues of importance to the researcher may overshadow concerns of research participants. Several authors set out to critique medicalization, but found that research participants were mainly concerned with their interactions with healthcare providers, desiring more information and respect. Women generally wished to deliver in a biomedical setting, primarily for safety (El-Nemer et al., 2006; Cindoglu & Sayan-Cengiz, 2010; Liamputtong, 2004: Otis & Brett, 2008). The degree of medical intervention and/or the lack of control or choice were not resonating themes in the interviews. In fact, despite Caesarean sections being feared in a few contexts (Grossman-Kendall, 2001; Parkhurst & Rahman, 2007; Kabakian-Khasholian et al., 2000), some participants associated a higher degree of medical intervention, including Caesarean section, with superior healthcare and actively sought this kind of treatment (Behague, 2002; Cindoglu & Sayan-Cengiz, 2010; Liamputtong, 2005).

Researchers focused on similar aspects of 'medicalized' birth during data collection, perhaps owing to their own middle-class interests or exposure to feminist literature on childbirth. They devoted considerable space to various aspects of medicalized birth that affected women's birth experiences. The frequency of vaginal examinations during labour (El-Nemer et al., 2006; Hassan-Bitar & Wicks, 2007; Kabakian-Khasholian et al., 2000), restrictions on movement during birth (Kyomuhendo, 2003; Liamputtong, 2004; Otis & Brett, 2008), enemas and/or shaving before birth (El-Nemer et al., 2006; Jamas et al., 2009; Kabakian-Khasholian et al., 2000), the need for emotional support during labour (du Plessis, 2005; Cindoglu, & Sayan-Cengiz, 2010; Jamas et al., 2011) were dealt with in detail. This information was elicited during interviews, sometimes with probing; it is interesting that other aspects of women's lives that might have impacted their birth experiences were not explored in greater detail. For example, privatized healthcare was perceived to be superior in several contexts, although unaffordable to many women: in Turkey, women opted to give birth in public hospitals, although if it were within their means, they would have preferred private healthcare (Cindoglu, & Sayan-Cengiz, 2010); women in Egypt said they would avoid public hospital births in the future, a few specifying birthing in a private clinic with a private doctor as the preferred alternative (El-Nemer et al., 2006); women in Ghana also reported being able to access better treatment in the private sector where

they would be treated more respectfully (Yakong et al., 2010). However, these important findings received fleeting mention and little discussion. Researchers did not seek to understand the basis of these perceptions, nor did they analyze the implications of these trends.

The ways in which women navigated the health system were discussed and interpreted in various ways. Parkhurst and Rahman (2007) depicted women in rural Bangladesh as agents making conscious decisions to stay away from the substandard available health services, instead choosing to give birth at home. The authors suggested that these women avoided formal maternity services because they believed physicians' decisions were financially motivated. Similarly, in exploring why women opted for Caesarean sections in Brazil, Behague (2002) moved away from framing the problem in terms of individual women's and physician's actions, opting instead to focus on the social and economic context shaping women's and physicians' individual decisions. For Behague, the decision to choose Caesarean section was a form of resistance by poorer women negotiating the public health system to access the best available services or what Behague termed "private-like care …in the public healthcare" (2002, p. 484).

In contrast, some authors represented women as passive subjects oppressed by a patriarchal health system. Liamputtong attributed women's preference for institutional delivery to "the modernization or Westernization of Thai society" and the medicalization of childbirth in Thailand (2004, p. 470). She went on to argue that women engage in "passivity discourse" in submitting to medical dominance, pointing out that rural women are less likely than middle-class women "to exercise their choices and control over their childbirth experiences" (ibid, p. 476) and concluded that "women's satisfaction with their childbirth is determined by their involvement in making decisions concerning their childbirth and their sense of control over the whole process" (ibid, p. 476), an assertion that was not supported by her findings. According to Kabakian-Khasholian et al., "Lebanese women's perception of the obstetric care they receive [was] characterized by the feeling of passivity" (2000, p. 111). They went on to argue that "women in remote rural areas had less demanding attitudes… [that] could be attributed to their low social class and low educational level as compared to women from other areas" (ibid, p. 111).

In attributing such preferences to passivity and social class, these researchers overlooked the social and economic contexts of women's lives and their concerns for their own safety (see Cindoglu & Sayan-Cengiz, 2010; Liamputtong, 2004). Moreover, they normalized the act of resisting medicalization, an action associated with the women's health movement that burgeoned in the West in the 1970s (Annandale, 2009). In so doing, they constructed the West as normative, and universalized the

experiences of white, middle-class women in the West (Grewal, 1999; Mohanty, 1988). Additionally, their analyses often overlooked the ways in which some women subverted the health system by arriving late at hospital or choosing to deliver with indigenous midwives. In fact, a number of studies suggested that rural women's birth is medicalized to a lesser extent than that of urban women (e.g., Behague, 2002; Kabakian-Khasholian et al., 2000; Liamputtong, 2004). According to Kabakian-Khasholian et al., "[t]he vast majority of women from the remote rural villages in the Bekaa and Akkar reached the hospital quite late during their labor, most delivering very soon after reaching the hospital. Therefore, many routine procedures during labor were not experienced by this group of women" (2000, p. 108). Because such findings were not explored in greater details, it was unclear whether this was due to a lack of access to healthcare, or whether these women chose to subvert an oppressive system of medical care. In my own research in rural Sri Lanka, I found that women, especially those with previous birth experiences, frequently delayed their admission to hospital to shorten the length of what they perceived to be an unpleasant and unnecessarily lengthy hospital stay (Kumar, unpublished data).

Very few authors provided a class-based analysis of birth experiences (exceptions, Behague, 2002 and Liamputtong, 2005), and fewer still considered ethnicity (exception, Tebid et al., 2011) or other difference. In most cases, the primary axis of analysis was gender; little consideration was given to how income, employment status or geographic location. For example, Yakong et al. (2010) argued that the treatment of women in healthcare reflects "the general patriarchal African culture characterized by power imbalance and control and the social construction of gender" (2010, p. 2437) but did not go beyond discussing gender in their analysis of the social structures that support women being treated this way within healthcare. Their sample was made up of women from a rural village, more than two-thirds of whom had no education. Could it be that their marginalized social status enabled healthcare providers to treat them in this way, rather than an attribute of "African culture?" This is not to deny gender as an axis of oppression, but to point out that this kind of representation not only perpetuates the understanding of women's lives in Third-World contexts in relation to 'Traditional Patriarchal Cultural Practices' (Narayan, 1997), but also reinforces the construction of the colonial subject as 'Other' (Spivak, 1994). In this way, important internal variation is overlooked (Mohanty, 1988) such as, in this instance, access to resources that contribute overwhelmingly to birth experiences.

In the few studies that focused on women's experiences in midwife-led obstetric care, researchers were constrained to some extent by the medicine/midwifery binary, in which women's positive

experiences were attributed somewhat uncritically to the midwifery paradigm. This binary is blurred in the global North, where midwife-led birth care is usually connected to a larger referral system for emergency obstetric care (see e.g., Berg, Olafsdottir & Lundgren, 2012; Department of Health Western Australia, 2011), whether birth takes place at home or at a midwife-led birth centre. My analysis of the three papers that focused on midwife-led birth care in the global South revealed that the 'birth centres' were located within teaching hospitals or were integrated into formal emergency obstetric care. The preference for hospital- or clinic-based births among women in some contexts may stem from an awareness of the complications of childbirth and the need for referral services, which may not be available through indigenous birth attendants who are usually not connected to a larger framework of emergency care. Similarly, preferences for private healthcare and/or overly medicalized public healthcare, even Caesarean section, may be ways for women to seek what they perceive to be respectful care. As El-Nemer et al. suggested, "skilled help from the heart" (2006: p. 91) may be what is needed – this model of care would merge the continuity of care and the woman-centred approach of midwifery with medical technology as and when required.

CONCLUSIONS

In this paper, I demonstrated how women's experiences are represented in research may have wide-ranging implications: a focus on improving access to healthcare in resource-poor contexts aligns with frameworks that produce and reproduce social inequalities between and within contexts. By using a post-colonial feminist lens to sift through this body of research, I was able to identify ways in which research participants' experiences may have been misrepresented. Women's dissatisfaction with obstetric services was a resonating theme in the papers under review, but particular sources of dissatisfaction were emphasized by the largely unacknowledged researcher. This meant that 'medicalized' aspects of childbirth were explored and critiqued without adequate attention to social and economic aspects of women's lives that could affect their birth experiences. The critique of medicalization was applied in a number of papers without consideration for the social contexts of women's lives: researchers tended to homogenize women's experiences by paying inordinate attention to gender and overlooking internal differences based on social class, ethnicity, or other status. Women's experiences in the global South, like elsewhere, cannot be universalized. Research efforts that tend to universalize women's experiences in regions of the global South, or in Third-World contexts, or in 'developing countries,' may well be embracing research that

constitutes Third-World women as 'Other' (Mohanty, 1988; Spivak, 1994). Reflexivity may help resolve this dilemma of representation, but it is important to keep in mind Spivak's observation that "the subaltern cannot speak" (1994, p. 104), because she is so often silenced or misrepresented in research.

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