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Labour and birth experiences and awareness of pain relief among Kurdish women

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Abstract

Introduction: Childbirth experience is considered an essential issue for health policy makers in developed countries, but Kurdish women's childbirth experience has received little attention.

Purpose: To assess Kurdish women's labour and birth experience, identifying their awareness of, and desire for, labour pain relief. The study also explores healthcare professionals' views on intrapartum care.

Design and Methods: An explanatory sequential mixed methods design was adopted. A quantitative survey was conducted with 256 women who gave birth in a major hospital in Iraqi Kurdistan. Qualitative interviews were conducted with nine of these women and 14 healthcare professionals.

Findings: Both statistical and qualitative analyses were applied. The majority of women were dissatisfied with their labour and birth experience. Women graded their childbirth as painful; most were unaware of labour pain relief options but wanted pain relief for any future birth. Antenatal visits had no effect on women's preparedness. Interview data indicated factors contributing to women's negative childbirth experience including: fear of childbirth pain, lack of choice, staff members being attentive only during labour, little staff/patient communication, no privacy, frequent examinations and interventions such as episiotomy. Positive experiences included perceived staff competence, presence of birth companions and positive birth outcomes. Healthcare professionals revealed that shortcomings in care were due to resource constraints, high admission rates, staff shortage and excessive workload.

Conclusion and Recommendation: Several factors negatively affecting the childbirth experience need to be addressed, whilst positive factors should be reinforced. Antenatal preparation of women for childbirth and a labour pain management policy are necessary. Exploring the Midwifery-Led Care Model could provide solutions to the current issues with Kurdish maternity care services.

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Dedication

This thesis is dedicated to:

My parents, for their unconditional love, prayers and everything they have done for me
throughout my life.

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List of abbreviations used

Abbreviation	Meaning
ARM	Artificial Rupture of Membrane
C/S	Caesarean Section
CEQ	Childbirth Experience Questionnaire
CINAHL	Cumulative Index to Nursing and Allied Health
CQC	Care Quality Commission
FGM	Female Genital Mutilation
FMU	Freestanding Midwifery Units
GLM	General Linear Model
HMU	Hawler Medical University
KRG	Kurdistan Regional Government
MICS	Multiple Indicator Cluster Survey
MoH	Ministry of Health
NHS	National Health Service
NICE	National Institute for Health and Care Excellence
NRS	Numerical Rating Scale
OU	Obstetric Units
PHC	Primary Healthcare Centres
SBA	Skilled Birth Attendants
SPSS	Statistical Package for Social Sciences
TBA	Traditional Birth Attendant
TENS	Transcutaneous Electrical Nerve Stimulation
VAS	Visual Analogue Scale
WHO	World Health Organisation

Chapter One: Introduction

1.1 Introduction

This thesis reports a study that was carried out to explore Kurdish women's childbirth experiences and their perceptions, awareness and attitudes towards labour pain and pain relief in a large governmental hospital in Iraqi Kurdistan. This chapter introduces the study by describing: first, the personal and professional motivation for the study; second, Iraq in general and Iraqi Kurdistan in particular, where the research was conducted; and third, the Iraqi and Kurdistan healthcare system and health workforces.

1.2 Personal and professional motivation for the study

As a woman, born and raised in the Kurdistan region of Iraq, I have proper knowledge about the difficulties encountered by women undergoing labour in the delivery rooms. Through my personal experience, I have always heard distressing stories from my mother, sister, relatives and friends regarding their labour and how painful it was. They were all frightened about childbirth and this affected the way they perceived labour and birth.

Through my professional experience in the field of nursing and midwifery, I am aware that Kurdish women frequently lack knowledge regarding pharmacological and alternative therapies for relieving their pain during labour and parturition. There are no straightforward booklets or educational sessions available about this topic in Iraqi Kurdistan healthcare settings, even during antenatal visits. Women normally experience pain during labour and not knowing how to deal with the pain is extremely difficult for Kurdish women.

I have worked as a clinical nurse and as an assistant lecturer at Hawler Medical University in Erbil city for several years; I have always been concerned about improving women's

health, specifically their reproductive health. When I worked in the Labour Unit I observed many women suffering from pain in labour, they did not receive pain relief. It became clear that there was an urgent need to establish better intra-partum care and education for women in Kurdistan. Through reading the literature and visiting a UK maternity hospital, I became aware of health care and education provided for women (during pregnancy and labour) in the UK. I became aware of the guidelines for midwives caring for women in labour and those specific guidelines for pain relief in labour. Consequently, I realised how women's childbirth experience is an essential issue that still needs to be fully explored in the Kurdistan region.

In addition, there is no study which satisfactorily addresses the issue of Kurdish women's childbirth experiences, the availability of pain relief during labour, and information pertaining to it. This is a cause for concern and provided further motivation to investigate the issues involved.

1.3 Demographic and socio-economic status of Iraq

Iraq is situated in the Middle East, geographically sharing borders with Turkey, Iran, Kuwait, Saudi Arabia, Jordan and Syria, with a total area of 438,445 km² (World Health Organisation, WHO, 2006a), as shown in Fig. 1.1. The main administrative structure of Iraq comprises of nineteen governorates, of which four are in the Kurdistan Region. Each governorate is divided into districts and sub-districts consisting of urban and rural areas. Baghdad is the capital and largest city of Iraq. Arabs and Kurds are the main ethnic groups of the country (Wahab, 2010).

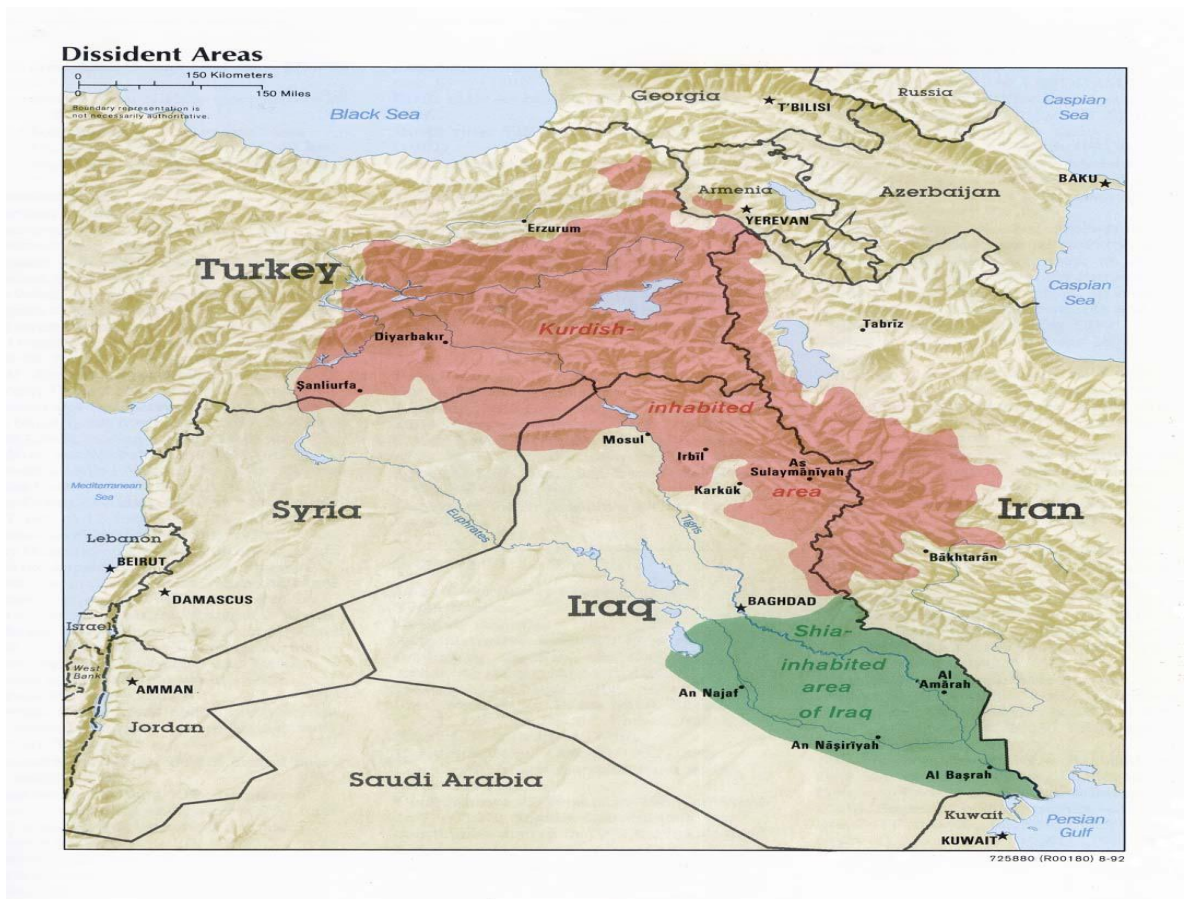


Fig. 1.1 Map of Iraq and Kurdistan (Kurdish Institute, 2016)

Iraq's economy is dominated by the oil sector. Three decades of inappropriate policies, particularly in 1990 when Iraq attacked Kuwait and suffered subsequent economic sanctions, have significantly reduced Iraq's economy (WHO, 2006a; WHO, 2006b).

The total population of Iraq is estimated to be 32,778,000. The annual population growth rate during 2002-2012 was around 3%. Iraq has experienced population movement from rural to urban areas, and two-thirds of the population (66%) lives in urban areas. The infant mortality rate is 28 per 1000 live births, while the maternal mortality ratio (per 100,000 live births) in the last three decades decreased from 110 to 67 deaths, which is still higher than in neighbouring countries. The total fertility rate (per woman) in Iraq is 4 (WHO, 2015).

1.3.1 Kurdistan: geography and population

Kurdistan, the historical land of the Kurds, is a strategic area situated in the Middle East, rich in many natural resources such as water, oil, gas, minerals and metals (Lobaido et al., 2003; Meho and Maglaughlin, 2001). It comprises important parts of Syria, Iraq, Iran, and Turkey (see Fig. 1.1). These parts were separated on two distinct occasions: first in 1514 and second in 1923. The first division occurred after the Chaldiran battle, when Kurdistan was divided between the empires of the Ottomans and Persians. The second division took place from 1920 to 1923 when Britain and France further changed Kurdistan and its political contour by dividing Ottoman Kurdistan among Turkey, Iraq and Syria. The estimated size of the land where the Kurds constitute the majority of the population ranges from 596,000 to 777,000 km² divided as follows: Turkey (43%), Iran (31%), Iraq (18%), Syria (6%) and the former Soviet Republics (2%). The Kurds in the former Soviet Union (USSR) came under the auspices of that empire when former Ottoman and Persian territories were absorbed into the USSR. While there is no official census concerning the total number of the Kurds between the four countries, the majority of the references agree that today there are more than 30 million Kurds, at least one-third of whom live outside historical Kurdistan, particularly in Europe (Finland, France, Greece, Sweden, the UK) and the US (Meho and Maglaughlin, 2001).

It is important to note that the fourth largest ethnic group in the Middle East are Kurds, after Arabs, Persians, and Turks and they are one of the biggest stateless nations in the world (Meho and Maglaughlin, 2001). Ethnically, the Kurds are an Indo-European speaking people, and religiously the majority are Sunni Muslims. Additionally, other minorities live in Kurdistan, such as Assyrians and Armenians (who are Christians) and Turkomans (Sunni/Shia Muslims) (Gunter, 2003).

The Kurdish people speak the Kurdish language and they have different dialects which can be divided into two major groups: Kurmanji and Sorani. The former dialect is the most widely spoken. Kurdish identity has been systematically and determinedly suppressed by Turkey, Iran, Iraq and Syria. The Kurdish language was forbidden except in Iraq, which in 1958 officially recognised it as the second language of the country, and provided the Kurdish language schools (Meho and Maglaughlin, 2001).

The Kurdistan region in Iraq is a semi-autonomous region, situated in the north of Iraq, comprising four governorates: Al-Sulaymaniyah, Erbil Duhok and Halabja (Kurdistan Region Statistics Office, KRSO, 2015). The capital of the Kurdistan region is Erbil governorate, comprising ten administrative districts (KRSO, 2015). Erbil governorate was initially established in 1923.

The total population of the Kurdistan region is 5,472,436 (KRSO, 2015) and the infant mortality rate is 20.5 per 1000 live births, while the maternal mortality ratio (per 100,000 live births) from 2004 until 2012 decreased from 19 to 16.53 deaths, which is less than in Iraq as a whole (MoH KRG, 2012).

The current situation in the region (*i.e.*, the ongoing fight against a terrorist group called ISIS¹, budgetary issues with the central government in Baghdad and a massive humanitarian crisis) brought unforeseen challenges to Kurdistan and caused great financial burden to the Kurdistan Regional Government (KRG). Today, there are approximately 2 million internally displaced persons and refugees (Syrian) taking sanctuary in the region which has increased the financial hardship, and had a huge impact on all the elements of governmental organisations including the health system. However, it is important to note

¹ ISIS: Islamic State of Iraq and Syria

that the current study was conducted just prior to the beginning of the aforementioned issues.

1.4 History of the healthcare system

1.4.1 Healthcare system of Iraq

The formal healthcare system in Iraq dates back to the 1920s when the first independent Iraqi government was established. The first Directorate of Public Health Services was formed during the 1920s, while in 1952 a new Ministry of Health (MoH) was established, whose organizational structure was formalized in 1959 (Wahab, 2010).

In the 1970s and early 1980s, an efficient healthcare system was developed due to the remarkable social and economic development that characterized Iraq during the period when the country was a model of prosperity in the Middle East region. This era was associated with improvements in numerous significant health outcomes. Conversely, the capacity and performance started to depreciate during the 1980s and the 1990s due to two debilitating conflicts (the Iran–Iraq and Gulf wars) and economic sanctions, leading to a severe deterioration in indicators of population health (Al Hilfi et al., 2013; Shabila et al., 2010).

Some impacts of the sanctions were reduced as a result of the subsequent “oil-for-food” program, but significant damage arose in the health system prior to the invasion of Iraq by the coalition forces in 2003, at which time the health system suffered from insufficient supply of medicines, non-functional equipment and vulnerable infrastructure (Al Hilfi et al., 2013). The war in 2003 and the fall of the previous regime, brought about the most

fundamental alteration to the healthcare structure since the 1950s (WHO, 2006a; WHO, 2006b).

The health information system is not well organised and existing records are often inaccurate or ambiguous. Several avoidable inadequacies exist in the healthcare sector due to the lack of access to data, which leads to the delivery of poor quality health services. Other factors that hinder the delivery of quality healthcare services include lost and unreliable data and poor quality documentation. The system is still based on old-fashioned paper forms filled by a statistical clerk, and there is a lack of computerisation. In addition, health centres or hospital outpatient departments usually either lack medical records or keep inadequate records (Wahab, 2010).

Shabila et al. (2012) found that there is a poor referral system, poor infrastructure, uneven distribution of health personnel, resource deficiency, and poor use of information technology in primary care systems. Generally, no guidelines or standards for managing common conditions are available, and if they exist, they are usually inadequately disseminated (WHO, 2006a).

There have been some achievements in improving the functions of the national health information system in Iraq in the past few years. Enormous investments have been made into the health information system in terms of provision of hardware, software and technical expertise. According to the country's recent assessment in 2011, which thoroughly reviewed the various components of the health information system, there are a number of strengths such as a relatively strong routine health information system within MoH that reviews almost all relevant administrative, health and diseases records in MoH institutions on a monthly basis; a well-functioning registration system for births and deaths;

and well documented and regular annual reporting on health system, morbidity and mortality indicators (Ministry of Health, 2011).

1.4.2 Healthcare system of Iraqi Kurdistan

The Ministry of Health in KRG in Iraq was established in the early 1990s, which followed the basic organizational structure of the Iraqi MoH. Those health services delivered by the public sector through hospitals and primary healthcare centres (PHC) provide services at very low fees and everyone has equal opportunity to access them.

There was no modern hospital until 1929, where the first hospital (without operating theatre and inpatient beds, but including a delivery room) was constructed (Wahab, 2010). The healthcare system in the Kurdistan region enormously suffered during the previous regime in Iraq. However, over the last decade, skilled and devoted healthcare professionals sought to improve health facilities and insufficient investment in the sector. As a result, several improvements have been accomplished, yet more improvements need to be pursued (Ministry of Planning, MoP KRG, 2013).

Through two different channels, the Kurdistan region guided efforts in the provision of health services. The first one is the support of the public health service by the regional Ministry of Health. This includes all public health centres and hospitals in urban and rural areas. The second one is the private health sector, including all the facilities run by private institutions such as hospitals, clinics, chemists and laboratories. Private hospitals are licensed and monitored by MoH which lists these clinics under its supervision and mentoring activities. Financing of private facilities is on an entirely private basis while the

public sector receives its total funding from the Ministry of Finance (Heshmati and Darwesh, 2007; WHO, 2006b).

In the region, there are 69 public hospitals and 52 private hospitals (MoH KRG, 2012). In Erbil governorate, there are now twelve public hospitals, 197 PHCs, seven small private hospitals and many private clinics (Shabila et al., 2010). The total population of Erbil (or Hawler) city is approximately two million, with an average annual growth rate of 3.4% at the end of 2005. Increasing birth rate is the only factor of high growth rate, and is not necessarily the result of population growth by migration from rural to urban areas (Heshmati and Darwesh, 2007). However, although there is no recent and up-to-date information regarding these figures, they may have been changed since then.

1.5 Medical and nurse education

All graduates of secondary school (after twelve years of education) must pass a national examination for enrolment in college: typically students enter college or university at about 19 years of age (Mosawi, 2008). According to WHO's health statistics, Iraq has 21925 physicians, or 6.9 per 10 000 population (WHO, 2012). The above figure is lower than other neighbouring countries (Iran =8.9, Turkey 15.4 and Jordan=24.5). Currently, 23 medical schools are present in Iraq and around 1500-1800 medical personnel graduate each year. All medical schools follow the standard Iraqi curriculum based on the British model of medical education established during the period of British influence in Iraq (Al Hilfi et al., 2013). The medical school curriculum in Iraq is a 6-year course of study, after which a degree of bachelor in medicine and surgery is awarded (Mosawi, 2008).

In the past, most nurses and midwives were trained to secondary school level, and the health system relied greatly on foreign nurses for advanced nursing positions, while poorly educated Iraqi nurses provided the majority of care. Currently, the majority of nurses obtain a bachelor's degree from twelve colleges or universities and around 700-800 nurses graduate yearly (Al Hilfi et al., 2013). The number of nursing and midwifery personnel in Iraq is estimated to be 43,850 (*i.e.*, 13.8 per 10000 population) (WHO, 2012).

Regarding human resources working in the health sector in Kurdistan region, such as dentists, pharmacists and nurses, there are a number of categories within each of the professions (except nurses) such as rotator (resident), urban practitioners, practitioners and specialists. The number of physicians per 10 000 population is 11 and the number of nurses per 10 000 population is 16.1 in the region (MoP KRG, 2013; MoH KRG, 2012).

1.6 Antenatal visit

Almost all pregnant women in the Kurdistan region have access to antenatal care, which is provided in most PHCs. The Multiple Indicator Cluster Survey (MICS) in 2011 showed that 78% of pregnant women received antenatal care from a skilled provider at least once during their pregnancy. A skilled care provider includes a doctor, nurse, or midwife (MICS, 2012a). Antenatal services in Iraqi Kurdistan include an assessment of pregnant women through history taking, blood pressure, abdominal examination and blood investigations, urine test, provision of tetanus toxoid immunization and iron/folate supplementation. Also educational topics such as health talks are provided to cover nutrition, danger signs of pregnancy, family planning and breast feeding. However, no childbirth education programme specifically addresses topics around labour and birth process, coping strategies or pain relief options (if any) exists. Raoof and AL-Hadithi (2011) found that the most

commonly discussed topics during antenatal visits were nutrition and family planning. Generally the wealthy families attend private clinics for their antenatal care while the only choice for poorer women is to attend the government run health services.

1.7 Care of women in labour

Giving birth is regarded as a major social event in Kurdish society. The woman who gives birth, no matter where the birth is taking place (at home or in hospital), will receive support from family and friends. Usually relatives and friends visit the woman and bring gifts for the baby and congratulate the woman on becoming a mother. Commonly, one or more family members stay with the woman for a period of time after birth. The woman will be given social and emotional support, for example, providing care for her and the baby (*i.e.*, bathing, changing clothes, cooking and housekeeping).

Women in Iraqi Kurdistan are encouraged to give birth at health institutions with the intention of providing a safe and hygienic birth for the mother and her newborn baby. Also another intention is that facilities and services provided are better than home in terms of availability of skilled personnel and medical equipment. For instance, if a woman who is giving birth in a hospital or healthcare centre encounters any difficulties, health care facilities are available. Some women still prefer to give birth at home: Traditional Birth Attendants (TBAs) take care of such women and conduct the delivery. They will be paid by the family (husband) of the labouring women. Those women who live in inaccessible regions tend to give birth at home. In Iraqi Kurdistan, there are training courses for TBAs, usually based at the health institutes. A licence is provided on completion of the course. Usually these courses focus on utilising hygienic materials and how to refer a woman in emergency situations.

However, these TBAs can only provide care and deliver babies of those women who are at low risk and if anything goes wrong (e.g., any emergency situations), the women will be referred to hospital in order to receive the required treatment/care. In addition, these women may not receive sufficiently prompt action/treatment as the referral system (usually transfer by a private family car) might be less than optimal, leading to negative consequences.

Although many women do not receive one to one care or support and the hospital environment might not be as comfortable as home, hospital birth is the only option for most Kurdish women. In hospital they can obtain prompt treatment during emergencies and they may feel safer in such an environment. No pain relief options are available to women either at home or at hospital (except private hospitals where analgesic injections and epidurals are available).

There are different types of healthcare providers in the Iraqi Kurdistan region; nurses/midwives, obstetricians, and traditional birth attendants (certified). Nurses are educated at either university (four years) or preparatory institution (two years), after 12 years of schooling. Obstetricians are educated at university (six years) and work in governmental and private hospitals. They may also have private clinics, which are open in the evening times and where patients pay in order to be seen by a physician or obstetrician.

As with many countries neighbouring Iraq, midwives or others who provide care to the labouring woman work under the supervision of the obstetrician. In Iraqi Kurdistan, there is no midwifery training up to degree level; however there is an effort to establish a midwifery training degree in the area. In 2012, a team from London's Royal Free Hospital Maternity Unit visited Iraq to help launch the country's first midwifery school. Abdul-

Kadir, one of the Iraqi team members stated that “*A lot of women give birth in the community with the support of a doula, but without any medical help. In hospitals, the maternity service is led by obstetricians, who deliver care that would be provided by a midwife in the UK*” (O'Neill, 2012, p.2). The meaning of doula in the aforementioned paragraph involves one of these individuals - either TBAs or women's relatives. Consequently, a College of Midwifery has been established in the Hawler Medical University and its graduates will be awarded a Bachelor degree in Midwifery after four years. Recently the degree was awarded to its first group of graduates.

Findings of Iraq's MICS revealed that approximately 91% of births were assisted by Skilled Birth Attendants (SBAs). More than half of all births (60%) were delivered with the assistance of a doctor either in public or private sector. Certified midwives or nurses assisted with the delivery of more than a quarter of births (28%), and uncertified midwives and TBAs assisted with 10% of births. Additionally, the survey demonstrated that three out of every four births (74%) occurred in a health centre or a hospital in the two years prior to the survey (approximately 85% of births). The highest percentage of births that took place in hospitals (public and private) and health centres is found among urban women compared to rural women (MICS, 2012a; MICS, 2012b). The percentage of total deliveries taking place in health institutions in the Kurdistan region was around 92% in 2006, increasing to 95.1% in 2011 (MOH KRG, 2016). In Iraqi Kurdistan, the numbers of obstetricians working in labour units is less than the number of midwives or other healthcare personnel in the same unit. No data is published regarding the ratio of obstetrician/midwifery personnel.

Regarding the roles of healthcare professionals in the Kurdistan region, although the actual care for women in labour is delivered by midwives/nurses and they are the ones who deliver the babies, they do not have autonomy in their work and they work under the supervision of obstetricians. Midwives do not have prescribing privileges and they follow obstetricians' order, for example, when to augment the labour (oxytocin administration, ARM). It is obstetricians who possess the main power in managing the cases; they are the decision makers. When a labouring woman visits hospital, she will first be seen by a doctor and, after initial assessment, the doctor decides whether she will be admitted to the delivery unit to give birth or go home and wait until the labour is established. If a woman is admitted to the delivery unit, another doctor assesses her and makes a file for her, recording all the examinations and investigations needed. Afterwards, the required actions (such as how many oxytocin unit should be given or what to be done) are passed on to midwives/nurses in order to be undertaken. Then, the latter will take care of the woman, deliver the baby and follow up the case. However, in case of emergency, the doctors will manage the case. Usually the obstetrician controls the entire unit in terms of providing any medical intervention and conducting the delivery of high risk women without a midwives' input.

The clinical guidance on caring for women during labour and birth developed by the National Institute for Health and Care Excellence (NICE) in the UK, states that: "*A woman in established labour should receive supportive one-to-one care*" (NICE, 2007, p.7). In Iraqi Kurdistan, there is no rule or regulation regarding the client/midwife ratio as one nurse/midwife may be looking after numerous women simultaneously. Neither does this ratio apply in private maternity hospitals where there is a lower (but still not one-to-one) client/midwife ratio. This is comparable to some Middle-Eastern countries, such as

Palestine, where government hospitals have the highest deliveries per provider ratio (Wick et al., 2005).

As mentioned above, there are still women who prefer to give birth at their own home and have a private midwife or certified birth attendant to look after them during their labour, deliver their babies and provide care. These women usually receive one to one care and support from their midwives and can obtain a better care with regard to continuous support. Besides their midwives, these women can be accompanied by many (usually close) relatives.

Six care practices that sustain normal birth have been identified by Lamaze International. Care practice five is about “Spontaneous pushing in upright or gravity-neutral positions”. It focuses on freedom of movement and also encourages women to find the most comfortable positions, which is beneficial according to evidence based practice (Lamaze, 2007). Women in labour need to have freedom to respond to contractions in their own ways and have continuous emotional and physical support throughout labour (Lothian, 2002). Although all clinical care guidelines confirm the importance of freedom of movement and encourage women to move and adopt whatever positions they find most comfortable throughout labour, this is not the situation in Kurdistan. One reason for this poor practice is that the healthcare system is outdated and it is not based on evidence-based practice. There is a lack of privacy for labouring women due to the manner in which the labour rooms are designed. Women are admitted to a shared labour room which varies in terms of number of beds, ranging from two to four beds with only curtains separating them. Free movement therefore would be difficult in such situations.

Expectant mothers and their families should be provided with a comfortable and reassuring birthing environment (Lothian, 2002). Almost all women in labour in Kurdistan are accompanied by at least one of their family members, usually their mother or sister. However, those women who give birth at home can be accompanied by as many relatives as they wish. Women in labour obtain their physical and social support from their companion. Contrary to practices in Western countries (Declercq et al., 2013), the Kurdish husbands do not attend childbirth either at home or in health institutions due to values inherent in Kurdish culture and religious beliefs. However, husbands of labouring women will stay at the hospital in case they can provide any assistance. For example, they may be required to provide blood to their wife if they need it. Blood banking is available in every hospital but if someone needs a unit of blood, one of their family members has to donate a unit of blood in order to receive a unit from the blood bank. The transfused blood will match with the receiver's blood type but the donated blood does not always need to be of a particular type.

Women during labour usually restrict their food or fluid intake because they were told to do so by their mothers or grandmothers and also because they are not encouraged to drink by healthcare staff. An intravenous oxytocic infusion is routine practice for the augmentation/induction of labour. Fetal monitoring is inconsistent and a partograph is not used. A record which is manually filled in is used to record any information about the woman such as socio-demographic data, medical history, examinations and treatments.

Women are encouraged to walk during the early phases of labour, in the later stages of labour they will be confined to bed. Women do not have a choice of care in labour. Generally, women are not involved in decision making regarding the way in which care is

given. This situation is unlike that of the UK and that found in most developed countries. In almost all hospitals in Iraqi Kurdistan, the supine and the lithotomy position is the only position for women in labour and childbirth. Episiotomy is common practice, especially for the first birth, but no data are available to quantify this issue. This situation is similar to that in Iraq's neighbouring countries such as Iran (TorkZahrani, 2008). The high rate of episiotomy could be as a result of Female Genital Mutilation (FGM) which was a common practice in the Kurdistan region.

1.7.1 Obstetric consequences of FGM

In the past, a vast majority of women in Iraqi Kurdistan had undergone some types of FGM. In 2010, Wadi, a German-based NGO, published a study on FGM in the Kurdish region of Iraq, which found that 72% of women had undergone FGM, the majority of them type I FGM (see definitions below) (Saleem et al., 2013; Yasin et al., 2013; Wadi, 2010). The FGM practised in the region is not the kind of FGM that impinges on obstetric outcome (*i.e.*, it does not increase the likelihood of episiotomy).

Women's attitudes towards FGM have now changed as approximately 84% of women (aged 15-49 years) in the Kurdistan region believe that the FGM practice should be eliminated; and the current generation of Iraqi Kurdistan women tend not to allow their daughters to undergo this procedure (MICS, 2012b). It is of considerable importance to note that in 2011, the Kurdish Regional Parliament passed laws banning FGM (KRG, 2011).

A collaborative study was conducted by WHO from 2001 to 2003 in six African countries (Burkina Faso, Ghana, Kenya, Nigeria, Senegal, and Sudan) to find out the impact of FGM

on obstetric outcome. The study recruited 28 393 women attending for singleton delivery at 28 obstetric centres in those six countries. The women were examined prior to the delivery to determine whether or not they had undergone FGM, and were classified according to the WHO criteria:

- FGM I, removal of the prepuce or clitoris, or both;
- FGM II, removal of clitoris and labia minora;
- FGM III, removal of part or all of the external genitalia with stitching or narrowing of the vaginal opening.

It was found that women with FGM were significantly more likely to have adverse obstetric outcomes than those without FGM (postpartum haemorrhage, caesarean section, extended maternal hospital stay, infant resuscitation and stillbirth or early neonatal death). Risks were greater with the more extensive FGM types (Banks et al., 2006) rather than the FGM type 1 formerly practiced in Kurdistan.

1.8 Summary

Both professional and personal reasons were the motivation for this study. Given the current health and maternity care services in Iraq and Kurdistan, it is important to explore the situation with labour, birth and intrapartum care in Kurdish settings in order to suggest ways to improve this service provision.

1.9 Structure of the thesis

A brief summary of the structure of the thesis is provided below to help guide the reader through subsequent material.

Chapter Two: presents a literature review concerning labour and childbirth experience worldwide, exploring the relevant literature concerning Iraq generally and the Kurdistan region particularly (if any). This chapter concludes with the rationale for conducting this study, outlining the research aims and objectives of the study.

Chapter Three: first provides a comprehensive description of the methodology including the quantitative/qualitative debate, the philosophical framework underpinning the current study and the rationale for adopting a mixed methods research approach, in particular the sequential explanatory design. Second, it provides a detailed description of the research setting, population and sample, methods of data collection and analysis including the quantitative, qualitative and integration phases. It also provides a thorough explanation of issues surrounding validity and reliability in mixed methods research and ethical considerations with regard to the study.

Chapter Four: presents the findings of the study that were obtained from a variety of methods. This chapter is divided into four sections. The first section details findings from a questionnaire survey. The next section comprises the findings from qualitative interviews with women who had participated in the questionnaire survey, followed by findings obtained from qualitative interviews with healthcare professionals.

The final section brings together all the findings (quantitative and qualitative findings) and integrates them in context.

Chapter Five: discusses the main findings of the study in the light of the relevant literature. Then, it highlights the implications of the study for midwifery and medical practice in Iraqi Kurdistan. It ends by identifying the strengths and limitations of the study and provides suggestions for future research.

Chapter Six: summarises the main conclusions of the study and follows by the recommendations for improving the healthcare practice in the Kurdistan region with regard to antenatal and intrapartum care.

Chapter Two: Literature review

2.1 Introduction

This chapter presents a review of the literature on labour and childbirth experience worldwide. First, the procedure used for the literature review is described, together with the inclusion and exclusion criteria for the studies reviewed. The results of the review are then discussed. Finally, the gaps in the existing literature are highlighted and aims and objectives of the thesis stated.

2.2 Aim of the review

The aim of this review is to investigate and summarise studies that have examined the experience of different aspects of labour and childbirth from women's own perspectives. Since the experience during labour and birth is a multidimensional and complex subject, studies focusing on the following were included in the review:

- The concept of personal control (which in this context usually means being involved in the birth process; for instance, by being well informed, having procedures explained, and being given the opportunity to take part in decision making).
- Labour pain experience and women's satisfaction
- Awareness and attitudes toward labour pain relief

The search was limited to those studies published from the last two decades until the present, as it was argued that this period considers the current changes towards recognising the value of the childbirth experience to the woman and her family (Larkin et al., 2009). It is worth mentioning that the initial literature search was conducted prior to the data

collection with a subsequent search being conducted recently (2016) in order to add the most up-to-date literature in the field into this literature review.

2.3 Search strategy

In order to establish a comprehensive review, a broad search strategy was used to identify relevant studies. A wide range of databases were used, including the Cumulative Index to Nursing and Allied Health (CINAHL), Medline and Scopus. Other online search engines such as Google Scholar and the Internurse archive of nursing articles were searched manually to ensure all relevant studies were included in this literature search. All keywords and different synonyms that might guide to relevant literature to the subject of this study were included in the search in all the above mentioned databases. The followings are the main keywords used:

Childbirth; Labour; Experience; Pain; Pain relief. These key words have been combined by using AND. In order to capture all the relevant literature with regard to the scope of this study, different synonyms have been used and these were combined using OR. The followings are the synonyms used:

Pain or discomfort or pain perception or pain experience

Labor or labour or childbirth or natural childbirth or parturition or parturients

Women's experience or childbirth experience or birth experience or satisfaction or self control or experience

Pain relief or analgesics or pain management or epidural or complementary therapy

Knowledge and attitude or knowledge or attitude or awareness

Kurdistan region or Kurdistan or Kurdish or Iraq or Iran or Turkey or Jordan or Middle East

In addition, the grey literature has been searched to identify any relevant documents that were of considerable importance in enriching this thesis such as documents from governmental and non-governmental organisation web-pages. All the references were imported and managed by a referencing management software package: EndNote.

2.3.1 Inclusion and exclusion criteria

Inclusion and exclusion criteria were used for literature searching to evaluate all studies in order to be consistent within the literature review. The criteria were chosen to be consistent with the research aims. Table 2.1 show the detailed inclusion and exclusion criteria for the literature search in this study.

Table 2.1 Inclusion and exclusion criteria for the literature search

Inclusion criteria	Exclusion criteria
<ul style="list-style-type: none"> - Papers published in the last two decades until present (2016). - Papers involving women in labour or women who had experienced labour. - Papers examining labour and birth experience, labour pain, control, satisfaction, pain relief, knowledge and attitude regarding pain relief. 	<ul style="list-style-type: none"> - Papers focusing on experience of particular intervention such as pushing intervention during birth. - Papers regarding labour and birth experience but conducted after a long postnatal period (e.g. 2 years after birth). - Papers on experience other than natural childbirth (water birth and cesarean delivery).

2.3.2 Study flow diagram

Comprehensive searching with the above-mentioned keywords in all pre-stated databases resulted in more than a thousand papers (N=1403). Three rounds of screening filtered these papers: in the first round, the papers were screened by title, secondly; the papers were screened by titles and abstracts and the last round screened papers by full text. After the

first round, seventy six percent of the identified papers were excluded (N=1060). A full text of the remained papers were obtained for the final screening (N=93). Eight articles were also identified in the manual search. Finally, 101 articles were included in the final screening to meet the inclusion criteria of the literature search with 48 studies meeting the criteria and being reviewed (see the Fig. 2.1).

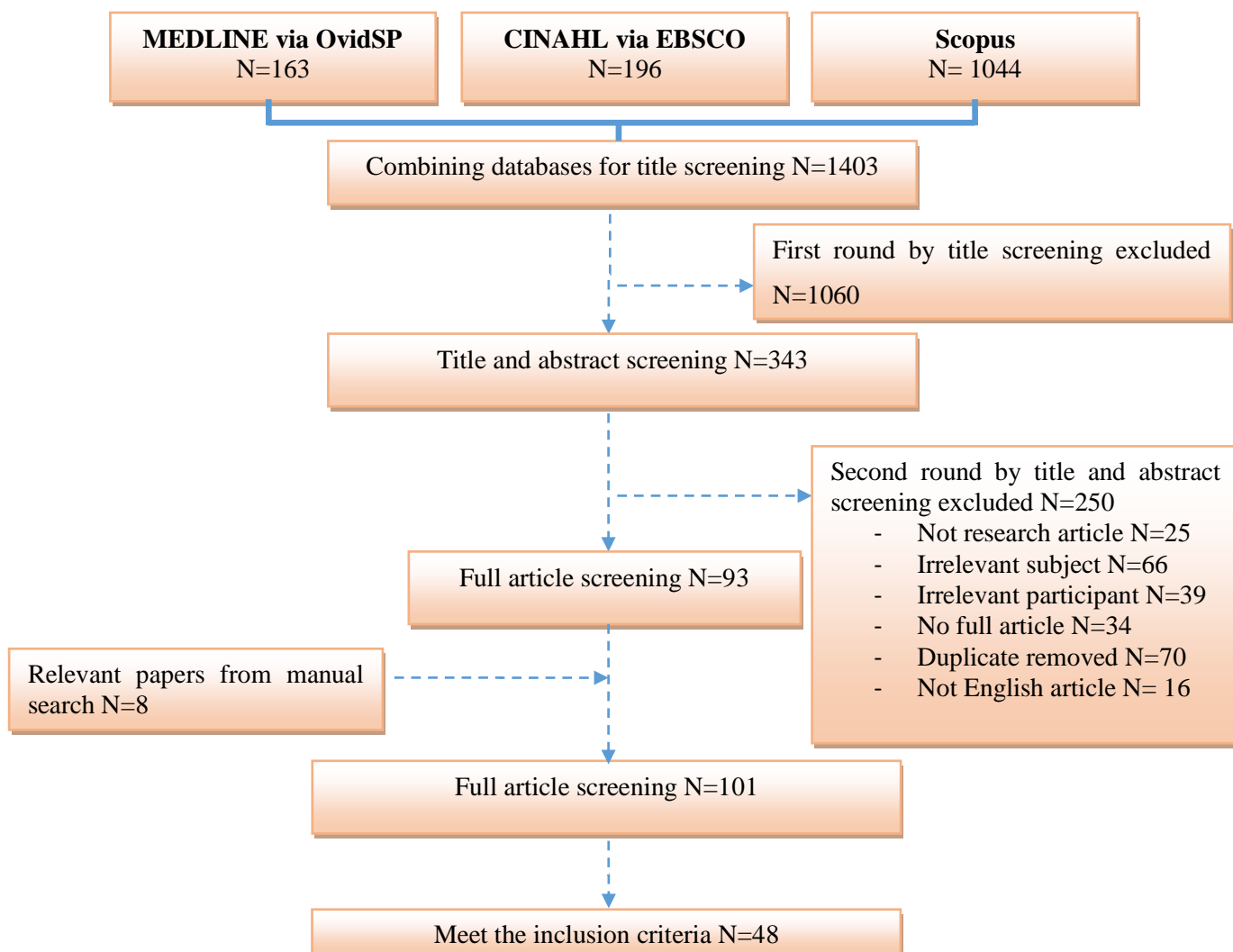


Fig. 2.1 Flow chart of literature review

2.4 Literature review results

Forty eight studies met the criteria for inclusion in the literature review. All studies examined the issues surrounding labour and childbirth experiences: these issues are:

experiences of pain perception and intensity, personal control and satisfaction and women's awareness of pain relief options during labour.

From European countries including the UK, Republic of Ireland, Finland, Belgium, Sweden, Iceland and Italy, thirteen studies were included. Fifteen studies were from Middle-Eastern and Asian countries (Kuwait, Jordan, Iran, UAE, Pakistan, India and China). Eleven studies were from USA, Canada and Australia. Five studies were from African countries (Nigeria, Uganda, Ghana and South Africa), two studies were from Brazil and two were Cochrane and critical reviews. It is important to acknowledge that a few studies have been conducted to explore the childbirth experience among Kurdish women in Iran but no literature has been found to study women's childbirth experience in Iraq generally and in the Kurdistan region particularly. Most of the studies had a quantitative research approach using questionnaires and surveys, whilst, other studies had a qualitative research approach using semi-structured interview, telephone interview and focus groups.

The following sections (headings) presented in this review are the main recurrent topics discussed in the literature reviewed.

2.4.1 Labour and pain

When thinking about pain, people usually ask a common question which is why do we need pain? On one hand, pain (acute) is considered to be advantageous. It commences a reaction to assist the person to instantly withdraw from harm. On the other hand, chronic pain, which is experienced over a long period, is the pain that medical sciences struggle to relieve and which commonly affects every element of life in a negative way, such as physical, emotional or social. Pain associated with labour and childbirth, which is the most

significant event in any woman's life, marking the transition from "womanhood to motherhood" and the beginning of family life, appears to have the very specific purpose of producing another human being (Moore, 1997).

Pain during labour is regarded as a normal consequence suffered by women during childbirth, and is not considered to be a pathological condition. Labour pain is characterised by acute and intermittent pain that begins as the uterus contracts, after which point it increases in intensity when the contractions intensify, and diminishes when the uterus is relaxed (Bricker and Lavender, 2002).

Labour pain is considered as an acute pain with two main dimensions: firstly, sensory or physical and secondly, emotional or affective (Lowe, 2002). As pain is subjective and the pain threshold differs from person to person, individuals may respond to it in a variety of ways. An individual may find a specific type of stimuli as painful while for others it is not painful at all. When thinking about the self-consciousness of pain, it is noteworthy to recognize that any feeling of pain occurs as a part of the overall experience (Resnik and Rehm, 2001). It is also important to note that some kinds of pain have psychological causes. An individual who experiences distress emotionally may also feel pain due to their distress. For instance, several men state that they feel compassionate pain whilst supporting their wives in labour. Even if a person experiences pain of psychological origin, this does not mean that their pain is not real (Resnik and Rehm, 2001).

Labour and childbirth is usually a painful process and has been since the earliest experiences of human beings. This concerns all different ethnic and cultural groups. The main sources for pain during labour are due to: first, stretching of the reproductive tissues such as the cervix, vagina and vulva; second, uterine contractions which cause tissue

hypoxia (lactic acid build-up) and these contractions last for many hours (Rowlands and Permezel, 1998). The uterine muscle (myometrium) is comprised of smooth muscles, the distribution of which varies throughout the uterine length. The upper part of the uterus contracts strongly due to its higher muscle density while the lower part contracts weakly and passively because of its lower muscle density (Coad and Dunstall, 2005).

Although the perception of labour pain among women is varied and individualised, for most of them it is considered to be intensely painful as experienced by the majority of Finnish parturients (Ranta et al., 2011) and many studies around the world have found that parturient women experience worse labour pain than they expected (Lally et al., 2008). In the USA, Gibson (2014) identified that pain was a recurring theme among the women's interviews. Consequently, many women fear childbirth. Several researchers in Iran reported that pregnant Kurdish women express their fears related to childbirth, such as fears associated with labour pain and the health of their babies (Khosravy et al., 2013; Shahoei et al., 2011a; Shahoei et al., 2011b). In a qualitative study, Fenwick et al. (2015) reported several factors (stimuli) that contribute to childbirth fear among pregnant Australian women. These factors were recorded as fear of the unknown, negative previous birth experience, labour pain and feelings of loss of control. Fenwick and colleagues also documented that the quality of information and support women received during their pregnancy (from hospital staff and friends) moderated their ability to overcome their fear of childbirth and associated anxiety.

In order to avoid labour pain, many women request caesarean section (C/S) (Faisal et al. 2013). In Iran, Dehghani et al. (2014) identified that those women who chose to have elective C/S had a higher level of fear of labour pain and childbirth compared to those who

chose to give birth vaginally. In addition, Bagheri et al. (2013) explored Iranian obstetricians' views with regard to women's choices of birthing methods. Several factors had been identified as influencing women's choice. Obstetricians reported that some women choose C/S due to their fear of childbirth pain and did not see it as a major surgery. Other factors were related to the obstetricians, such as their income, high stress levels when conducting a vaginal delivery, shortage of midwives, and early hospitalisation which makes both the women and obstetrician tired.

Every woman during labour and childbirth is surrounded by many conflicting feelings of excitement, enjoyment, ambiguity, apprehension, fearfulness and horror (McLachlan and Waldenström, 2005; Moore, 1997). There are quite a few women who pass through labour with little or no pain but the majority experience some degree of pain, while in some cases this would be very severe (Chamberlain et al., 1993). The severity of labour pain is influenced by the complex and multifaceted interactions of physiological, psychological, socio-cultural and environmental aspects (Leeman et al., 2003) such as poor education, anxiety and late antenatal care. With the presence of these factors the level of labour pain is rated as more severe. The presence of anxiety may exacerbate pain: through relieving pain, a mother's anxiety can be reduced. Also, the pain in labour represents severe physiological stress which, if it is not relieved, can result in catecholamine release. This will cause constriction of blood vessels which may affect the placental blood supply. These represent negative effects of labour pain if not relieved appropriately (Brownridge, 1995, Russell et al. 1997). This is in contrast with the findings of Kuti and Faponle (2006), in which they found that labour pain perception was not influenced by educational level among Nigerian women.

Nevertheless, having confidence in their body was an important element women in Iceland described to cope with their pain (Karlsdottir et al., 2014). Ghanaian women reported that midwives' support (encouragement) alleviate their suffering, although it did not actually reduce their pain (Ampofo and Caine, 2015).

2.4.2 Labour and pain relief

Labour pain and the approaches to minimise the sensation of pain represent a major concern in the provision of health care to labouring women in Western countries (Huntley et al., 2004). For that reason, since ancient times there have been attempts among scientists and healthcare providers to discover a substance or a method to reduce labour pain (Takrouri, 2009).

There are two major categories of methods to control and alleviate pain experienced during labour: pharmacological and non-pharmacological methods. Regarding the former, many countries around the world use analgesic medications as part of standard care delivered for labouring women, such as the anaesthetic Entonox (nitrous oxide and oxygen), epidural analgesia and the painkillers pethidine, diamorphine and tramadol (Bricker and Lavender, 2002). There are a huge number of non-pharmacological options that can be used by a woman in labour, such as relaxation techniques (including breathing technique, yoga, and listening to music), changing position and movement, hydrotherapy, acupressure or acupuncture, massage, hot or cold application, hypnosis, aromatherapy and transcutaneous electrical nerve stimulation (Capogna et al., 1996). These techniques act by altering the level of pain or distract attention from the pain (Albers, 2007; Smith et al., 2006).

Many studies worldwide have investigated the benefits of using pain management techniques, including both pharmacological and non-pharmacological interventions, and such techniques have become part of standard care delivered for women during labour in many developed countries such as the United Kingdom and the United States (Hamidzadeh et al., 2010; Leeman et al., 2009; Tournaire and Theau-Yonneau, 2007; Bhattacharya et al., 2006; Huntley et al., 2004; Leeman et al., 2003). A study was conducted in the USA to review the availability of pain management options for labouring women in different sized hospitals. It was found that pharmacologic interventions and epidural analgesia were used increasingly over time (the study period was 1981 to 1997) and that there had been a consistent decrease in births with no pharmacologic pain management intervention, especially in the smaller hospitals. It also suggests that labouring women in different locations encounter different analgesic choices (Marmor and Krol, 2002).

Murray et al. (2010) found that their participants (African women) believed in natural childbirth without using any pharmacological intervention as they believed that medication would slow delivery and harm the baby. Instead they used natural pain relief measures such as walking or drinking hot tea. In many countries, providing good pain management techniques, including both medications and alternative therapies, are part of their hospital protocols and there are guidelines concerned with these subjects produced by bodies such as NICE and The Royal College of Midwives in the UK (RCM, 2012; NICE, 2007). In addition, the majority of labouring women in developed countries are aware of these options and can choose pain management interventions based on their preferences. In the USA, the majority of women (83%) had one or more types of pain relief medications

during their labour. Also, most of them used non-pharmacological measures to relieve their pain and increase their comfort (Declercq et al., 2014).

However, for labouring units in developing countries such as Iraq, medication is rarely used as a mode of relieving labour pain and non-pharmacological techniques are ignored by midwives. Raven et al. (2015), state that most women reported lack of pain relief as poor aspects of care in a rural county in China. A narrative inquiry study on five Ghanaian women conducted by Ampofo and Caine highlighted that women described their labour and birth as a very painful experience and they expressed the desire for pain relief. None of the women were given the choice of pain relief prior to or during labour. Ampofo and Caine (2015) reported that the Ghanaian women intuitively used non-pharmacological measures to cope with pain such as (touch, massage, changing position, movement and breathing technique).

Lawani et al. (2014) conducted a study to assess the practice of Nigerian obstetricians with regard to pain relief prescription to women giving birth. They reported that 49% of obstetricians prescribed labour analgesia and only 20 obstetricians routinely provided their parturients with analgesia. Those who did not offer analgesia to labouring women had concerns about adverse fetal and maternal effects, cost, unavailability; and some of them perceived that pain relief is not necessary and believed that labour is a natural process.

2.4.3 Labour experience

The entire childbirth experience can be affected by the pain felt during labour and childbirth, in two ways: First, individual perception of the pain and second, the coping techniques women may use to relieve it (Callister, 2003). For some women, it is clear that

coping with labour pain is the focus of their personal experience, whereas for other women an individual philosophy of labour and childbirth is their experience rather than just dealing with the pain (McNeil and Jomeen, 2010).

In Australia, Whitburn et al. (2014) found that women's state of mind during labour affects the meaning they give to their experience. A study was conducted in the Republic of Ireland by Larkin et al. (2012) on 25 women who had experienced labour. They explored the women's experiences of childbirth using a qualitative design (focus group). It was found that women experienced labour and birth in three different periods: before labour was established (being in early labour prior to and during admission to hospital), during labour and childbirth and after birth or consequences. In the first period, some participants stated that they were confused as to whether they were actually in labour or not and sought advice from the hospital. Most women felt lonely and unsupported at the time between 'not in labour' and 'being in labour'. Once the labour was established, participants had different experiences including both positive and negative. Some of them experienced anxiety due to numerous factors such as specific intervention, hospital environment and noise from other parturients. One of the positive experiences was that some of the participants felt that the staff did their best in providing care. Participants stated that if they received information during the course of labour it helped them to feel in control, they wanted better information. Some women felt that they had a good relationship with the professionals, especially a midwife, while others stated that they had some disputes with their midwives. It was noticed that the relationship with the carers influenced the women's experience of control. After the birth of a newborn, most women felt isolated and the lack of time for staff to attend to them was a feature of all groups.

Similarly, Murray et al. (2010) conducted a study on the experiences of African refugee women giving birth in Australia. The findings were similar to the previous findings in which the women felt alone and fearful. At the same time women did not have knowledge about the health or hospital environment thus they felt that what was happening in the hospital environment was not adequately explained. The language barrier was the main reason for being unaware. However, those women who could communicate in English felt more in control during childbirth. Most women reported that the staff, specifically midwives, were very caring and kind to them but staffing levels were often described as inadequate when participants needed help. Karlsdottir et al. (2014) reported that Icelandic women highly valued the presence of “*good midwives*” who were helpful to manage their pain. Women also considered the quality of the “*midwife’s professionalism*” as an important aspect in which enabled them to deal with their pain (p.321).

Cipolletta and Balasso (2011) found that their study participants (Italian women) did not involve themselves in decision making and accepted the way the care or intervention was given. Pain perception was a common feature among women who had experienced labour and childbirth. Some women tried not to avoid pain as they attributed a meaning to pain, considering it as intimately connected to the experience of the birth, while others used some pharmacological pain relief. All women mentioned the positive role of midwives’ support and described them as very competent and kind. In addition, some women clearly stated that the hospital environment has an impact on the overall birth experience again either positively or negatively.

A study conducted in Pakistan found that more than half (66%) of women reported labour experience as unacceptable and only 34% reported acceptable experiences. It was found

that the factors associated with an unacceptable experience included no prior knowledge, primigravida, induction of labour and staff's attitude as being non-cooperative. In each case the opposite of the aforementioned factors were found to influence the labour experience in a positive way (Khaskheli and Baloch, 2010).

This research review has found that the presence of a companion during labour and birth influences different aspects of women's experiences including physical and psychological aspects. In the United Arab Emirates, Mosallam et al. (2004) found that the majority (87.5%) of women felt that the presence of a support person is essential and they were more positive than those who had no companions. Besides, Mosallam et al. (2004) noticed that the duration of labour was remarkably shorter in those women who had companions and they also required less pharmacological interventions (analgesia). Another study conducted in Canada by Price et al. (2007) found that women believed that their birth experience was improved by the support received from the family members and close friends. All women stated that the support persons they had chosen were necessary to their birth experience as they offered them a means of distraction to help "forget the pain" or "pass the time". Additionally, all participants recognized the importance of their healthcare professionals' role and thought that their companion complemented the care provided by the staff. In Ghana, women also reinforced the importance of having a support from a family member besides support from a hospital staff (Ampofo and Caine, 2015).

2.4.4 Childbirth experience and satisfaction

Numerous factors were identified that influenced the women's satisfaction during the entire labour process. These factors include sense of control, self-efficacy, childbirth preparation, involvement in decision making, labour pain and its relieving method, mode of delivery,

labour expectations being met, medical interventions and staff or midwife support (Cipolletta and Balasso, 2011). Personal control was found to be an essential factor of women's satisfaction (Goodman et al., 2004). McCrea and Wright (2001) reported that women in their Northern Ireland study felt that they were capable of controlling labour pain equally their midwives/doctors. Additionally, most of the women were satisfied with their pain relief. Similarly, Capogna et al. (1996) conducted a study of 611 women in five different European countries (Italy, Finland, Belgium, Portugal and UK) and found that participants had a high level of satisfaction with analgesia, particularly epidural analgesia.

A phenomenological study was conducted in Finland by Callister et al. (2001) to explore the lived experience of women who gave birth. It was noticed that participants had mixed feelings during their labour and birth. The researchers described these feelings as a "bittersweet paradox" as most of the participants complained of pain, but when they first saw or touched their new-born babies they almost forgot the pain experienced. Participants had an ability to handle the labour and childbirth pain as many established a sense of personal control or confidence. Also, they used less medication to relieve the pain and instead, several non-pharmacological measures (movement, massage and breathing techniques) were used.

O'Hare and Fallon (2011) found that their study participants in the Republic of Ireland were in control internally since they used breathing techniques, while externally, in terms of decision making regarding any intervention, they relinquished their control and gave the responsibility to the midwives. Another study which was conducted in Sweden found that their study participants reported that they were actively involved in the birth process. They were also satisfied with their own accomplishment (Waldenström et al., 1996). Contrary to

the above findings, the survey conducted by Oweis (2009) in Jordan found that women had low control and were not satisfied with their childbirth experience. Also, there was a statistically significant relationship ($P < 0.01$) between the total mean score of childbirth satisfaction and perceived pain control.

A critical review of ten qualitative studies conducted by Van der Gucht and Lewis (2015) identified that individualised and continuous support is one of the essential elements in improving women's ability to deal with pain of childbirth. A study in Australia aimed to identify the effect of 'primary midwife-led care' on childbirth experience conducted by Maclachlan et al. (2015), reported that women who received primary midwife-led care were more positive regarding the overall childbirth experience compared to those women who received standard care. In a recent Cochrane review conducted by Sandall et al. (2015), several advantages of the midwife-led care model for mothers and babies were reported. These advantages included intervention reduction such as episiotomy and instrumental birth. Another advantage was that women who received care from this type of model were less likely to have preterm birth. Fenwick et al. (2015) conclude that *"Provision of woman centred maternity models that minimise obstetric intervention, offer personalised conversations following birth, and are sensitive to identifying; listening and assisting women to modify their fears in early pregnancy are required to promote positive anticipation and preparation for birth"* (p.239).

2.4.5 Culture and labour experience

Values, beliefs and customs vary for every ethnic group. This variation includes a cultural distinction in the personal experience of pain perception and behaviour. It is a common conviction that women in specific ethnic groups experience labour pain in a different way

from others but it does not mean that these women should be denied the same level of pain relief. Each culture has its own exclusive language of pain perception and experience. Consequently, keeping pain private or expressing it publicly may be desirable or undesirable when viewed within the framework of belief for a certain social group. Different cultural values and beliefs may, for some, normalise the experience of pain which for others may be problematic (Moore, 1997).

Religious faiths also contribute viewpoints to the meaning of significant life experiences. It has been documented that the occurrence of major life events, such as childbirth, increases both religiosity and spirituality. This was a common feature among Jewish, Christian and Muslim women (Beigi et al., 2010; Callister et al., 1999; Khalaf and Callister, 1997).

A study was conducted in Australia by McLachlan and Waldenström (2005); they examined the childbirth experience of culturally diverse women (women born in Vietnam, Turkey and Australia). Three hundred women participated in the study (100 in each group) who had all given birth at the same hospital. Vietnamese women experienced labour pain as more painful but they used less pain relief. In spite of describing their overall birth experience as negative, they felt less anxious and more confident during labour and birth. Australian and Turkish women were similar in some aspects having anxiety and a sense of panic. In contrast to Vietnamese women, Australian women used more pain relief of all kinds, except for relaxation and breathing techniques, which were more often used by Turkish women. Turkish women described their experience as “wonderful, pleasant, or okay” and were more positive (92%), compared to 79% of Australian women. It was concluded that cultural background influenced the women’s response to childbirth (McLachlan and Waldenström, 2005). Indeed, Kangas-Saarela and Kangas-Kärki (1994)

found that their Nigerian study participants described their labour pain as severe and the majority of them would undertake measures to alleviate it.

It has been documented in the literature that labour pain is a universal element in every woman's childbirth experience regardless of her ethnicity. Nevertheless, the way she responds towards pain is, as above, to some extent influenced by her cultural and religious beliefs. Culturally diverse women described their labour pain differently. For some it was unbearable, terrifying, horrible, indescribable, and sweet pain. Other women accepted and tolerated it through relying on their religious faith, and others attempted different means to reduce the pain such as trust in their own ability to cope with the pain or in their midwives' ability (Nakano et al., 2011; Beigi et al., 2010; Abushaikha and Oweis, 2004; Lundgren and Dahlberg, 1998; Harrison, 1991).

2.4.6 Women's knowledge and attitude toward pain relief

Women during pregnancy have a right to essential knowledge and information about labour pain and its relief. The source of this information varies and it may come not only from antenatal classes but also from previous experiences, books, media/internet, friends and relatives and by asking questions of the clinic staff (James et al. 2012; Mugambe et al., 2007; Henry and Nand, 2004a). Unfortunately, the women who attend antenatal classes are often those who have knowledge about labour pain and its relief and they usually read books or gain information from other sources, while, others may not attend those classes and may remain less aware. It is important therefore that every short encounter in an antenatal clinic should be used as a means for informing those prospective mothers who remain unaware. It is essential that every woman should also be given a pamphlet with all the information about the choices and availability of pain relief. Otherwise, there is a

possibility that women may obtain information from individuals who lack reliable knowledge. Also it would be useless if a prospective mother was advised by health workers about the advantages of specific pain relief which was not available in their clinic or hospital (Russell et al., 1997). However, studies indicate that women could use a broad variety of coping strategies to alleviate their pain and anxiety during labour, even if they did not attend any antenatal training (Escott et al., 2004).

Henry and Nand (2004a) carried out a survey of 496 women who underwent labour in Australia and found that 98% of women received information regarding labour pain management during their antenatal period. Most women described themselves as “very” or “quite” knowledgeable towards their pain relief choices both antenatally and intrapartum. Women who had a higher educational level and low parity also accessed formal sources of information such as antenatal classes, midwife, and doctor. The more access to antenatal sources (three or more), the more epidural analgesia was used. The majority of the participants planned to use a specific or unspecific pain relief method, while only 14% planned to avoid any kind of pharmacological pain relief. It was also found that those women who had information about pain relief, were satisfied with their pain relief (Henry and Nand, 2004a).

Barakzai et al. (2010) conducted a study in Pakistan and reported that nearly two third (65.5%) of their study sample were aware of pain relief options, particularly injections, whereas few of them were knowledgeable about epidural analgesia. Capogna et al. (1996) found that women’s knowledge regarding epidural analgesia depended on the hospital, information received, education and social class.

Some concerns influence women's decisions regarding labour pain management. The most reported concerns were maternal and fetal side effects, efficiency of method, wanting natural birth, wanting to be in control and possible impact on the mother-baby bond (James et al., 2012; Mugambe et al., 2007; Henry and Nand, 2004a).

Several studies in South Africa and India documented that most of their study participants were knowledgeable about pain relief options during labour (James et al., 2012; Mugambe et al., 2007; Henry and Nand, 2004a). In addition, Raynes-Greenow et al. (2007) noticed that there was a huge inconsistency between participants' "perceived knowledge" and "actual knowledge" regarding intrapartum pain management.

In contrast, some studies in South Africa and Zimbabwe (Murira et al., 2010; Ibach et al., 2007) found that their study participants were poorly informed about the labour process and had little knowledge regarding available methods of pain relief. Some women reported that health professionals ignored their requests for analgesia and, if they responded, they were unable to offer them an effective pain relief. Nabukenya et al. (2015) also reported that the majority of Ugandan women did not have knowledge about labour analgesia and those who were aware of it, gained their knowledge from friends and families. Not surprisingly, the majority of them wanted labour analgesia for their future childbirth. Sadawarte and Bhure (2013) found that Indian women in rural part of central India were poorly educated about labour pain and had limited knowledge of measures available for labour pain relief.

Ampofo and Caine (2015) reported inadequate antenatal education on labour pain management in Ghana. In a cross-sectional descriptive study in Nigeria, it was documented that the knowledge of Nigerian pregnant women about non-pharmacological pain relief was limited (Anarado et al., 2015). Anarado et al. (2015) recommended that adequate

information on childbirth and labour pain relief should be given to pregnant women during their antenatal by nurses or midwives. Ibach et al. (2007) concluded that a thorough programme concerning the labour process and pain relief options, should be incorporated into antenatal education.

Miquelutti et al. (2013) conducted a qualitative study to assess labour experience of different groups of Brazilian women, those who participated in a systematic 'Birth preparation program' and those who did not. Miquelutti and colleagues report that those women who participated in the program documented that their self-control was maintained during labour and used different pain relieving strategies to manage the labour pain. In addition, these women stated their satisfaction with the birthing experience. In contrast, women who received routine antenatal care, reported that they lacked the control to overcome labour pain.

2.5 Justification of the study

As demonstrated in this chapter, there is a body of literature concerning women's labour and birth experience in western countries. Although some studies have been conducted in Middle Eastern countries, no studies have been found that explore women's experiences during labour and birth in Iraq generally and the Kurdistan region particularly. The study reported in this thesis aimed to address the gap in knowledge about Kurdish women's experience of labour and childbirth. By doing so not only will it deepen our understanding, it will provide implications that can be used in the clinical practice setting.

As a body of literature was found to examine women's labour and childbirth experience, and as the literature lacks Kurdish women's experience, it was of particular importance to study Kurdish women's labour and birth experience. A lot of literature in developing countries was found to identify women's knowledge and attitude towards pain relief, thus, this piece of research intends to specifically identify Kurdish women's awareness in this regard. In addition, exploring healthcare professionals' views with regard to the intrapartum care was another recurrent topic in the literature and as the literature lacks Kurdish healthcare professionals' perspectives, this led to considering exploration of their perspectives too.

Given the important insights obtained from the literature reviewed in this study, it is essential to state that the aims and objectives of the study were shaped by a consideration of this literature and thus the following aims and objectives were decided upon:

2.6 Aims and objectives

The main aims of the study are to:

- Assess Kurdish women's experiences of labour and childbirth.
- Identify awareness of labour pain relief of those women who went through labour and delivery in a general maternity (public) hospital in Erbil city.
- Identify women's desire or wish for pain relief.
- Discover the barriers that may prevent the management of pain during labour.
- Investigate the relationship between participant's perception or knowledge of labour pain relief and demographic variables.
- Identify clinical variables in childbirth process.

- Explore healthcare professionals' perspectives with regard to intrapartum care provision.

The main objectives of the study are to:

- Adopt and modify a questionnaire from previous studies to develop an appropriate tool to address the research aims.
- Select an appropriate setting (e.g. postpartum care units).
- Examine women's perceptions and their experiences and gather data on relevant variables (e.g. age, educational level, childbirth experience).

Chapter three: Methodology and methods

3.1 Introduction

Research methodology is the study of how research can be applied to a given problem in a reliable scientific manner. Whilst research methods certainly constitute a part of research methodology (Kumar, 2008), the scope of research methodology is far wider than that. In considering research methodology, researchers need to address any relevant concepts, theories and philosophical underpinnings of their research. They need to justify the logic behind using specific approaches in the context of their study and explain why a particular method is employed. It is important for the researchers to understand the research techniques/methods as well as the research methodology. It is also necessary that researchers need to identify how to develop specific tests and by what means apply certain research methods. Besides, they also have to be well-informed about other relevant and less relevant methods (Kothari, 2004).

This chapter provides details regarding both the methodology and methods to be applied in the present study. It begins with the philosophical framework underpinning the research follows by a brief description of methods that will be applied, with justification for using the specific design. Then, the sampling, setting, recruitment strategy and data analysis will be explained. Finally, the ethical issues surrounding planning and conducting the study will be described.

3.2 Philosophical framework

3.2.1 Quantitative/Qualitative debate

For more than a century, there have been long standing disputes and debates concerning the superiority of one or the other of two main research paradigms. These two paradigms are documented as “positivist/empiricist” and “constructivist/interpretivist”. The positivist paradigm underlies quantitative methods whereas the constructivist paradigm underlies qualitative methods. Consequently, the dispute between these two paradigms has sometimes been described as the quantitative/qualitative debate (Tashakkori and Teddlie, 1998). Those researchers who prefer the quantitative paradigm alone (quantitative purists) emphasise the importance of objectivity and generalisations, whilst qualitative purists refute the idea of positivism and claim the superiority of constructivism and idealism (Johnson and Onwuegbuzie, 2004).

Both quantitative and qualitative researchers view their paradigm as the ideal method for research studies and adhere to the “incompatibility thesis” (Howe, 1988), which postulates that the paradigms of both quantitative and qualitative research cannot and should not be mixed, since they each have a distinct philosophical point of view (Johnson and Onwuegbuzie, 2004).

Regardless of the main paradigmatic differences between quantitative and qualitative research, there are some connections and similarities between them. For instance, both paradigms attempt to answer the research question using empirical observation. Sechrest and Sidani (1995) state that both paradigms define their data and make arguments from their data. Additionally, both quantitative and qualitative researchers may attempt to

minimize bias and other sources that threaten the validity of every research study by using triangulation in their data (Onwuegbuzie and Leech, 2005).

3.2.2 Pragmatism

The philosophical assumption that supports the combination of those two approaches is called pragmatism (Doyle et al., 2009). Pragmatism opens the door for the mixed method researchers to use multiple means, diverse views, different assumptions, and different kinds of data collection as well as data analysis (Creswell, 2003).

The philosophy of pragmatism incorporates the concept of “what works” using different approaches. The research problem/question is the most important aspect rather than the methods. According to pragmatic perspectives, the focus is on the research problem and how it can be addressed. Researchers may utilise diverse methods to understand the research problem and to answer the research questions (Creswell, 2003). Pragmatic researchers argue that the outcomes are more important than the method or the process, hence the “end justifies the means” (Johnson and Onwuegbuzie, 2004).

Pragmatism has been identified as the most suitable paradigm for mixed methods research due to its attention to answering research questions by using pluralistic approaches to obtain better understanding and enough knowledge to elucidate the research problem (Tashakkori and Teddlie, 1998). Pragmatic viewpoints can offer researchers many personal advantages. First and most importantly is that it allows researchers to be flexible in their investigative techniques, as they try to solve various problems in the study. Regardless of individual researchers’ philosophical orientation, pragmatic researchers are most likely to promote cooperation among them (Onwuegbuzie and Leech, 2005).

Creswell (2003) states that pragmatism is not overcommitted to a specific philosophy. Pragmatic researchers have freedom to select the methods and procedures of their research that are able to answer the research questions, in order to achieve their purposes. Pragmatism does not aim to resolve the epistemological differences between the positivist and constructivist paradigms but it attempts to use a philosophy that fits positivist and constructivist insights together to gain a practical solution (Johnson and Onwuegbuzie, 2004).

3.3 Mixed methods research

Mixed-method research designs aim to bind together the strengths of both quantitative and qualitative data, while minimising the weaknesses associated with each approach. The recent history of mixed-method designs in 20th century social and human sciences began with researchers who considered that both the qualitative and quantitative epistemological paradigms had strengths and weaknesses with regard to their research questions. Thus they sought to use the two approaches complementarily (Johnson et al., 2007). Creswell et al. (2003) defined mixed methods study thus:

“A mixed methods study involves the collection or analysis of both quantitative and/or qualitative data in a single study in which the data are collected concurrently or sequentially, are given a priority, and involve the integration of the data at one or more stages in the process of research” (p.209).

The general advantage of using mixed-method designs in a study is that it permits the researcher to generate a more comprehensive understanding than that which could be gained from the use of either single method design (Carr, 2009). In addition, Greene’s

(1989) review of the theory and practice of mixed method evaluation generated the following purposes of mixed method design: ‘triangulation’, ‘complementarity’, ‘development’, ‘initiation’, and ‘expansion’ (Greene et al., 1989). Furthermore, the use of mixed-method designs in a nursing research context has been well demonstrated in many studies. Recently, the combination of quantitative and qualitative design has become increasingly common among social and health researchers, as evidenced by the volume of mixed-method papers, studies, and books published (Carr, 2009).

This study adopted a mixed methods research design. It was documented by some researchers that mixed methods enable them to bridge the gap between both quantitative and qualitative paradigms.

3.3.1 Rationale for mixed methods research adoption

Due to lack of evidence currently available, the initial phase of this study involved gathering information on Kurdish women’s views and attitudes regarding labour pain, childbirth, and pain relief. This can be obtained by multifarious methods, but in this case the most appropriate method for collecting a representative dataset was by using a questionnaire survey. This was designed to allow the efficient and effective gathering of a large volume of mainly quantitative information on the subject of interest. Analysis of this survey data allowed an overall picture of the women’s views and attitudes to be generated. The results of the questionnaire survey helped to inform the questions that were asked as part of the interviews.

Despite the advantages associated with using a questionnaire survey in the study, it would not by itself generate a great deal of fine detail nor provide comprehensive information

(Polit and Beck, 2006) regarding the women's perspectives. In addition, some of the research aims would not be achieved by using a questionnaire survey only. To enrich the data and answer the research aims more accurately and in greater detail, this research was designed to include a series of semi-structured in-depth interviews with a group of women who had already participated in the questionnaire survey.

Furthermore, as this study also aimed to explore the healthcare professionals' perspectives about childbirth care, several semi-structured qualitative interviews were conducted with selected representatives of the healthcare staff. It is important to note that the women interviewed in the study raised concern about some aspects of their childbirth care which were related to healthcare professionals (either professional, clinical or social aspects). Thus, examining the perspectives of healthcare professionals played an important role in enriching this study and enhancing the overall scope with regard to the subject of interest.

3.3.2 Mixed methods designs

After selecting mixed methods research as an overall framework for this study, the next stage was to determine the specific design most appropriate to the research problem. Research designs are a system of gathering, analysing, interpreting and reporting the data (Creswell, 2003). According to Creswell and Clark (2011), there are four decisions to be made prior to the selection of an appropriate mixed methods design in a study: 1) the interaction level between quantitative and qualitative methods, 2) the priority of the strands (*i.e.*, relative importance or weighting), 3) the timing (implementation) of quantitative and qualitative methods, and 4) the procedures for mixing both designs. Table 3.1 illustrates the different designs of mixed methods research.

Table 3.1 Mixed methods designs

Designs	Characteristics (Priority)	Interaction	Timing	Mixing
Convergent	Concurrent quantitative and qualitative data collection, separate analysis, and then merging the two data set	Independent	Equal emphasis	Interpretation
Explanatory	Sequentially implemented methods starting with quantitative data collection and analysis then followed by a qualitative phase	Interactive	Quantitative emphasis	Data collection
Exploratory	Sequentially implemented methods starting with qualitative data collection and analysis then followed by quantitative phase	Interactive	Qualitative emphasis	Data collection
Embedded	Either the concurrent or sequential collection of supporting data with separate data analysis (using qualitative data set within quantitative design or vice versa)	Interactive	Either quantitative or qualitative emphasis	Design level
Transformative	Concurrent or sequential data collection and analysis of quantitative and qualitative data sets within a theoretical framework	Interactive	Equal, quantitative, or qualitative emphasis	Design level
Multiphase	Merging the concurrent and/or sequential collection of quantitative and qualitative data sets over multiple phases in a study	Interactive	Equal emphasis	Design level

Adapted from (Creswell and Clark, 2011)

In this study, the explanatory sequential mixed methods design (see Fig. 3.1) was adopted. As mentioned in the above table, the first phase began with the collection and analysis of the quantitative data. The second phase (qualitative) was informed by and followed the

results of the quantitative phase. It also allowed the quantitative data to be explored and explained in more detail (Creswell, 2003; Creswell and Clark, 2011).

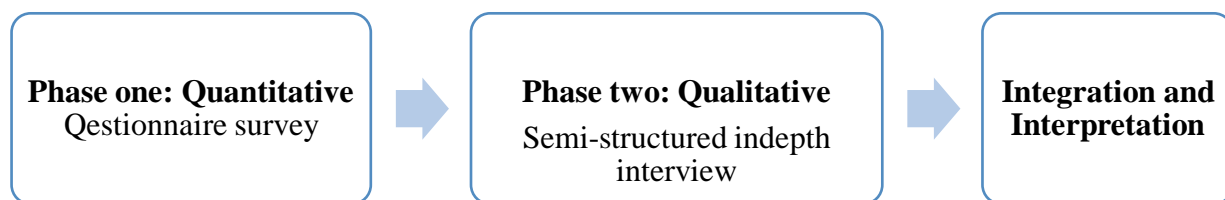


Fig. 3.1 Explanatory sequential mixed methods design, adapted from (Creswell, 2003)

3.4 Setting

In each of the four governorates of Kurdistan region/Iraq there is one governmental hospital that provides maternity services. There is similarity among these hospitals in terms of the design of the buildings, the number of medical and nursing/midwifery personnel and the provision and availability of medical equipment. For instance, all hospitals provide the same care to labouring women including pain relief options. In addition, the values and beliefs of women in Iraqi Kurdistan towards pregnancy and childbirth is the same across the four governorates. The data that would be obtained in one governorate is comparable to others. Thus, this study was conducted in a major maternity hospital in Erbil governorate which is a public hospital for maternity cases. Apart from wards designated for gynaecological and obstetric cases, it consists of two functional units which provide care for labouring women (delivery ward and postpartum care unit). The questionnaire study was conducted in the postpartum care unit, as women referred there after giving birth are in a more stable condition and better able to reply to the researcher's questions. It would be unethical to attempt consent and data gathering during labour.

3.5 Population and sample

The population of a study denotes the entire target population that meet the inclusion and exclusion criteria defining the study sample (Polit and Beck, 2006). In this study, the population comprised women who were admitted to the hospital because they were in labour and who subsequently gave birth. Usually women tend to remain at hospital for eight hours or a full day after childbirth. The study sample of women comprised those who speak Kurdish regardless of their ethnicity due to the fact that there are other ethnic minorities living in Iraqi Kurdistan. The sampling frame of healthcare professionals comprised those staff who work in the delivery unit.

3.6 Methods of data collection

Research methods can be described as all those techniques or methods that are used to collect data and conduct research (Kothari, 2004). This study involved two phases: the quantitative phase and the qualitative phase. These phases will be described in detail separately in the following sections.

3.7 Quantitative phase

3.7.1 Survey

There was an existing questionnaire that had been used to address the issues of childbirth experience elsewhere, originally developed by Dencker et al. (2010). The survey used here was based on this questionnaire, the ‘Childbirth Experience Questionnaire’ (CEQ) with some modifications. Prior commencing the questionnaire survey, the primary author of CEQ was contacted in order to obtain permission for using the questionnaire as one of the tools for data collection in the current study. It is important to state that the approval has

been obtained. Hence, CEQ has been used as a tool for generating a quantitative data on women who have recently undergone labour and birth at the time of data collection period.

There are several existing tools for assessing women's experiences of labour and birth but they mainly focus on one aspect of childbirth experience. For instance, the Wijma Delivery Expectancy/Experience Questionnaire, the Childbirth Self-efficacy Inventory and the Labour Agency Scale measure fear of childbirth, self-efficacy and coping during childbirth and perceived personal control, respectively (Wijma et al., 1998; Lowe, 1993; Hodnett and Simmons-Tropea, 1987). The rationale for adopting the CEQ was due to its multidimensionality and easy structure. In addition, the CEQ comprised of items and domains that were resultant from interviews with patients, and discussions among midwives and other staff members, and also pilot tested on a number of women (primiparas).

In order to investigate the research aims fully, a limited number of modifications were therefore applied to the questionnaire (see Appendix A for the questionnaire). The issues of the validity and reliability of the study tool were determined by conducting a pilot study.

The questionnaire consisted of four parts:

1. Participant characteristics and demographic information.
2. Information from women's clinical records such as mode of delivery, induction used or not.
3. Questions related to the women's perception of labour pain and their personal birth experience.
4. Questions related to the women's information of, desire for and availability of pain relief.

The CEQ comprises 22 statements regarding the childbirth experience holistically including 4 Visual Analogue Scale (VAS) items. These statements were categorised into four domains which enable researchers to assess the four areas of childbirth experience. These domains were defined as follows: own capacity (8 items), professional support (5 items), perceived safety (6 items) and participation (3 items) (See Appendix B).

One statement (“I felt I could have a say in the choice of pain relief”) was removed and replaced by a statement of a women’s choice to eat or drink (“I felt I could have a say whether I could eat or drink”). The reason behind removing the original item was that I was already aware, from my professional experience, that there are limited pain relief options available. Thus, women have no choice with this regard. The expression of “My midwife” was altered to “the midwife/staff” due to the fact that the childbirth care is provided by different categories of staff. Even if the care was provided by the same category of staff, it would not have been one particular staff member.

The researcher conducted the survey verbally in the Kurdish language. For that reason, the questionnaire was translated into Kurdish with assistance of another bilingual Kurdish speaker, carrying out back-translation in order to ensure consistency of the questionnaire form. This helped ensure that identically worded questions were asked of each questionnaire respondent.

The response style/format for the questions (apart from VAS) is recorded in a 4-point Likert scale. The scale ranged from “Totally Agree” to “Totally Disagree”. These 4 response options were coded as follows:

- Totally Agree= 4
- Mostly Agree=3

- Mostly Disagree=2
- Totally Disagree=1

Regarding the VAS questions (ranging from 0-100), the scores were converted to categorical values and the coding was recorded as shown in Table 3.2.

Table 3.2 Scheme for categorisation of VAS scores

VAS score	Categorical value	Representing
0-40	1	Totally Disagree
41-60	2	Mostly Disagree
61-80	3	Mostly Agree
81-100	4	Totally Agree

(after Dencker et al., 2010)

The VAS scores were also categorised in equal intervals (*i.e.*, 0-25, 26-50, 51-75, 76-100) in order to check whether this produced any difference in interpretation of the answers. The data showed no significant differences; therefore the original format was preserved to promote compatibility of interpretation between datasets.

In order to generate data on participants' socio-demographic and clinical information, questions related to participants' demographic and clinical information were added. In addition, as the intention was to assess the women's awareness of, desire and wishes for pain relief options, questions entailing these aspects were also added.

3.7.2 Pilot study

A pilot study enables researchers to observe whether the entire recruitment process works or may basically involve testing a tool for data collection (Gerrish and Lacey, 2010). To

check the feasibility and the clarity of the study tool, it is advisable to conduct a pilot study prior to conducting research (Polit and Beck, 2006).

A pilot study is usually conducted on a small sample of participants with similar characteristics to those in the study. The aim of conducting a pilot study is to identify questions that are vague and usually misinterpreted as well as picking those questions that are often missed out. Modifications can then be made to the study tool to avoid wasting money and time (Gerrish and Lacey, 2010). Parahoo (2014) state that

“the first and most efficient way to find out the quality of a questionnaire is to test or ‘pilot’ it. The responses will give the researcher a fair idea of whether all the respondents understand the questions in the same way, whether the format of the questions is the most suitable for this population, whether they understand the instruction and how relevant the questions are. She can also find out whether the length of the questionnaire and its structure are likely to affect the responses” (p.302).

In this study, a pilot was conducted prior to conducting the research. A pilot sample should be similar to the actual study sample (Parahoo, 2014). Therefore, a pilot was carried out on a convenience sample consisting of 15 women who gave birth recently in the aforementioned hospital.

It is important to note that the purpose of conducting a pilot study prior to undertaking the main study was to assess the recruitment approach, whether it was realistic and workable or not. It also served to check the clarity and feasibility of the study tool and to assess the time required for the questionnaire to be completed.

No modifications were required to be made to the questions as the respondents had no comments on the wording or phrasing of the questions. On the whole, the approach used to collect the data on the subject of interest noticed to be feasible and applicable. Additionally, no one commented on the length of the interviews, in fact they were thankful for the opportunity to have their voice heard concerning their labour and childbirth experiences. However, it is important to note that there were some instances where the respondents required more explanation about the VAS questions. For that reason, a simple example was first demonstrated in front of them and they were shown how to respond to such questions.

3.7.3 Quantitative sampling and sample size

There are two main types of sample documented in the literature and these are probability and non-probability (LoBiondo-Wood and Haber, 2014; Parahoo, 2014; Gerrish and Lacey, 2010). The key characteristic of a probability sampling is that the cases are randomly selected from the target population. There are different types of probability sample and these are reported as simple random sample, stratified random sample, systematic random sample, and cluster random sample. However, in non-probability sampling the cases are not randomly selected and the qualitative researchers often use this type of sampling which contribute to more in depth understanding of phenomena of interest. The non-probability sampling includes purposive sampling, theoretical sampling, snowball sampling and quota sampling (Parahoo, 2014; Gerrish and Lacey, 2010).

Several authors highlighted that there are some types of sampling strategies that are used in both quantitative and qualitative research. Convenience sampling is one of the sampling types that is reported to be frequently used in quantitative and qualitative studies (Parahoo, 2014; Gerrish and Lacey, 2010).

Parahoo (2014) states that *“Although probability samples are likely to be more representative than non-probability sample, representativeness is not necessarily assured with random selection. The decision on which form of random sampling to use depends on, among other things, the availability of lists, the composition of the population and the research questions. Whatever the sampling methods, these must be described in enough detail for you to decide whether the sample has any bias. Just stating that a random or a convenience sample was drawn, without explaining how, is not helpful”* (p.277).

The sampling strategy used for the purpose of survey conduction in the current study was convenience sampling. In convenience sampling the cases that are selected to be included in the sample are those who are accessible (Gerrish and Lacey, 2010). The rationale for choosing a convenience sample was based on several factors such as time constraints and easy accessibility.

One of the criticisms of this type of sampling is that convenience sampling tends to generate a less representative sample. However, LoBiondo-Wood and Haber (2014) claim that *“when a non-probability sample is carefully chosen to reflect the target population through the careful use of inclusion and exclusion criteria and adequate sample size, you can have more confidence in the sample’s representativeness and the external validity of the findings”* (p.236).

Therefore, careful consideration was given to generating a representative sample by using the inclusion and exclusion sampling criteria (see Table 3.3), taking participants from different times of the day (morning and afternoon and even cases who have given birth at night participated in the study as they had to stay for the next morning) and taking an adequate sample size.

The sample size was calculated using an online sample size calculator tool from Creative Research Systems (<http://www.surveysystem.com/sscalc.htm>) as referred by Parahoo (2014). The total population of women who had given birth in the hospital during the data collection period was 3043. For a 95% confidence level and confidence interval of six, the required sample size was calculated as 245. However, the total number of women who actually participated in the questionnaire survey was slightly in excess of this at 256.

In order to generate a representative sample, both primiparous and multiparous women were included from different age groups, educational levels, ethnicity and socio-economic status. Women who gave birth surgically such as by caesarean section were excluded from the study because their labour and birth experiences are different from those who delivered vaginally. The inclusion and exclusion criteria are listed in Table 3.3:

Table 3.3 Inclusion and exclusion criteria of the study sample

Inclusion criteria	Exclusion criteria
<ul style="list-style-type: none"> • Women who gave birth vaginally (<i>i.e.</i>, vaginal delivery, with or without episiotomy) (forceps delivery if any) 	<ul style="list-style-type: none"> • Women with chronic diseases such as diabetes mellitus or gestational diabetes, hypertension, heart diseases.
<ul style="list-style-type: none"> • Full-term delivery including inductions 	<ul style="list-style-type: none"> • Women with postpartum complication
<ul style="list-style-type: none"> • Those women who gave birth to a live and healthy neonate 	<ul style="list-style-type: none"> • Caesarean section deliveries
<ul style="list-style-type: none"> • Primiparous or multiparous 	<ul style="list-style-type: none"> • Women who gave birth to stillborn or anomalous neonates
<ul style="list-style-type: none"> • Women who speak Kurdish 	<ul style="list-style-type: none"> • Women who do not speak Kurdish

Those women who were available during the data collection period, met the inclusion criteria and consented to take part in the survey were included in the study. The sample comprised of 256 women who had recently given birth at the time of the survey.

3.7.4 Survey recruitment and administration

The researcher filled in the questionnaire as the participants replied, because it was anticipated that some of the participants would be unable to read and write (due to high levels of illiteracy in the region). When the researcher contacted the potential participants face to face, she introduced herself; explained the purpose of the study and responded to their questions. The potential participants were asked to take part in the study if they were willing to. The participant information sheet and informed consent process were considered and will be explained in the ethics section.

At the completion of the questionnaire, the participants were thanked for their time and their participation in the study. In addition, those participants who were willing to be approached to take part in the follow-up interview were asked to provide their contact details. Surprisingly, due to the physical and emotional tiredness expected to accompany childbirth, many women accepted the invitation to take part in the survey and were happy to talk about their childbirth and answer questions. Staff members leaving women unattended could be one possible reason for women consenting to participate when approached by a non-staff member. Another reason might be because local women have been exposed to research interviews previously as the hospital is a public hospital and patients are often exposed to research studies from different health fields. Another reason is that they might want to share their experiences to help future cohorts of labouring women.

It is important to note that only a limited number of women rejected the invitation to participate in the study (22 women), giving the remarkably high acceptance rate of 91.5%.

3.8 Qualitative phase

3.8.1 Semi-structured interview

Qualitative data can be collected by different means such as semi-structured interviews, focused interview and observations. One of the main and widely used methods is the semi-structured interview (Creswell, 2003). With in-depth interviewing, the point is to offer participants the opportunity to describe their understandings and experiences in their own words (Treacy and Hyde, 1999). This type of interview was chosen to enable more in-depth and comprehensive interviewing of postnatal mothers. The interviews of the women were conducted in the Kurdish language spoken by the majority of people in Iraqi Kurdistan. The interviews of the healthcare professionals were also conducted in Kurdish (apart from one which was conducted in English); however, some technical words and medical terminologies were spoken in English. All the interviews were audio-recorded after obtaining participants' permission.

Semi-structured interviews were guided by open ended questions that were generated after analysis of the results of the quantitative survey. The interview guides for different categories of participants are included in the Appendix section (see Appendices C1-4).

3.8.2 Qualitative sampling and recruitment

A purposive sampling strategy was used to recruit participants for the qualitative interviews. Purposive sampling is the most common type of sampling in qualitative studies (LoBiondo-Wood and Haber, 2014). This type of sampling is characterised by purposely

selecting participants from a pre-specified group (Gerrish and Lacey, 2010). Participants were selected purposively (those who had already participated in the questionnaire survey) based on their different characteristics (age, parity, education, aware or not aware of pain relief, satisfied or not satisfied with their experience).

For healthcare professionals, the purposive sampling was based on their years of working/experience and different categories (midwives, nurses and doctors). Based on observations made during the data collection period, the characteristics of the healthcare professionals working in the hospital were clarified: for example, the different categories of staff (nurses/midwives and doctors); those with experience in the field compared to those who were young and had recently arrived in the unit. This enabled recruitment of a sample representative of the total population. Recruiting participants based on these characteristics facilitated the exploration of all aspects of childbirth experience and care.

In any qualitative study, sample size is related to the issue of data saturation. Inclusion of participants was therefore continued until the data reached saturation, when no new information was discovered during the interview collection phase (*i.e.*, I have noticed that the women were saying very similar things, thus no new data were emerging) (Polit and Beck, 2013).

The in-depth interviews with women were conducted after the completion of the survey and preliminary analysis of the questionnaire (within two months) to allow mature reflection on behalf of the participants. The face-to-face interviews were conducted in a private room at the hospital in order to enable the freedom of expression and comfort of participants. In Iraqi Kurdistan hospitals, there are rooms which are usually used by the nurses or midwives of that unit. Thus, after obtaining the permission from the director,

these rooms were used for the purpose of conducting the interviews with the women and healthcare professionals. The information and background of the participants (women and healthcare professionals) will be illustrated in the beginning of qualitative sections (4.3 and 4.4) in order to aid the reader easily link the data of a specific participant with their background and relate who had particular views or perspectives.

Prior to beginning the interview, the participant information sheet was explained and considered and a completed consent form was obtained from all the categories of participants (including women who had previously consented for the survey). The time of the interviews was arranged depending on the interviewees' preference and convenience. The estimated time of each interview relied on the proposed number of questions and amount of data to be gathered. The duration of the interviews varied, ranging from 40-55 minutes. However, the interview duration with doctors was much shorter compared to the interview duration of women and other healthcare professionals (lasting 20-30 minutes). Despite this, rich data were collected.

As a researcher, I remained conscious of the need to be reflective throughout the interview process since preconceptions of participants regarding me (gender, age, nationality, and professional background) could affect the quality of data being gathered. I had to be cautious about how my thoughts and background could affect the quality of data. Thus, as I explained the aims of the study in detail, I also explained to participants that I was not an employee of the hospital, in order to avoid any bias that may change their responses. In addition, I emphasised that I was keen to listen to their experience and their concerns about both negative and positive parts of their experience. Indeed, this influenced the interview and helped the women to speak more than they would have with someone else.

I was also aware that my role as a healthcare professional could influence the data being gathered. Therefore, I had to maintain a neutral stance about the area being studied in order to avoid any distortion of the participants' responses. In some instances, I had to use the follow-up questions during the interviews to motivate the participants to speak but I refrained from expressing personal opinions and views on the subject. Examples for the follow-up questions that were asked during the interviews include: "what do you mean by ...?"; "Could you tell me more about that?"; "Can you give me an example?"; "Why is that important to you?". I also had to focus on what the participants were saying during the interviews in order to avoid missing or ignoring vital data. Audio-recording the interviews enabled me to listen to the participants' responses carefully, ensuring that no essential data was left out or ignored.

3.8.3 Challenges for the qualitative interview recruitment

It should be noted that despite the fact that many participants in the quantitative survey were interested to take part in the qualitative interviews, some difficulties were encountered in getting in touch with those women thought most likely to be informative (*i.e.*, those who had a distinct response to the quantitative questions, women who had no schooling education and those who lived in rural areas). During the questionnaire survey women were asked whether they would like to participate in the subsequent qualitative interviews. For those who were interested in taking part, their contact telephone numbers were obtained. When recruitment for the qualitative interviews commenced, their numbers were called but in several cases it was not possible to make contact (due to phones being switched off, not being answered or technical issues with the service). Some of those successfully contacted were unfortunately not able to participate. This was due to some issues related to family

obligations; e.g. having no one to look after their children, or the disapproval of husbands. Other reasons encountered included difficulties in accessing them due to distant locations and transportation issues and cost being involved. Thus, some important categories of women were not included, for example, women who had no schooling were not included in the qualitative interviews.

The audio-recording of interviews had to be stopped in several instances, particularly when interviewing those women who brought their babies with them. These were either due to feeding their baby or trying to calm them down once they cried. Afterwards the audio recording was resumed. Despite these interruptions, detailed in-depth information was obtained.

3.9 Data analysis in mixed methods research

Creswell and Clark (2011) argue that in mixed methods research, data analysis “*consists of analysing separately the quantitative data using quantitative methods and the qualitative data using qualitative methods*” (p.203) and then combining and analysing both sets of data together (Creswell and Clark, 2011; Andrew and Halcomb, 2009). After analysing the quantitative data, the intention was to recruit those participants who were typical or representative of a different group, as well as those who ‘scored at extreme levels outside the norm’ to enhance our understanding on why they have scored like that for qualitative interviews (Creswell and Clark, 2011).

The following sections explain the data analysis techniques in detail.

3.9.1 Quantitative data

The data were analysed by using the Statistical Package for Social Sciences (SPSS) Version 21, through applying descriptive (proportions and percentages) and inferential statistics (e.g., Chi-squared test and Regression). According to the nature of variables, different inferential statistics were applied.

In order to know how the women experienced their labour and birth for a particular aspect being examined in the survey, the questions related to the women's general labour and birth experience, were divided into two responses by combining positive responses together (Totally Agree + Mostly Agree) and combining negative responses together (Totally Disagree + Mostly Disagree). Then, responses were categorised into: positive experience and negative experience. Some responses needed to be reversed for the negatively worded statements such as "I felt scared during labour and birth".

After cautious considerations, the General Linear Model (GLM) was applied to find the associations between different domains of childbirth (Own Capacity, Professional Support, Perceived Safety, and Participation) and some selected demographic variables.

The demographic variables of interest were antenatal visits (yes/no), educational level (no schooling, schooling, degree level), home area (urban, sub-urban, rural) parity (primipara, multipara) and age.

The childbirth domains were continuous variables and were selected as dependant variables. The other demographic variables were considered as independent variables. It is important to note that some variables such as education level and parity were re-coded in order to aid easier interpretation of the result.

In addition, the assumptions for using GLM were checked prior to adopting it in analysing the associations between the dependent and independent variables. All the assumptions were met. The main key assumptions for regression are:

1. Linear relationships.
2. Residuals are independent.
3. Residuals are normally distributed.
4. Variance of residuals does not differ by predicted values (homoscedasticity).

The associations between the women's level of awareness regarding labour pain relief and selected variables (similar to the GLM), were sought by processing Logistic Regression. This is due to the fact that the dependent variable was a binary variable (whether women are aware or not). It is also necessary to mention that the assumptions (independence of residuals and linearity of logit function) were checked before applying the test and were met.

3.9.2 Qualitative data

The data that results from a qualitative enquiry provide descriptive information of the subject being studied. It is the researcher's responsibility to provide a clear picture of the data that have been collected and make sense of them by making inferences (Burnard et al., 2008).

There are several computer software programmes available for qualitative data analysis such as ATLAS.ti. and NVivo. These software packages facilitate the management and organisation of a huge amount of qualitative data but they do not analyse the data (Burnard et al., 2008). However, despite the availability of such programmes, I decided to analyse

the qualitative data manually due to several reasons (besides Microsoft word, post-it-notes was used). The main reason was that analysing the data manually provided more opportunities to develop familiarity with the data. Another reason was that I did not have previous experience with such programmes and it was thought to be time consuming as it needed time to become familiar with the software and use it effectively.

Based on different ontological and epistemological stances, there are diverse qualitative methods available and thus different approaches for qualitative data management and analysis exist. Framework approach is one of the methods of data management that is increasingly used among researchers of healthcare field (Gale et al., 2013; Smith and Firth, 2011) such as in nursing (Ward et al., 2013) and midwifery (Furber, 2010).

The framework approach is a method of data analysis and was developed by social policy researchers in the UK in the 1980s (Ritchie et al., 2014; Ward et al., 2013; Smith and Firth, 2011). Spencer et al. (2014) defines framework approach as

“an analytic tool that support key steps in the data management process, including the indexing and sorting tasks common across many different approaches, but adds one further steps, namely data summary and display. Its name comes from the thematic framework which is used to organise data: each study has its own framework comprising a set of descriptive themes, subdivided by a succession of related subthemes, which are identified through familiarisation with the original material” (Ritchie et al. 2014, p.283).

The framework analysis shares many similarities with thematic analysis in terms of the stages, especially the initial steps when significant and recurrent themes are identified.

Spencer et al. (2014) outline that the last stage linked to 'framework' where a framework matrix is constructed.

The current study employed the framework analysis approach as a method for qualitative data analysis. Several studies highlighted the advantages of this framework. For instance, Ritchie and Lewis, (2003) state that this approach empowers researchers to explore the data more in depth and systematically, at the same time, maintaining transparency on how the data are analysed and how themes are developed. This promotes the rigour of the process of data analysis and ultimately the credibility of the findings (Ritchie and Lewis, 2003).

As mentioned earlier, my characteristics such as gender, age, nationality, professional background could influence the data being collected, here also it is worth mentioning that these characteristics could influence the data analysis and the sense that I made of the data. As an Iraqi Kurd woman, I shared understandings about the subject matter with the women in this study. In order to avoid any preconceived opinion about the area being studied, I had to be cognisant of these factors throughout the data analysis. I supported the interpretations and inferences I made by evidence (*i.e.*, participants' quotations) ensuring such characteristics did not influence the data analysis. However, a complete avoidance of preconceived ideas is impossible therefore my interpretation of the data might have been influenced by my own subject position (as a woman, from the same cultural background, and of a similar age).

Ward et al. (2013) claim that this approach can be beneficial for novice qualitative researchers as the practiced researchers are supporting them. They further mention that "*it provides a clear track of how data moved from interview to transcripts to themes, with summaries in charts enabling researchers to discuss ideas*" (Ward et al. 2013, p.2425).

Ward et al. (2013, p.2426-8) described the process of the framework analysis as follows:

- “Stage 1 familiarization – through immersion in the data”

Framework analysis approach was initiated by becoming familiar with the entire interviews using the audio-recordings and transcripts. This is an important stage in the data analysis and interpretation (Spencer et al., 2014; Gale et al., 2013). In the current study, all interviews were audio-recorded, for this purpose a digital device was used. The interviews were conducted in Kurdish language (the issue of translation will be considered later).

Conducting the interviews in person facilitates the researcher in becoming more immersed in the data (Ward et al., 2013). All the audio-recordings in this study were listened to, then, all the interviews were transcribed verbatim and each participant/transcript was given a fictitious name to be used for quotations. The main aim for doing this was to protect the participants’ anonymity.

The process of transcription is documented to be an important way to be immersed in the data (Gale et al., 2013). After transcribing all the interviews, all the transcripts were studied and considered. This ensured that no data was left over-looked or missed out (Ward et al., 2013).

After immersion in the data and becoming familiarised, by reading the transcripts repeatedly it was possible to start to label those sentences or passages thought to be important. This process is called coding and these labels or paraphrases form the ‘code’.

Codes could refer to ‘substantive things’ such as specific behaviour, incidents, views, beliefs and emotions (Gale et al., 2013). The below figure is an example of the coding.

	Codes
59. P: One of the worst aspects to me was when the baby was about to deliver,	- Crowded ward
60. it was very uncomfortable; there were no vacant beds to lie down.	
61. It was very, very unpleasant.	- No available bed:
62. Even my mom (she was with me) told the staff members to find a place for me.	unpleasant experience
63. They were searching all over the rooms and all of the rooms were full of patients.	
64. There were no any vacant places to sit and give birth.	
65. That was very, very unpleasant indeed.	

Fig. 3.2 Coding example

Coding the data was carried out by exploring the transcripts thoroughly and by using ‘line-by-line’ technique (Gale et al., 2013).

- “Stage 2 developing a theoretical framework by identifying recurrent and important themes”

Gale and Colleagues suggest that *“after coding the first few transcripts, all researchers involved should meet to compare the labels they have applied and agree on a set of codes to apply to all subsequent transcripts. Coding can be grouped together into categories..., which are then clearly defined”* (Gale et al., 2013, p.4).

It is important to note that a small set of interviews were selected and translated into English in their entirety to allow a demonstration of the analytical approach’s validity. The translation was carried out by the researcher. Another bilingual person who is competent in both Kurdish and English languages checked the accuracy of the translation in order to

enhance the validity of the translation. The intention was to maintain the original meaning of the translated interviews as close as possible.

The translated transcripts were then sent to the research supervisory team and were analysed separately by both the researcher and two research supervisors. Afterwards, we discussed the analysis together. This was intended to ensure that the analytical process was conducted effectively. Similar coding was created by both, my research supervisors and I. This initial analysis improved the rigour and consistency of the data analysis process.

In addition, throughout this stage notes were made regarding any patterns that were emerging in the data and how these might be linked. Several headings (themes), supported by more detailed subthemes, were identified. After discussing the codes and recurrent categories, the researcher with her supervisory team reviewed a list of topics which had emerged from the data, in order to develop an initial framework for organising and managing the data (Spencer et al., 2014). The development of the framework was aided by using small 'Post-it' notes in order to sort and resort the data until a clear structure emerged (Spencer et al., 2014), see Appendix E for the initial framework.

- "Stage 3 indexing and pilot charting"

This phase began by applying the initial framework (that developed in the earlier stage of data analysis) to the remaining transcripts. Spencer et al. (2014) state that "*indexing simply shows which themes or subthemes is being mentioned or referred to within a particular section of the data, in much the same way that a subject index at the back of a book works*" (p.300).

This was carried out by reading each phrase, sentence and paragraph of transcripts in more detail and deciding ‘what is this about?’ in order to identify which parts of the framework apply (Spencer et al., 2014) (See Appendix D a transcript with codes).

Then, post-it-notes were used to index each related theme and sub-themes. This process allows the researcher to be further immersed in the data; promoting the refinement of the emergent themes and subthemes (Ward et al., 2013).

- “Stage 4 summarizing data in analytical framework”

The summarising stage allows researchers to reduce the data into understandable brief summaries of what participants had said (Ward et al., 2013).

Ultimately, the materials were reduced into brief summaries for each participant corresponding to a particular theme or subtheme. This allowed sense to be made of the data without referring back to the original context frequently. This was presented in a matrix using Microsoft Word. See Appendix F for the data matrix.

- “Stage 5 synthesizing data by mapping and interpreting”

Smith and Firth (2011) report that the development of the final conceptual framework requires an iterative forward-backward movement within and between the data. In this stage, themes and subthemes were compared and checked against the original texts in order to make sure that an appropriate context was presented (Ward et al., 2013). This approach enhances the transparency and rigour of the data analysis process.

This process allowed the refinement of the themes and subthemes and the final conceptual framework to be formulated (see the conceptual framework in the next chapter, Fig. 4.3 and Fig. 4.4).

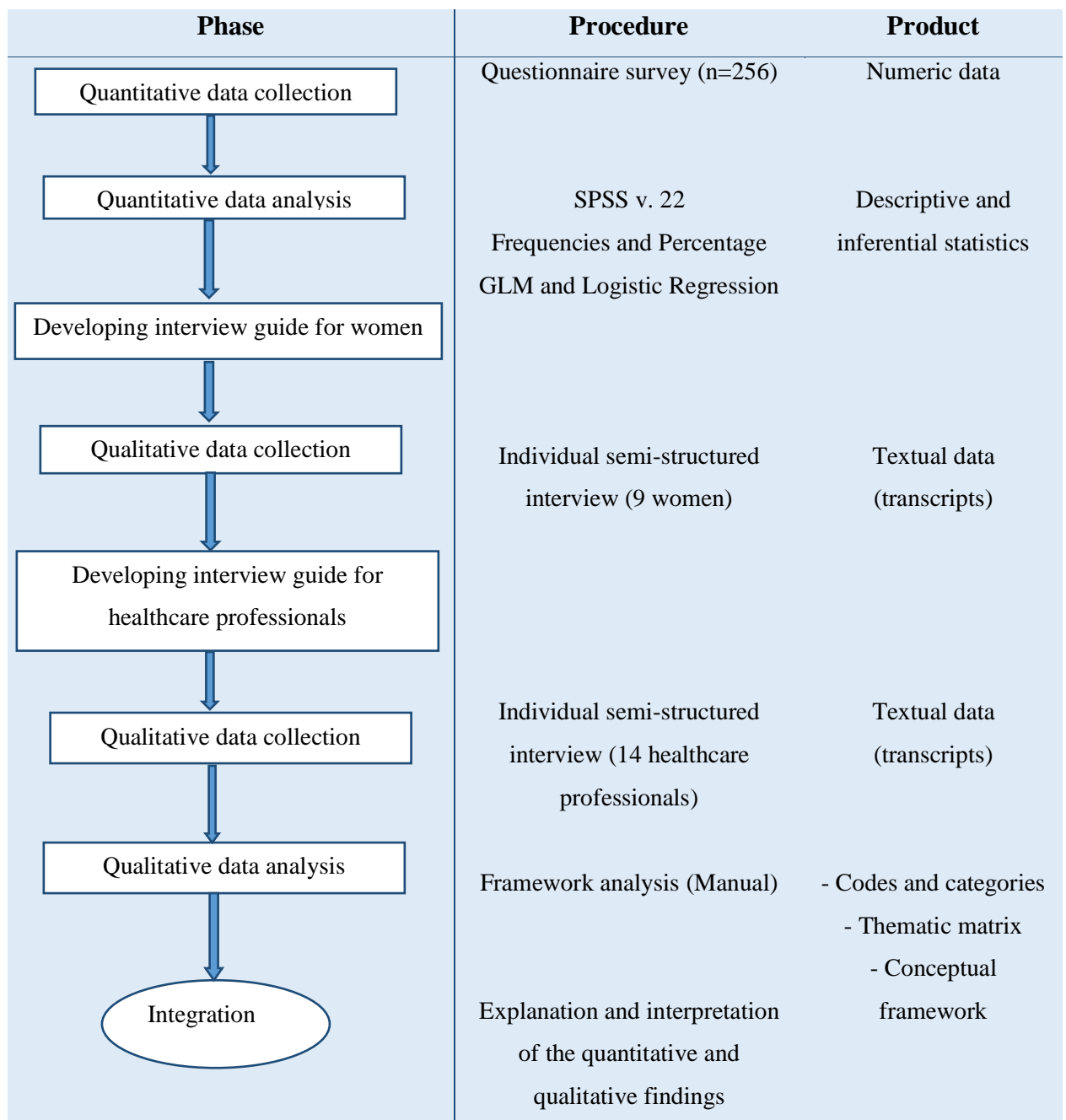
3.9.3 Integration

Integration in mixed methods research denotes to the stage or stages where the integration or mixing of the quantitative and qualitative data occurs in the research process (Tashakkori and Teddlie, 1998; Greene et al., 1989). Several possibilities exist for the purpose of integration ranging from the early stages of the study (during the formulating process of the study) (Teddlie and Tashakkori, 2003) to the integration of both quantitative and qualitative results in the interpretation stage (Onwuegbuzie and Teddlie, 2003).

Ivankova et al. (2006) suggest that in the sequential mixed-methods design, integration of the quantitative and qualitative phases occurs in the intermediate stage, when the findings of the quantitative phase (1st phase) inform the data collection in the qualitative phase (2nd phase).

The current study mixed both quantitative and qualitative approaches at different levels. In the intermediate stage, the results of the quantitative phase guided the interview questions for the subsequent phase (qualitative interviews) and formed the criteria for selecting the participants.

Creswell and Clark (2011) state that *“for an explanatory design, the meta-inferences relate to whether the follow-up qualitative data provide a better understanding of the problem than simply the quantitative results”* (p.237). Then, the findings of the quantitative and qualitative phases were integrated in a separate section to provide a clear picture for the entire study outcome (Ivankova et al., 2006). Finally, the results of both quantitative and qualitative parts were joined together and were critically analysed in juxtaposition. The overall study process is illustrated in a visual model (see Fig. 3.3).



Adapted from Ivankova et al. (2006)

Fig. 3.3 Visual model for mixed method research: the explanatory sequential design

3.10 Validity and reliability in mixed methods research

Validity, reliability and trustworthiness are usually required in mixed methods research when the quantitative method is dominant and the qualitative method is supportive (Giddings and Grant 2009).

3.10.1 Validity and reliability of quantitative data

- *Validity*

Validity means to what extent the questionnaire measures what is intended to measure, and if so, whether it does so accurately and correctly (Gerrish and Lacey, 2010). A variety of validity tests exist that can be done to ensure the validity of the data, results and their interpretation (Parahoo, 2014; Creswell and Clark, 2011). In quantitative research these approaches are classified as: content validity, face validity, criterion-related validity and construct validity.

Content validity: Creswell and Clark, (2011) explains this type of validity as “*how judges assess whether the items or questions are representative of possible items*” (p.210). This can be achieved by assessing the instrument using a panel of experts.

Face validity: assesses the instrument subjectively that items in a scale confirm that is clear, relevant and unambiguous (Gerrish and Lacey, 2010). Parahoo (2014) claims that the content and face validity are the most frequently documented types of validity in the literature.

Criterion-related validity: assesses whether the scores are related to an established standard measure (Creswell and Clark, 2011; Gerrish and Lacey, 2010).

Construct validity: examines whether the instrument measures what it aims to measure.

Several authors document other types of validity such as internal and external validity. Internal validity refers to the extent to which a researcher can conclude that there is a relationship between the independent and dependent variable (Polit and Beck, 2006). External validity denotes the extent to which a researcher can conclude that his/her findings are generalisable (*i.e.*, apply to a larger population) (Creswell and Clark, 2011; Bannigan and Watson, 2009).

Although the current study used an existing validated questionnaire, it is important to state that several measures were taken to demonstrate the validity and reliability of the questionnaire; due to the fact that the sample and the setting of the current study were different.

Regarding validity, the data collection tool (questionnaire) was subjected to an expert panel (research supervisory team) in order to establish content validity. In addition, to ensure the face validity, the questionnaire was given to peers and colleagues to assess its validity. The pilot study mentioned earlier, was conducted in order to ensure the validity of the data collection tool. The sampling criteria facilitated the generation of a representative sample which is generalisable (*i.e.*, ensuring external validity).

- Reliability

Researchers who conduct quantitative studies also consider the issue of reliability which means that “*scores received from participants are consistent and stable over time*”. The reliability of scores can be achieved by statistical procedures of ‘interval consistency’ (Creswell and Clark, 2011, p.211).

In this study, the Chronbach's alpha coefficient was applied for measuring the internal consistency of the pre-developed domains (Own Capacity, Professional Support, Perceived Safety, and Participation). The findings of the Chronbach's alpha showed acceptably high levels of internal consistency except for the participation domain (Own Capacity: 0.69, Professional Support: 0.83, Perceived Safety: 0.68, Participation: 0.5). This low value of alpha for this domain might be due to the limited number of items included (only three) (Tavakol and Dennick, 2011).

3.10.2 Validity and reliability of the qualitative data

Lincoln and Guba (1985) suggest a set of criteria to assess the trustworthiness of qualitative research. These are: credibility, transferability, dependability and confirmability.

Credibility: Gerrish and Lacey (2010) describe credibility as a "*fit between participant's views and researcher's representation of them*" (p.139). Here several strategies were applied to enhance the credibility of the qualitative findings.

1. Credible results will be produced by adopting the triangulation. This was achieved by taking different participants such as a number of women and different categories of staff (Flick, 2014; Creswell and Clark, 2011).
2. "Peer debriefing" meetings with peers and colleagues not involved in the research in order to disclose the researcher's own blind spots. In addition, regular meetings with supervisors enhanced the credibility of the findings by discussing the analytical process and emerging findings with them (Flick, 2014).
3. Discrepant or negative views and ideas (analysis of negative cases) are illustrated and explained in the findings (Flick, 2014; Creswell, 2003).

4. Communicative validation of the data and interpretations emerged from interactions with the participants of the current study; “member checks” (Flick, 2014). This was carried out after each interview, where I provided a summary of what have been discussed in order to eliminate any misunderstanding. In addition, after data analysis, I consulted some participants to validate the interpretations I have made. As this was done through phone calls, not all the participants were accessible to be consulted as they did not answer the phone calls.

Dependability: refers to the transparency of the research process and decision trail (Gerrish and Lacey, 2010). The following strategies were used to ensure the dependability of the current qualitative findings.

1. To make sure that there are no mistakes the transcripts were double checked.
2. Using memo and short description of cases; and participation of the research supervisory team in the coding process and data analysis enhanced the transparency of the research process (Flick, 2014; Creswell, 2009).

Transferability: denotes to the sufficiency of the description so that findings might be transferred to similar settings and situations (Gerrish and Lacey, 2010).

- Rich and thick description of the data was used in order to convey findings. Purposive sampling was used, which facilitated the production of a broad range of perspectives (Teddlie and Yu, 2007; Creswell, 2003).

Confirmability: refers to the establishment of clear links between the data, findings and inferences (Gerrish and Lacey, 2010). Using the Framework analysis approach enhanced this element of trustworthiness.

3.11 Ethical considerations

3.11.1 Ethics approval

Formal ethics approval was obtained from the Ethics Committee of both the University of Sheffield and Hawler Medical University. Permission to carry out the study was obtained from the director of the hospital for the purpose of data collection in order to carry out the study (see Appendices I1-3).

3.11.2 Informed consent and participant information sheet

The participant information sheet detailing all the necessary information concerning the research process was considered with all participants. Verbal and written consent was obtained from all participants prior to the survey and qualitative interviews (see Appendices G and H). Verbal consent from the women was only obtained once which was prior to the survey.

Holloway and Wheeler (2010) reinforce a framework that outlines key principles to be addressed by all researchers in the field of health and social care. These principals are documented as: respect for autonomy, non-maleficence (causation of harm should be avoided), beneficence (“do good” and balancing benefits against risks) and justice (ensure research strategies and procedures are fair) (p.55). The following measures were undertaken to ensure the above-mentioned four key principles:

All the participants in the current study (participants in the quantitative and qualitative phases) were allowed to make an informed choice voluntarily without being coerced.

1. The type and purpose of the study was explained in detail.
2. The participants were given the right to withdraw at any stage of the study.

3. The rights, dignity, confidentiality, well-being and safety of participants were protected throughout the research process.
4. Issues of participant anonymity were addressed carefully, the personal information was kept privately and was accessible only to the researcher and supervisors; the audio recordings and transcripts were stored in a safe locker and will be discarded after completion of the study.
5. The principle of justice was ensured by providing accurate information to participants.
6. The participants' privacy and confidentiality were protected.
7. Any potential difficulties or risks likely to be incurred by participants (women) were identified and avoided in order to protect the women and their new-born babies from any potential risks (see Table 3.4).

Table 3.4 Potential ethical issues in the study and planned strategies

Potential ethical issues	Planned strategies
If the researcher identifies a clinical issue during interviewing (e.g. malpractice)	The researcher will react appropriately based on the nature of the issue. In case of apparent malpractice, it is the researcher's responsibility to report the issue in order for it to be investigated.
If the participant requests to be interviewed beside her baby(ies).	It depends on the participant's wishes in which way they are interviewed. They will not be detached from their babies.
When some participants may not be in a position to give their consent without their husbands' decision.	Joint consent will be obtained from the participants and their husband.
To avoid perception of being a part of the staff in the institution.	The researcher will wear a different dress to ensure the participants that the researcher is not a staff member and their care will not be affected.
If a particular question is found to be disturbing during the survey or interviews.	The researcher will halt the survey or interview and the respondent will be free to decide whether to continue or withdraw from the study.

3.12 Summary

The present chapter demonstrated the methodological characteristics and methods applied in the study. Pragmatism was adopted for the study as it supports the philosophical assumption of combining two different methodological approaches and methods for data collection.

As the study adopts two different methods of data collection (quantitative and qualitative), different sampling strategies were distinguished and the validity and reliability of both methods were emphasised. Ethical considerations were also highlighted and all participants were informed about the aims of the study and their rights were protected. The findings of the study from all data collection sources are presented in the following chapter.

Chapter Four: Findings

4.1 Introduction

This chapter outlines the findings from all the data collected during the study in a comprehensive way and it is divided into four major sections. The first section is about quantitative data that was obtained from the questionnaire survey (256 women) in which the findings will be presented in detail. The second section presents the findings from the qualitative data obtained from the interviews with women; and entails four major themes, each with several sub-themes. In the third section of this chapter, the findings from the qualitative data obtained from the interviews with different categories of healthcare professionals (nurses/midwives and doctors) will be presented. Lastly, both quantitative and qualitative data findings will be integrated and displayed in the final section.

4.2 Quantitative data findings

As mentioned in the previous chapter, the quantitative data were analysed using a software package used for statistical analysis called SPSS Statistics version 22. The overall number of women who participated in the questionnaire survey was 256. The number of those who refused to participate in the study was 22. Therefore, the response rate (91.5%) was substantial.

4.2.1 Demographic data

Table 4.1 shows the demographic data of the study sample. Concerning the age of women, more than half of the study sample (60.5%) was aged between 20-29 years and only 10.9% of women were aged under 20. The mean age of the study sample was 26.39.

Regarding the participants' highest educational level, 35.5% of them had not attended school at all in their life, whilst, 32.8% and 10.2% of women had completed primary school and intermediate school respectively and only 6.3% of women had completed secondary school. An approximately equal proportion (7.8% and 7.4%) of the study sample had diplomas² or bachelor degrees. However, none of the study sample had any higher degrees such as master or doctoral degrees.

Of the participants, the majority of them lived in urban (47.3%) and suburban (41.0%) areas³, whereas only 11.7% lived in rural areas. Concerning the ethnicity of the study sample, out of the 256 women, only 3 women were Turkmen and 5 were Arab, whereas the rest of them (96.9%) were Kurds.

Table 4.1 Demographic data

Demographic information	Category	No. (%)
Age group (years)	Under 20	28 (10.9)
	20-29	155 (60.5)
	≥ 30	73 (28.5)
	Total	256 (100.0)
Age: Mean (SD)	26.39 (5.65)	
Highest educational level	No schooling	91 (35.5)
	Primary school	84 (32.8)
	Intermediate school	26 (10.2)
	Secondary school	16 (6.3)
	Diploma degree	20 (7.8)
	Bachelor degree	19 (7.4)
	Higher degree	0 (0.0)
	Total	256 (100.0)
Home area	Urban	121 (47.3)
	Suburban	105 (41.0)
	Rural	30 (11.7)
	Total	256 (100.0)
Ethnicity	Kurd	248 (96.9)
	Turkmen	3 (1.1)
	Arab	5 (2.0)
	Total	256 (100.0)

² Diploma: refers to two years study in institution after secondary school graduation (i.e., after 12 years schooling).

³ Urban: refers to major cities which feature dense population and major establishments, whereas, suburban refers to towns with lesser population and establishments.

4.2.2 Clinical obstetric information

This section displays the data about the participants' clinical information. As shown in Table 4.2, most (69.2%) of the study sample were multiparous with 30.8% of them having just experienced labour and birth for the first time. The mean parity of the women was 2.55. The mean gestational age of the participants was 39.18 weeks. In addition, the mean weight of the newborns was 3.41 kg.

Table 4.2 Clinical obstetric information

Item	Mean	Median	Std. Deviation	Min.	Max.
Gravida	2.97	2.5	2.001	1	13
Para*	2.55	2.0	1.57	1	12
Abortion (either spontaneous or induced)	0.42	0.0	0.84	0	6
Gestational age (weeks)	39.18	39.0	0.85	37.0	42.4
Weight of newborn (kg)	3.41	3.5	0.49	2.00	4.80
*1st			79 (30.8)		
*2nd			64 (25.0)		
*3rd			56 (21.9)		
*4th			29 (11.3)		
*5th			12 (4.7)		
*6th			14 (5.5)		
*7th			1 (0.4)		
*12th			1 (0.4)		
*Primipara (%)			79 (30.8)		
*Multipara (%)			177 (69.2)		

The table below (4.3) shows information on antenatal visits, over the half (53.1%) of the study sample had antenatal visits during their pregnancy and the rest of them (46.9%) did not have any antenatal visits. The number of these visits varied from 1 to 7 with a mean of

3.90 visits. The most frequently-occurring result was three antenatal visits (10.9% of sample) with seven visits being the maximum (reported by almost 8% of women).

Table 4.3 Information on antenatal visits

Antenatal visit information	Category	No. (%)
Antenatal visit	Yes	136 (53.1)
	No	120 (46.9)
	Total	256 (100.0)
Frequency of visits* (n=136)	One visit	16 (6.3)
	Two visits	19 (7.4)
	Three visits	28 (10.9)
	Four visits	23 (9.0)
	Five visits	20 (7.8)
	Six visits	10 (3.9)
	Seven visits	20 (7.8)
	Total	136 (100.0)
	Mean*	3.90

*Of those who made antenatal visits

Regarding women's delivery information, as mentioned in the previous chapter, the caesarean section deliveries were excluded from the study as experiences will vary from those who gave birth by normal vaginal delivery. Thus, only those who gave birth vaginally were included. None of the women had any instrumental delivery such as forceps or vacuum extraction. Almost 30 percent (29.7%) of the study sample gave birth without perineal trauma. Less than half of the study sample (43.8%) gave birth by vaginal delivery assisted by episiotomy and 26.6% of them had a spontaneous vaginal tear during childbirth (Table 4.4).

The majority of the women (98.8%) gave birth spontaneously while only 1.2% of them had labour induction using oxytocin or amniotomy (Artificial Rupture of Membrane, ARM). However, the labour of 80.5% women was augmented by using either oxytocin or ARM or both (oxytocin infusion, 25.8%; ARM, 18.8%; oxytocin infusion and ARM, 35.9%). A combination of both oxytocin and ARM was the most common usage with the labour of 35.9% of women being augmented by using both methods.

Table 4.4 Labour and birth information

Labour and birth	Category	No. (%)
Delivery mode	Vaginal delivery without episiotomy or tear	76 (29.7)
	Vaginal delivery with episiotomy	112 (43.8)
	Vaginal delivery with tear	68 (26.6)
	Vaginal delivery using forceps	0 (0.0)
	Vaginal delivery using vacuum extraction	0 (0.0)
	Total	256 (100.0)
Labour induction	Spontaneous	253 (98.8)
	Induced by Oxytocin	2 (0.8)
	Induced by amniotomy	1 (0.4)
	Total	256 (100.0)
Labour augmentation	Not augmented	50 (19.5)
	Augmented by oxytocin infusion	66 (25.8)
	Augmented by ARM	48 (18.8)
	Augmented by oxytocin and ARM	92 (35.9)
	Total	256 (100.0)

Table 4.5 below shows relationships between women's educational level and selected demographic variables. Of those women who had no schooling, 37.4 % of them did attend antenatal classes while 62.6% of them did not. Regarding those women who had a diploma or a bachelor degree, 74.4% visited antenatal clinics while only 25.6% of them did not.

There were highly statistical significant relationships between participants' educational level and antenatal visits as p value <0.001.

The educational group with the greatest proportion of multiparas (78%) was the no schooling group and the smallest proportion of multiparas (56.4%) was found in the higher education group. Almost 72% of those who had experienced higher education lived in urban areas whilst none of them were found to live in rural areas.

A significant result also applies to the relationships of educational level with parity (p=0.035) and area of living (p<0.001).

Table 4.5 Relationships between women's level of education and demographic variables

Demographic variable	Level of education No. (%)			Total	X ² value	p value	
	No schooling	Attended school (6, 9, or 12 years)	Diploma, bachelor, higher degree				
Antenatal visits	Yes	34 (37.4)	73 (57.9)	29 (74.4)	136 (53.1)	17.312	<0.001
	No	57 (62.6)	53 (42.1)	10 (25.6)	120 (46.9)		
	Total	91 (100.0)	126 (100.0)	39 (100.0)	256 (100.0)		
Parity	Primipara	20 (22.0)	42 (33.3)	17 (43.6)	79 (30.9)	6.688	0.035
	Multipara	71 (78.0)	84 (66.7)	22 (56.4)	177 (69.1)		
	Total	91 (100.0)	126 (100.0)	39 (100.0)	256 (100.0)		
Home area	Urban	30 (33.0)	63 (50.0)	28 (71.8)	121 (47.3)	23.295	<0.001
	Suburban	42 (46.1)	52 (41.3)	11 (28.2)	105 (41.0)		
	Rural	19 (20.9)	11 (8.7)	0 (0.0)	30 (11.7)		
	Total	91 (100.0)	126 (100.0)	39 (100.0)	256 (100.0)		

4.2.3 General labour and birth experience

Figure 4.1 shows overall satisfaction of women's general experience of labour and birth. More than half (58.6%) of the study sample were dissatisfied with their whole labour and birth experience whereas 41.4% of them were satisfied with their experience.

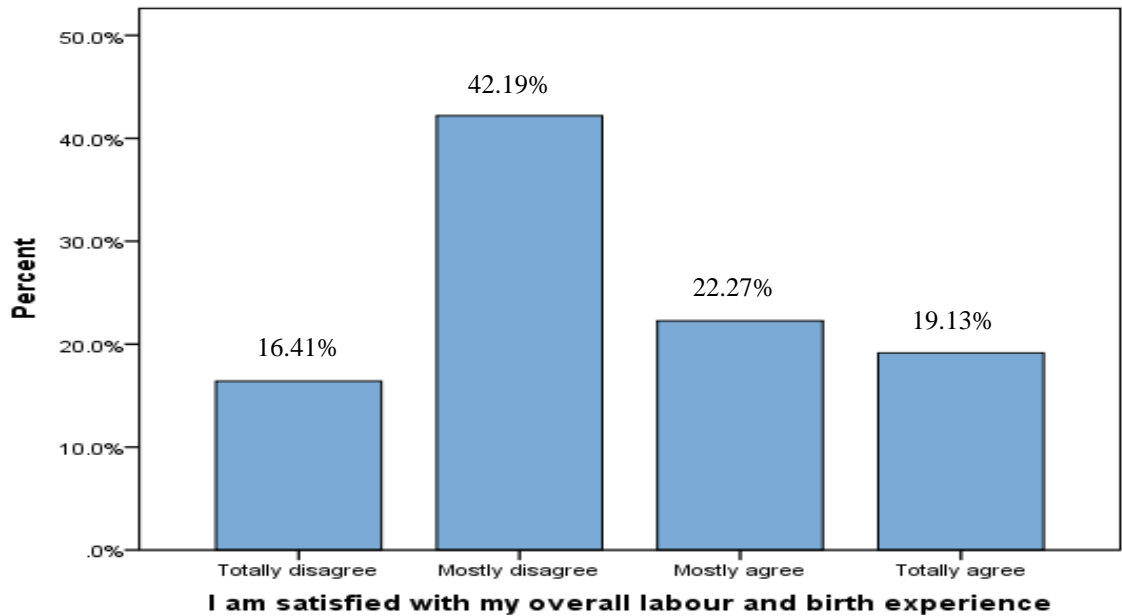


Fig. 4.1 Overall satisfaction with labour and birth

Table 4.6 shows the overall experience of women during their labour and birth. As mentioned earlier in Chapter Three, the original form of the questions demanded responses on a four point Likert scale (1=Totally disagree, 2=Mostly disagree, 3=Mostly agree, and 4=Totally agree). To aid clarity, the answers were amalgamated and re-coded into just two responses (1= Negative experience/Disagree and 2=Positive experience/Agree).

The majority (66.8%) of women stated that their labour and birth went as they had expected. Regarding women's own capacity, the majority of them had negative experiences in most of the aspects such as 90.62% of them were tired during their labour and birth. Also, 59.38% and 59.77% of women did not feel strong or capable during their labour and birth, respectively. Surprisingly, regardless to the above negative experiences, over half (52.34%) of the women did feel happy during their labour and childbirth.

The majority (85.93%) of the study sample had negative memories from their labour and childbirth and more than half (55.86%) of women stated that some of their memories from labour and birth made them feel depressed.

Women in this study had a choice either to move or sit during their labour as 97.65% mentioned that they were free in this regard. This applies to women's choice of eating and drinking during their labour with similar proportion (97.65%). However, these women were not free to decide their birthing position as this was the case for almost all of them (99.61%), due to the fact that the only birthing position that is allowed in Kurdistan Regional Governmental Hospitals is the lithotomy position.

The majority of women had positive experiences with their staff. For instance, 64.45% and 62.1% of women felt that their staff dedicated enough time for them and for their supporters, respectively. In addition, 83.59% of the study sample felt very well cared for by their staff. However, less than half (45.7%) of women agreed with the statement 'The midwife/staff understood my needs'.

Although 70.7% of women felt they did not have control during their childbirth, the majority (85.2%) of them did feel secure.

Table 4.6 General labour and birth experience

Labour and birth experience	Positive experience	Negative experience
	No. (%)	No. (%)
Labour and birth went as I had expected.	171 (66.8)	85 (33.2)
I felt strong during labour and birth.	104 (40.6)	152 (59.4)
I felt scared during labour and birth.	55 (21.5)	201 (78.5)
I felt capable during labour and birth.	103 (40.2)	153 (59.8)
I was tired during labour and birth.	24 (9.4)	232 (90.6)
I felt happy during labour and birth.	134 (52.3)	122 (47.7)
I have many positive memories from labour and birth.	112 (43.7)	144 (56.3)
I have many negative memories from labour and birth.	36 (14.1)	220 (85.9)
Some of my memories from labour and birth make me feel depressed.	113 (44.1)	143 (55.9)
I felt I could have a say whether I could be up and about or lie down.	250 (97.6)	6 (2.4)
I felt I could have a say in deciding my birthing position.	1 (0.4)	255 (99.6)
I felt I could have a say whether I could eat or drink.	250 (97.6)	6 (2.4)
The midwife/staff devoted enough time to me.	165 (64.5)	91 (35.5)
The midwife/staff devoted enough time to my supporter.	159 (62.1)	97 (37.9)
The midwife/staff kept me informed about what was happening during labour and birth.	148 (57.8)	108 (42.2)
The midwife/staff understood my needs.	117 (45.7)	139 (54.3)
I felt very well cared for by the midwife/staff.	214 (83.6)	42 (16.4)
My impression of the team's medical skills made me feel secure.	217 (84.8)	39 (15.2)
I felt that I handled the situation well.	195 (76.2)	61 (23.8)
I had control during my childbirth	75 (29.3)	181 (70.7)
I felt secure during my childbirth	218 (85.2)	38 (14.8)

4.2.4 Painfulness of childbirth

Questions concerning pain during childbirth and women's overall satisfaction during the labour process were assessed using a visual analogue scale. The scale started from 0 which denotes no pain and ended with 100 which denotes the worst imaginable pain. As illustrated in figure 4.2, the majority (83.59%) of women graded their childbirth pain

between 81-100. Conversely, only 1.17% of them claimed that their pain was not too intense as they graded it between 0-40.

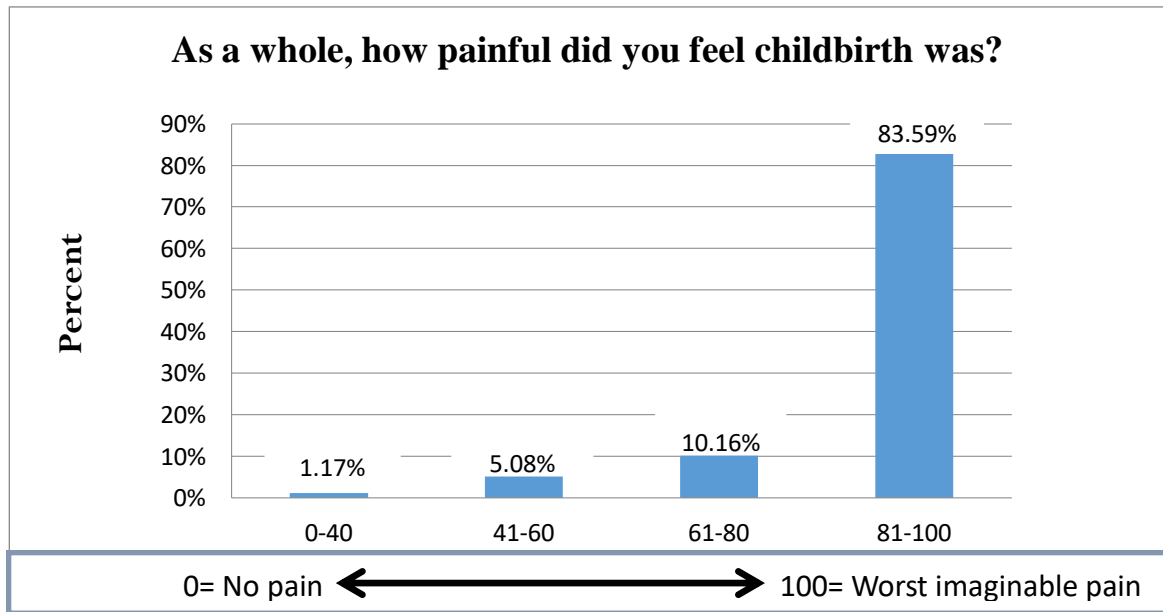


Fig. 4.2 Painfulness of childbirth

4.2.5 Awareness of and desire for pain relief

As demonstrated in Table 4.7, the majority of participants (81.65%) were unaware of pain relief options during labour and birth. Approximately 92% of women wished to have pain relief for any future birth. Furthermore, regarding the availability of pain relief options, 97.6% of women agreed that pain relief measures should be available to all clients going through labour and birth.

Table 4.7 Awareness of and desire for pain relief

Awareness of and desire for pain relief	Agree	Disagree
	No. (%)	No. (%)
I was aware of pain relief options during labour and birth	47 (18.4)	209 (81.6)
I would like to have better/more pain relief for any future birth.	235 (91.8)	21 (8.2)
Better/more pain relief measures should be available to all clients going through labour and birth.	250 (97.6)	5 (2.4)

4.2.6 Pain relief information

This section provides data on women’s knowledge about pain relief. The most common source of information among those who did know about pain relief options was friends/relatives (9.1%). Only 3.1% and 3.5% of women's knowledge came from healthcare professional and previous experience, respectively. Surprisingly, antenatal visits had no effect on women’s awareness concerning labour and birth pain relief as none of them (0.0%) stated antenatal visits as a source of their information (Table 4.8).

Most of the study sample (82.4%) did not know whether their hospital offered pain relief options or not. Only six women requested pain relief during their labour and childbirth none of whom received any. Three of them did not know why they had not received any kind of pain relief, whilst the other three women identified different reasons for not receiving any measures to alleviate their labour pain. The reasons were “medical team know better than me”, “too crowded and they (medical team) did not have enough time” and “medical team said it is unavailable”.

Table 4.8 Pain relief information

Item	Category	No. (%)
Source of information	Healthcare professionals	8 (3.1)
	Previous experience	9 (3.5)
	Media	6 (2.3)
	Books	1 (0.4)
	Friends/relatives	23 (9.1)
	Antenatal visits	0 (0.0)
	Not aware	209 (81.6)
	Total	256 (100.0)
Did you know whether your hospital offers pain relief options?	Yes	45 (17.6)
	No	211 (82.4)
	Total	256 (100.0)
Did you request for pain relief?	Yes	6 (2.3)
	No	250 (97.7)
	Total	256 (100.0)
For those who did request pain relief, why do you think you were not given pain relief? (N=6)	Do not know	3 (1.2)
	Medical team know better than me	1 (0.4)
	Too crowded and they did not have enough time	1 (0.4)
	They said it is unavailable	1 (0.4)
	Total	6 (100.0)

4.2.7 Associations between labour/birth domains and selected demographic variables

As mentioned in the earlier chapter, some domains were developed (Dencker et al., 2010) to evaluate the overall experience of labour and birth. In order to investigate the relationships between these domains and selected demographic variables such as home area, antenatal visits and educational level and parity; the General Linear Model (GLM) was used. Table 4.9 demonstrates the results of GLM analysis.

Regarding women's perceptions of their own capacity, on average, those women who live in urban areas had a higher own capacity coefficient than those who live in rural areas. This difference is statistically significant at $p = 0.019$ (95% CI 0.04-0.41). In addition, those women who live in suburban areas had higher own capacity than those who live in rural areas. This result is also statistically significant ($p=0.039$). P values of the other demographic variables indicate no significant results for the own capacity domain.

Significant results also apply to the perceived safety domain. As shown in Table 4.9, the perceived safety of those women who live in urban areas is significantly higher than those who live in rural areas since the p value equals 0.035 (95% CI 0.02-0.45). Similarly, those who live in suburban areas had a higher coefficient than those who live in rural areas ($p=0.048$, 95% CI 0.002-0.43). Furthermore, those women who had no schooling experience had a higher perceived safety than those who graduated from institutions or universities. This relationship is statistically significant as $p=0.008$ (95% CI 0.08-0.49). However, comparing those women who did go to school with those who had degrees shows no statistically significant association ($p=0.093$).

It is evident that there are significant relationships between women's own capacity and perceived safety with their area of living. Therefore, it can be concluded that women in this

study living in urban areas perceived both their own capacity and safety to be higher. It was also evident that education had an effect on women's perceived safety in this study as when the level of education increase, women perceive themselves to be less safe.

With regard to the participation domain, the results show significant relationships between women's participation and their level of education. Those participants who had no schooling experience participated more than those who had degrees ($p= 0.040$ and 95% CI: 0.01-0.31). Also, those participants who completed either primary or secondary school participated more than those who had degrees. This was also significant statistically at $p= 0.003$ (95% CI 0.07-0.34).

None of the demographic variables had an impact on the professional support domain as p values show no significant relationships.

Table 4.9 Associations between labour and birth domains with selected demographic variables

Domain		Own capacity		Professional support		Perceived safety		Participation	
		Coefficients (95% CI)	P value	Coefficients (95% CI)	P value	Coefficients (95% CI)	P value	Coefficients (95% CI)	p value
Variable									
Home area	Urban	0.223 (0.04 to 0.41)	0.019	0.184 (-0.11 to 0.48)	0.215	0.233 (0.02 to 0.45)	0.035	0.110 (-0.05 to 0.27)	0.172
	Sub-urban	0.192 (0.01 to 0.38)	0.039	0.045 (-0.02 to 0.33)	0.755	0.214 (0.002 to 0.43)	0.048	0.013 (-0.14 to 0.17)	0.873
	Rural ^a	-	-	-	-	-	-	-	-
Antenatal visits	Yes	-0.045 (-0.16 to 0.07)	0.436	0.0111 (-0.07 to 0.29)	0.226	-0.014 (-0.15 to 0.12)	0.841	0.018 (-0.08 to 0.12)	0.709
	No ^a	-	-	-	-	-	-	-	-
Level of education	No schooling	0.091 (-0.09 to 0.27)	0.310	0.234 (-0.04 to 0.51)	0.097	0.281 (0.08 to 0.49)	0.008	0.157 (0.01 to 0.31)	0.040
	Schooling	0.097 (-0.07 to 0.26)	0.239	0.159 (-0.09 to 0.41)	0.218	0.161 (-0.03 to 0.35)	0.093	0.207 (0.07 to 0.34)	0.003
	Degree ^a	-	-	-	-	-	-	-	-
Parity	Primipara	-0.063 (-0.19 to 0.07)	0.353	-0.022 (-0.23 to 0.19)	0.836	0.070 (-0.08 to 0.23)	0.372	-0.025 (-0.14 to 0.09)	0.656
	Multipara ^a	-	-	-	-	-	-	-	-
Age		-0.007 (-0.17 to 0.004)	0.223	0.013 (-0.003 to 0.03)	0.115	0.012 (-0.001 to 0.02)	0.065	-0.004 (-0.01 to 0.01)	0.332
R Squared		0.035		0.038		0.053		0.052	

^a = reference category

4.2.8 Associations between pain relief awareness and selected demographic variables

In order to derive the degree of association between a range of demographic variables and the awareness level of women regarding pain relief during labour and birth, a logistic regression analysis was conducted. Table 4.10 illustrates the results of the regression analysis. As shown in the table, Nagelkerke R^2 is 0.150 which indicates that 15% of the

variance is explained by the model and 84.0% of cases are correctly predicted by the model.

There is no evidence of an effect of home area, antenatal visits and parity on level of women's awareness regarding labour and birth pain relief options.

For level of education, there is a significant overall effect (the omnibus test, $p= 0.001$), which is evidence that there are differences between each specific educational level and the reference category (having a degree).

The odds of being aware of pain relief options of those women who did not go to school are 0.187 times that of women with degrees (*i.e.*, their odds of being aware of pain relief options are 81.3% lower than women with degrees). This relationship is statistically significant as $p= 0.001$ (95% CI 0.07-0.51). In addition, the odds of pain relief awareness for women in the schooling group are 0.259 times the odds for women with a degree (*i.e.*, their odds of being aware of pain relief options are 74.1% lower than women with degrees). This means they are less likely to be aware ($p= 0.001$, 95% CI 0.11-0.59).

To conclude, those women who had degrees are much more knowledgeable regarding pain relief options than those who did not have degrees.

Table 4.10 Associations between pain relief awareness and selected demographic variables

Variable		B Coefficient	Wald	Odds ratio (95% CI)	p value
Intercept		-0.820	0.583	0.440	0.445
Home area	Home area	-	1.592	-	0.377
	Urban	0.344	0.250	1.411 (0.37 to 5.44)	0.617
	Sub-urban	-0.177	0.063	0.838 (0.21 to 3.32)	0.802
Antenatal visits		-0.570	2.325	0.566 (0.27 to 1.18)	0.127
Level of education	Level of education	-	13.244	-	0.001
	No schooling	-1.677	10.788	0.187 (0.07 to 0.51)	0.001
	Schooling	-1.350	10.189	0.259 (0.11 to 0.59)	0.001
Parity		0.682	2.869	1.977 (0.89 to 4.35)	0.090
Overall % of correct classification				84.0	
Nagelkerke R²				0.150	

4.2.9 Summary

This section presented the results of the quantitative data which obtained by conducting a questionnaire survey. The findings show the demographic and clinical information of the women participated in the survey. Their general labour experience which examined different aspects of labour and birth, their awareness about labour pain relief, their wishes of and desire for pain relief were also presented. The women experienced their labour mostly negatively, not satisfied with their childbirth experience and unknowledgeable about the pain relief option. These findings offered sufficient knowledge regarding some important aspects of women's childbirth experience.

The succeeding section will demonstrate the findings gained from the qualitative data analysis (women and healthcare professionals).

4.3 Findings from the interviews with women

This section presents the findings of the qualitative data analysis which explored the women's birth experience in more detail. This section describes the characteristics of the participants and discusses how the Kurdish women in this study perceived their experiences of labour and birth, how they described it in their own words and what mostly valued or concerned them. It also discusses the relationship/attitudes of staff members towards parturients as perceived by the women. These aspects will be thoroughly described within the context of the resultant themes.

The study participants comprised nine women interviewed within one to two months after their childbirth. The characteristics of all participants involved in the in-depth interviews are shown in Table 4.11.

Table 4.11 Women's background

No.	Name*	Age (years)	G-P ⁴	Level of education	Residency	Antenatal visits	Delivery mode	Other notes
1	Jwan	23	2-2	Diploma degree	City	4 visits	NVD ⁵ + tear	Labour augmented by oxytocin infusion
2	Mrwari	35	7-5	6 years schooling	City	Nil	NVD + tear	Labour augmented by amniotomy
3	Hori	41	5-4	6 years schooling	City	6 visits	NVD + episiotomy	Not augmented
4	Bahar	23	2-2	9 years schooling	City	3 visits	NVD + tear	Labour augmented by oxytocin infusion
5	Hawar	19	3-2	9 years schooling	City	4 visits	NVD + episiotomy	Labour augmented by oxytocin infusion + amniotomy
6	Sazgar	26	3-3	Bachelor degree	City	1 visit	NVD + tear	Labour augmented by amniotomy
7	Rekar	24	1-1	Bachelor degree	City	4 visits	NVD + episiotomy	Labour augmented by oxytocin infusion
8	Avin	23	2-2	9 years schooling	City	3 visits	NVD + tear	Labour augmented by oxytocin infusion
9	Sahla	25	3-3	6 years schooling	City	Nil	NVD + tear	Labour augmented by oxytocin infusion

* Pseudonym used to protect the participants' anonymity

⁴ G-P: Gravida-Para

⁵ NVD: Normal Vaginal Delivery

After analysis of the interviews, four main themes emerged from the data along with several sub-themes for each and there is overlap between the themes. The main themes are as follows:

- **Pain and related factors**
- **Pain relief**
- **Staff behaviour**
- **Hospital environment**

Figure 4.3 demonstrates a thematic framework of the themes and sub-themes and shows some interrelation between some sub-themes. Subsequently, each theme will be discussed in a comprehensive way. Since the analysis was grounded on the qualitative data, each sub-theme is elucidated with a number of extracts taken from the interview transcripts.

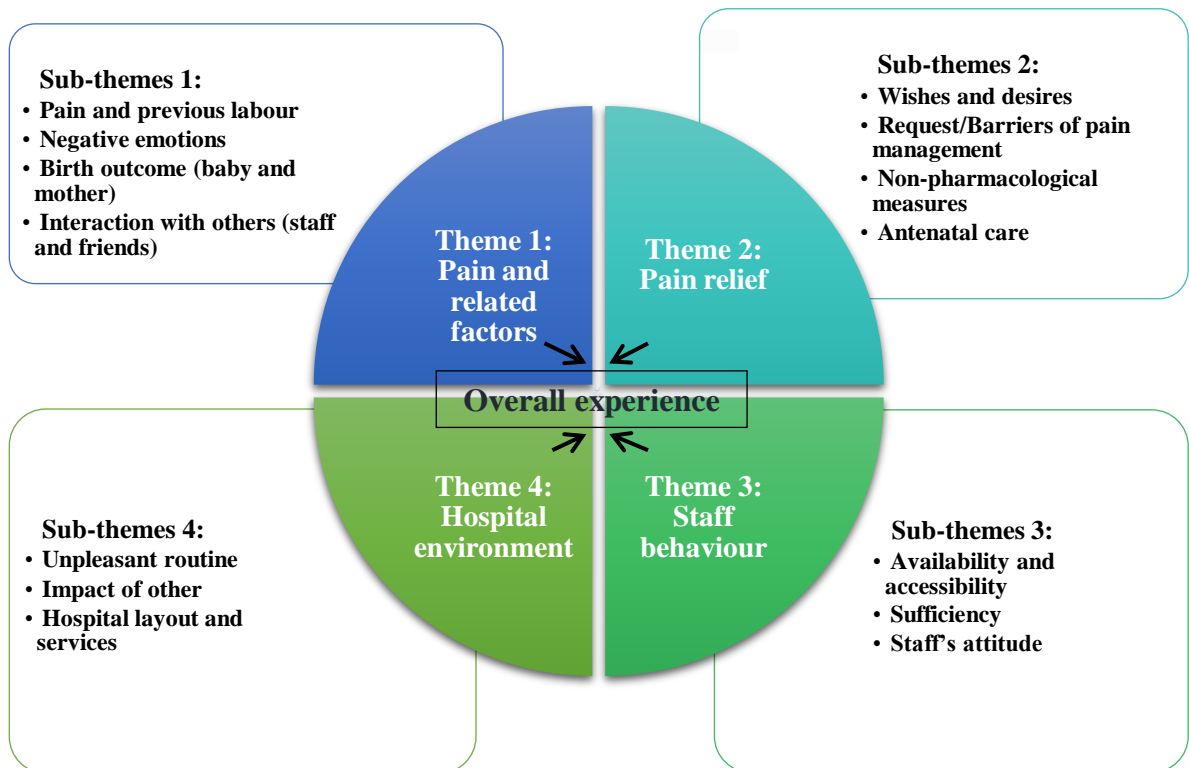


Fig. 4.3 Conceptual framework of the findings from the interviews with women

4.3.1 Pain and related factors

The data demonstrated several factors that played a major role in shaping the participants' birth experiences. For example, they described the following factors to be of the greatest importance: pain and previous labour, negative emotions during the labour process, birth outcome (healthy child and/or no maternal complication), interaction with others and being accompanied by family members and friends.

4.3.1.1 Pain and previous labour

The most common concern among the women was pain during the labour process. The women varied in relation to their pain and this was discussed by the women in relation to previous labour, age of participant. Most of the women described labour as "very painful" and "difficult". Usually, when the women talked about their labour and birth experiences they referred to their previous experiences in terms of the level of discomfort and pain they have perceived.

Hawar explained that one of the worst aspects of the labour process was its painfulness, describing it as "extremely painful". She further talked about her experience and compared the recent labour with her previous labour and childbirth. She anticipated that her labour would be easy and less painful as her last childbirth involved tolerable pain, while the recent birth was very painful and unbearable:

"Wallahi⁶ labour process certainly is very, very unpleasant; I was in pain so, so much. It was extremely painful. I had less pain during my first childbirth, my son, it was not that much painful. I said to myself this time is going to be the same but it wasn't. I was very, very anxious because I had a very painful labour. The pain was

⁶ Wallah(i): means I swear to Allah, which is used by Muslims for confirmation.

the worst part, it wasn't like that for my son, it was tolerable, I could sleep, I had a bit pain that's all but in this one I had very painful contractions. The pain was the nastiest thing in the whole process.” (Hawar)

In contrast, Sazgar explained that her current labour was considerably easier compared to the previous labour as this time she had given birth quickly with less pain:

“My pain was less compared to my last childbirth. Last time when I gave birth to my daughter, it was very, very painful but this time I gave birth within half an hour. Since the last labour was longer, I had to endure the pain more but this time was much shorter.” (Sazgar)

In addition, for those women who gave birth for the first time, labour and birth was described as a new experience in their life. Rekar was one of the primiparous women who described the process of labour and birth as a new experience and very uncomfortable:

“For me it was something new, it was my first birth. Everything was new and different for me because it was my first ever childbirth. So, everything was new to me, so new. What else... but it was very uncomfortable. It was very painful and difficult.” (Rekar)

Some women related the capability to give birth energetically with the age of the expectant mother. For instance, Mrwari (one of the mothers in the study at 35 years old) explained that although giving birth was difficult, it was largely dependent on the age of the labouring woman as she felt tired and did not have energy to give birth effortlessly. She further stated that she was confused throughout the labour process:

“Childbirth is difficult, very difficult. Year after year, when you get older, you become more tired. To be honest with you, I don't have ability now. I was tired,

very tired this time, from the first day of pregnancy and afterwards. I had pain during labour but it became more during the childbirth. I was so confused during the whole process.” (Mrwari)

4.3.1.2 Negative emotions

Some of the women were fearful of giving birth even before pregnancy or during pregnancy. The women in this study wanted to delay their pregnancies as they feared facing childbirth, their main concern being labour pain:

“But here {the region}, from the first day of pregnancy, our women think about their childbirth and what they are going through at that time. Although they are suffering from discomfort, nausea and vomiting during their pregnancy but at the same time they are worried about their labour and childbirth. I am one of them. The time lapse between my first and second child was four years. If it was my choice, I would want them to be ten years apart, because of the fear of childbirth. I was very, very frightened because of pain.” (Jwan)

For some, childbirth can be extremely frightening and traumatic, particularly for those women whose fears developed after a traumatic birth experience such as having experienced unbearable pain or tearing during the childbirth. Consequently, when they become pregnant again and their labour is due, they often request to give birth by operation (*i.e.*, caesarean section):

“I had a very severe pain; it was like I was dying. The pain drove me mad because it was unbearable. I was very anxious and I asked staff members to do me an operation and I even didn’t care about the consequences and complications of

operation. I was screaming, shouting and telling them to do operation on me.”

(Bahar)

One of the women wished she had given birth surgically and stated that beside a painful childbirth she had to endure an extra pain which arose from suturing as she had tears:

“I wish I had given birth by operation, you know why? I was in pain throughout the labour process and I had tear. The suturing was also very painful, I don’t know the anaesthesia was not working well; I could feel every stich. It was very painful and annoying, it made me so anxious.” (Sahla)

Some women explained that although their initial plan was to give birth by operation, because they were frightened to face the labour pain, other people influenced their decision. For example, Hawar mentioned that her husband persuaded her to have a vaginal childbirth as the pain is temporary and it is better than encountering post-operation complications or risks for suffering in post-partum life:

“Wallahi I requested operation but my husband did not let me to give birth by operation. I requested operation because I was so terrified of facing the pain. He did not allow me to have it and said to me that I don’t have any problems and the baby can be delivered normally, so it would be better to give birth normally without operation. He also said that the labour pain is brief just lasts for 1 or 2 days but after operation you never going to be like before.” (Hawar)

From the quote above it seems that Hawar was excluded from the decision making process of her own labour. However, she went on to indicate otherwise when she described the interaction with her husband as one of information giving, and possibly one of reassurance as he described to her that the pain from the operation would be longer than the pain from a

normal vaginal delivery. Indeed, Hawar was the only participant to refer to the influence of her husband on her labour choices in this way.

4.3.1.3 Birth outcome (healthy child and/or no maternal complication)

The data evinced that certain factors contributed to perceiving the overall birth experience either positively or negatively. For example, fear of labour pain may influence the women's experience negatively whereas some other factors may influence it positively such as positive birth outcome and giving birth without complication.

Having a positive birth outcome such as a healthy child was of considerable importance for the women and most of them described it as the best aspect of their childbirth experience. Some women explained that seeing their baby healthy (*i.e.*, without any abnormality) pleased them beside all the discomforts they have had:

“Childbirth is very unpleasant and there is nothing enjoyable about it but once the baby is born and when you see your child is normal and healthy, you will feel relaxed and delighted. I was concerned about the baby's health. I was horrified the baby would be sick or die. It was so nice and I felt happy when I saw the baby fine and healthy.” (Rekar)

In addition, some women were concerned about their own life and had fears of dying during childbirth. A woman valued the fact that she was alive after giving birth:

“The time when one gives birth is very exciting and you feel happy once you give birth. God saved me this time and all has gone.” (Mrwari)

4.3.1.4 Interaction with others

Some women mentioned other factors that were helpful during their childbirth. One of them stated that the presence of her friends during her childbirth made her feel more secure:

“My friends were so good, and also I had my friends with me in the last childbirth, my son. They were very supportive especially one of them who did stay with me until I gave birth and she even came with me to the postpartum ward. They were very helpful and they frequently went to bring senior doctors to see me. Wallahai, they were very helpful and taking care of me.” (Bahar)

Hori mentioned that the most important aspect of her childbirth experience was the competency of staff members in that they were efficient and knew what they were doing:

“Staff members were very good, when they examined me, they told me if my contractions stay like that, I will not give birth until late of that day but they did something I cannot remember what was it and after a while I gave birth. That was amazing.” (Hori)

On the contrary, Hawar was astonished by the skilfulness of one senior staff member and described that the other staff members were not as skilful as she was. This was highly valued by Hawar:

“Wallahi a doctor came there, she was a bit old; she came to me and asked some questions and then broke my water. I was so amazed by her proficiency. Other doctors almost five doctors examined me but they didn’t know what to do and just telling me that my womb is not open yet to give birth.” (Hawar)

4.3.2 Pain relief

As is evident from above, almost all the women mentioned that labour and childbirth were painful experiences and there were varied responses to it. One of the most important aspects that linked to pain was the means of managing it. It was of particular importance to the research aims to discover Kurdish women's perceptions of pain management during labour; and whether they requested or wished to have their pain managed at the time. The analysis highlighted this matter under the following sub-themes, each will be discussed in detail.

4.3.2.1 Wishes and desires

Analysis revealed that most of the women wished to have had pain relief measures during their labour and childbirth:

“I wish there were something to reduce the labour pain. In fact, it is like a dream to have something like that. I was lucky that I gave birth so quickly, I didn't have to suffer more otherwise there is nothing here to decrease your labour pain.” (Hori)

Bahar expressed her desire to have had some pain relief even if it was a relatively little change in making the pain less:

“At that time, I was so annoyed because of the pain so I wished to have some kind of injections, something to alleviate the pain even if it was a little bit. I was desperate to have something at least to relieve the pain a little bit.” (Bahar)

However, Avin thought that although childbirth has to be painful, she was not against having pain relief options to alleviate the labour pain:

“Childbirth is something that has to be painful; there is nothing to reduce its pain. If there would be something, I would love to have it because my birth was very painful and difficult.” (Avin)

Jwan explained that they have the right to be offered pain relief options during labour as many other women in other countries have that choice. She also further emphasised the importance of such facilities (if they were available) and how highly valued they would be:

“Why do childbirth have to be difficult, why not like other ordinary people {in other countries} who are not facing those difficulties and not to be frightened that much? Of course, I would like to have this facility [pain relief measures]. Everyone can give birth but the matter is the pain. If you can make it without pain or less pain it is very important.” (Jwan)

4.3.2.2 Request/Barrier of pain management

The data demonstrated that despite the unavailability of pain relief measures, some women requested or asked to have pain relief options and received different responses to their requests. It was also found that some women did not request pain relief due to their unawareness of its availability:

“Wallahi I didn’t know whether or not there is something available to reduce the labour pain. That is why I asked nothing.” (Hawar)

The quote above elucidates that Hawar was unaware about pain relief options and whether or not the hospital provides any. In addition, Rekar stated that only during some medical interventions such as episiotomy and suturing, were pain management means available:

“There was nothing to alleviate your labour pain here in this hospital; I only had anaesthesia during suturing and before that when they cut.” (Rekar)

Sahla requested pain relief options during her birth and was disappointed once she realised that there was nothing to reduce her pain:

“I did ask staff members to do something to reduce my pain, but there were nothing. I was waiting for something but after that I was disappointed because no one cared about it. They only gave me an injection which enhanced my contractions.” (Sahla)

Some women perceived that staff members were misleading parturients when it came to pain relief options. One of the women stated that during her labour, she asked staff members to offer her pain relief options (if any) but they misled her:

“When I was in labour, I asked staff members to do something about my pain but they said we will put it in your fluid [intravenous infusion]. I afterwards realised that it was the injection to increase your pain [contraction] rather than decreasing it.” (Bahar)

Jwan was completely aware of different kind of pain relief measures during labour as she had gained this knowledge through mass media, especially online resources. She explained that women in developed countries have many choices to decide on in order to give birth with less pain. Furthermore, Jwan gave an example of one of her relatives who gave birth painlessly, as she was living abroad:

“Now, in many... let’s say TV. No, no, not in TV but usually on internet sites when you look at them, you’ll see in other countries, women give birth with less pain. A woman has pain but it is not like that, she sits and talks. For example, she is sitting in a tub full of water and so normally she gives birth. She gives birth normally, with

slight pain. Wallah, one of my close relatives was living in the UK for several years, she has 2 children and she gave birth to both of them there. She told me that she gave birth twice without pain and without any difficulties, literally.” (Jwan)

As Jwan was aware of pain relief options, she endeavoured to find a way to give birth herself with less pain or less difficulty. She was aware that pain management in governmental hospital was unavailable, thus she sought private clinics to solve her problem. She also mentioned that she was keen to have pain management in her labour and she did not even care about its cost. After several visits to private clinics, doctors were unsupportive in this regard, encouraging her instead to avoid pain management (*i.e.*, epidural anaesthesia) because the doctors responsible are not sufficiently skilful:

“However, I visited a doctor here; she says that nowadays there are some injections available here to alleviate the labour and childbirth pain. But our doctors say that our anaesthetists are not reliable {not proficient}. If doctors say that themselves! What would the patients say or do? I am one of those who visited many doctors frequently to discuss this matter and to see if it is available so I can use it. Of course, in this hospital childbirth costs you nothing, but the pain relief injection is expensive and costly [in private hospitals]. You will pay money in order not to face these difficulties and to avoid painful childbirth. As I said I have visited many doctors several times, I didn’t care about the price but they told me that our anaesthetists are not too good or not reliable to some extent. When doctors say that, certainly the patient would not go for it.” (Jwan)

In order to avoid post-partum complications if she had an epidural, Jwan eventually decided to give birth in one of the governmental hospital as it was costless, safer for her and the baby even though no pain management options were provided:

“I had a hope to use the injection but when they say it will be injected through vertebrae and it is very sensitive, so I became less interested in it. I said to myself ‘let me face the difficulties and have the pain but not be disabled afterwards’ {laughing}.”(Jwan)

In addition, some women were concerned about drawbacks of pain management options such as health issues. Sazgar had concerns as some of her friends suffered from back pain after receiving epidural analgesia during their labour and birth. She stated that if there was something to alleviate the pain without side effects, she would take it:

“If it is not bad for health, I will go for it but they say that injection [epidural] is bad. I don’t like it just because of that. For example, 2 or 3 people, one of them was my colleague had epidurals and they say that they have backache afterwards. I would prefer to suffer the pain rather than suffering from back pain for the rest of my life.” (Sazgar)

From the findings, the only option women could choose to avoid their labour pain was seeking an operation. One of the women stated that due to unavailability of pain relief options during labour, many women ask for an operation, however she preferred to suffer the pain instead of having a caesarean section:

“There is nothing available to ease the labour pain and as a result many women here will decide to have an operation on them in order not to face the pain. But, I personally preferred to suffer the pain and even my doctor told me to give birth by

operation. I said no, I'd like to confront the pain rather than having operation. But when the pain intensifies, certainly you like to have something to relieve your pain. It is very painful.” (Mrwari)

4.3.2.3 Non-pharmacological measures

The analysis revealed that women in this study did not have any choice with regard to pain management; it is of particular importance to know how these women coped with their labour pain or what they did to reduce their pain.

Some women practiced limited non-pharmacological measures to reduce the pain such as walking and massaging, while others did nothing. Non-pharmacological measures used by the women were found to be limited and only a few of them sought these pain relieving methods. Walking, movement and massaging were the most common practices used by some of the women to overcome their pain:

“I was walking in order to get rid of pain, when I walked it was like distraction. I almost forgot my pain for a while once I was walking. It was not nice to lie on your back for a long time. So, I was feeling a bit better when I walked. I had the pain but the walking did reduce the pain a little bit. The pain was much worse when I was lying on my back.” (Hawar)

One of the women explained that movement was the only way she could do to reduce her pain. In addition, her relatives massaged her back and they were all praying for her:

“What I did to manage my pain was only moving around. If I was sitting and once I had pain, I was standing and started walking. While I was standing, I used to sit. This way worked for me and it was a bit comforting. My relatives also rubbed my

back and they were telling me to pray. They were also praying for me all the time.”

(Rekar)

Most of the women prayed during their labour in order to ease their pain. Avin stated that she prayed while her relatives applied some techniques such as massaging and reading the Qur'an in order to reduce her pain:

“My relatives were massaging my back and I was only praying. They were also praying and reading the Qur'an for me.” (Avin)

As well as praying, Sazgar described that shifting her focus into something else was useful in reducing her pain:

“I did nothing to reduce my pain, I only prayed. But there was something else that I found it useful in distracting me from my pain which was listening to other parturients' relatives. They were talking about different things such as food and some cooking experiences. It was somehow effective in deviating my focus into something else rather than focusing on my pain.” (Sazgar)

Although some of the women used a combination of methods to reduce the pain, others either only prayed or did nothing to confront the pain. In addition, the analysis showed that none of the women used any rituals or remedies to alleviate their pain:

“Once you are in that pain, you cannot reduce it by yourself. I was praying a lot, only praying. Some women and midwives in the past told parturients to lubricate their abdomen and their back by oils, but honestly I did none of them.” (Hori)

4.3.2.4 Antenatal care

As it was discovered that women used limited natural measures to cope with their pain, it is essential to recognise the women's perspectives on whether antenatal clinics had any effect on their labour and childbirth. Most of the women mentioned no impact of antenatal clinics on their labour and childbirth as there was nothing included related to their forthcoming labour. They also identified that antenatal clinics provide services which are mostly related to pregnancy. These services include blood pressure check-ups, blood tests (haemoglobin), height and weight, medication prescription, vaccination, ultrasound and abdominal examination:

“There was nothing available related to childbirth. They only prescribed me some medications and they also did ultrasound and abdominal examination to check the baby's growth and if there is any abnormalities and so on.” (Rekar)

Some women highlighted the importance of having specific classes in antenatal clinics in order to enhance their coping strategies during labour and birth:

“It is very essential to have something in antenatal clinics that prepare expectant mothers to deal with their pain. It is very important to educate women on different aspects of labour and birth. Here, there was nothing related to childbirth. They only checked my blood pressure, blood tests, and weight and these things. There is nothing else.” (Hawar)

Bahar mentioned the importance of such facilities (*i.e.*, childbirth classes) in decreasing women's fear before childbirth:

“There were some posters hung on the wall, if you wanted you can read them. These posters were about importance of vaccination and other things in pregnancy.

There was nothing like counselling or advice on how to prepare you for labour and childbirth which is very important. It is very important, many women may feel less fearful if they received information and advices on what is labour, how it looks like or how to deal with the pain.” (Bahar)

4.3.3 Staff behaviour

Another important aspect identified during the data analysis was the input and impact of staff members on the women’s general labour experience. Their concern was focused on the issues of staff’s punctuality, sufficiency, competency and attitude. These aspects will be thoroughly explored under the following sub-themes.

4.3.3.1 Availability and accessibility

The women described several factors that had an effect on their labour experience. One of the key factors was the presence and availability of staff members to provide care for the parturients. The women felt reassured once they were surrounded by staff members. Some of them described those moments when they were alone and no staff members were around as the worst aspect of their childbirth. Rekar preferred to be accompanied by a staff member throughout the process:

“When the staff members left me alone was the worst part of my childbirth. I was having contractions and I was calling them continually. I was asking the staff to come and stay with me and I even told my family to call them to be with me. It was not nice. I liked to have someone beside me all the time, a doctor, a nurse!” (Rekar)

Another concern the women had was staff members being unavailable most of the time. They described staff as being ‘not there’; and they had to frequently call them or send their

families over to the staff's station in order to provide them with the care they needed and begin frequently checking them up. Although staff members had been told to look after the women, they were delayed in responding to the women's or their families' requests, as mentioned by some of the women. In fact, although the perception of any delay is subjective, for these women it was considered to be crucial and it had a major influence on how they went through their whole labour process:

“If they [family] didn't go to call the staff to look after me, they [staff] wouldn't often come to see the patients. I was screaming, I had a relative with me, she was saying what should I do? And then she was going to call some staff members to see what was wrong with me. But it took about 5 to 10 minutes for staff to respond and come. You had to go and call them to come otherwise they were not there. It was not like someone is with you or sees you frequently. No, it was not like that.” (Hori)

Most of the women stated that staff were attentive and provided care mainly during the actual childbirth. They mentioned that staff members otherwise were not constantly on hand to approach the women during their labour. It was apparent that the women highly valued the notion of staff being available and attentive:

“They took care of everybody and I don't know whether there were enough of them or not. This is during the childbirth and prior to childbirth if you needed something they did it for you and then left you. No one came to tell me ‘I am a nurse or a doctor and I am responsible for taking care of you’. It was not like that.” (Jwan)

In addition, some of the women expressed the concern that staff were not giving adequate information and that there was absence of prompt responses when needed. The women mentioned that some staff members provided no information with regard to what they were

performing in terms of clinical procedures and interventions. Also, if the information was given, it was inadequate:

“When I came to hospital, a staff member immediately examined me and she only said that my womb was open two fingers. Then she told me to go to the delivery ward; and there they started to give me injections and other things. I don’t know what they were. I didn’t know what they were doing and what was happening next.”

(Avin)

For the aforementioned reasons, the contact time between staff and patients as perceived by the women was short, and when they communicated, it was brief. Some of the women highlighted the importance of being able to talk and of being listened to during the labour process and even post-delivery. This is evidenced by Hawar’s quote. She was grateful to share her childbirth experiences with others (including the researcher, in this case). She said that since childbirth is difficult, talking about it could be therapeutic:

“Bakhwai⁷ when you came and talked to me, I felt very happy. You made me happy by your chatting and when you started to ask questions so kindly, I admired you. I think other women when they gave birth, they just went home without talking to them. You asked so many good questions and I liked that very much. Of course, every patient would like to have someone to talk to, especially during childbirth when it is very unpleasant and depressing. Afterwards when I gave birth and you came in and asked questions I became very happy.” (Mrwari)

⁷ Bakhwai: means I swear to God, which is a Kurdish expression frequently used for confirmation.

4.3.3.2 Sufficiency

The analysis highlighted differences between the women in this study in terms of perceiving the sufficiency of staff members working in the Delivery Unit. For instance, some of the women felt that there were plenty of staff around to take care of labouring women, while others perceived that there was a shortage of healthcare personnel in the ward:

“There were lots of doctors and healthcare staff available and they were frequently and regularly seeing the women. They followed up all the patients; they came to see us very often.” (Hawar)

The data showed that those women who felt that the number of staff members was sufficient, were those who gave birth in the morning shift (8:00-13:00) in contrast with those women who gave birth either in afternoon or night shifts. Based on the researcher’s previous experience and casual observation during the data collection period, this was due to the fact that in the morning shifts the number of healthcare professionals (including all the personnel: doctors, midwives and nurses) who worked there was higher compared to other shifts. In addition, because the hospital was a teaching hospital, numerous undergraduate students from different schools were available under the supervision of their instructors (attending their clinical sessions). This facilitated in minimising the pressure on staff:

“It would be better if the number of staff were higher. In the past, I accompanied one of my nieces during her labour, when we arrived only a nurse was there; it was an evening time. Another of my nieces was with us, she is a nurse, she started to help the other nurse in giving injections and so on. I would have liked to be surrounded by many healthcare professionals. At that time I asked my niece ‘why is

it like that?’ and she said that during afternoon time it was like that, but morning shifts were better [more staff are around]. For me this time it was also very unpleasant when there was only one doctor present and I had to wait for a long time.” (Hori)

However, a couple of women mentioned that the number of staff members available to provide women with care was adequate as they could take care of all women in labour but they were busy:

“Their number was good, I mean it was adequate. They could take care of everyone but it was a bit slow in terms of responding to patients.” (Bahar)

Although Sahla stated that there were lots of staff members available, she stressed the importance of having more healthcare professionals in the delivery rooms:

“There were lots, lots of staff around, they were very frequently coming to see me. The number of nurses/midwives was more than the doctors. The more the staff, the better it would be.” (Sahla)

In response to the question I asked during the interview regarding the staff-patient ratio, most women stated that in order to receive a quality service and care, the number of staff should be half of the labouring women. Nevertheless, a few of them did not have any idea on this regard:

“At least, the number of staff should be half of the number of patients in order to provide them a good care and support. For example, one doctor should be assigned to take care for only two patients. The same should apply for nurses and midwives.” (Rekar)

It was apparent that some of the women differentiated between the staff such as doctors, midwives or nurses while others did not. Two discrete reasons for this differentiation might be that firstly, it could be due to the brief communication, if any, between staff and the women. Secondly, another reason as mentioned by one of the women was all of the healthcare professionals (both staff and students) used the same approach in treating the women. Avin and Bahar's narratives demonstrate these two variances:

"I could distinguish the staff members, it was obvious. I could differentiate between them, the nurses and doctors." (Avin)

"I could not differentiate between the staff, for me all of them were the same. A doctor was coming, and then a student was coming acting the same as the doctor. I was confused; I didn't know who is who. Their speaking, their attitude was the same. They administrated the same treatments; I couldn't distinguish between them." (Bahar)

Despite the availability of visual cues such as uniforms and name badges, some women did not differentiate between staff members. Regarding the verbal cues, whether staff introduced themselves by name and/or role, it is common for staff members to not introduce themselves. However, this cannot be generalised since there are still other staff members who introduce themselves to patients.

The data revealed that a lack of person-power had an impact on the provided services and ultimately interfered with the women's experiences. Some women experienced delays in receiving care in the delivery ward and felt neglected. Those women who waited for hours in order to receive the care they needed, complained about the shortage of staff. They thought that the main reason for not obtaining the care they required was due to insufficient

staff numbers. The following quote is an example of one of the women who was obliged to wait for a long time in order to be given care:

“The number of staff members was very limited including both nurses and doctors. Before stitching up my cut, I waited for hours, I was waiting for the responsible staff to start stitching it up. She [staff] put patients in the queue, she was alone that did suturing. There were lots of patients waiting to be sutured and everyone was calling the staff to do theirs first. Then, once it was my turn, I had a very painful suturing because they didn’t suture it when it was still fresh, I waited for a long time and this increased my discomfort.” (Sazgar)

4.3.3.3 Staff’s attitudes

During the analysis, a number of issues were identified regarding the women’s relationships with staff members. These can be divided into positive and negative experiences. On one hand, some women were concerned about the manner used by healthcare personnel during their care provision. The women recognised that the staff’s behaviour was ‘tough’ and ‘rigid’ with the women. Those women who experienced a tough or irritated behaviour from the healthcare professionals commented that only a few of the staff had this kind of attitude:

“When I came to hospital, one of the doctors examined me and I held her hand but she became anxious and got upset. That was so embarrassing for me; I regretted that I held her hand. Also, when I was admitted to the delivery unit, one of the staff members got angry with me; because I told them that I was breathless and she said ‘you don’t have breathlessness’. They were quite tough with patients. I only faced

two angry staff and that was what happened to me during my labour, it was very unpleasant." (Sazgar)

On the other hand, other responses to this question identified the staff's behaviour as 'good'. As Avin stated *'having good staff around me was one of the best parts that I experienced during my childbirth'*. This view was echoed by another participant who also encountered proper and suitable behaviour from the staff during her childbirth:

'The staff were all good and kind to me. They were very nice people. The doctor who stitched me up was very nice; she did her duty very nicely. The others were nice, the nurses and all of them were nice too.' (Rekar)

As data revealed, experiences varied between women as some stated that staff were supportive while others complained about negative attitudes from healthcare personnel. Although some of the women did not encounter this tough behaviour from staff when they gave birth themselves, they were witness to staff members behaving inappropriately towards other women. It was a major concern for some of the women which they perceived as an impolite attitude and expressed it as shameful:

"They were yelling at patients, which is not very nice. They say to patients 'don't scream' or 'this is not your first childbirth'. Childbirth is childbirth if it is the first time or the fiftieth time! This is not nice, to tell patients that 'it is not your first childbirth, enough! Don't scream!' It is shameful, I think pain is pain. Generally they are tough with patients. Not all of them, but many of them...I haven't faced any of these, but I have seen it. I was walking around and I have seen these attitudes."
(Jwan)

The data suggested some of the health providers lacked fundamental communication skills and that because of this the women felt distressed and frustrated. This was also an issue among those women who did not encounter such behaviour personally during their hospital stay. The women felt disappointed by seeing this behaviour and appreciated the notion of staff being supportive and 'kind-hearted', which enable them to attain a positive labour and birth experience:

“You know, it would be nice if we had kind-hearted staff instead of tough ones. They have to reassure patients with smooth and nice talk, and as a result the patient would appreciate their work. It is essential to reassure the patient and calm her down during such situations. For example, if a patient screams, they have to tell her smoothly that ‘this is going to end soon, just endure a bit more’ and the patient would be very happy.” (Jwan)

The women alluded to the notion of acceptable behaviour by the women. The women perceived that by being silent and not shouting would result in getting better care and more attention. *“If a patient shouts frequently, I have heard the staff saying ‘oh this is very annoying and even you can’t work close to her’. I have heard these things so many times.”* as Mrwari stated. The women expressed a common view in which they believed that the attitude of staff relied on patients themselves. They stated that those women who argued less and kept calm during the whole labour process received better care and attention from the staff members:

“They were all good to me, thank God. This is something that entirely relies on women themselves. If you were not making noises and not shouting, the doctors and staff would treat you the same way: kindly and calmly. If you were not shouting,

they would not be shouting too. If you were good, they would be good to you.”
(Avin)

The excerpt below illustrates that one of the women blamed some of the women for being irritable and thus annoying staff by shouting and not listening to what the staff asked them to do. For Sahla, this behaviour was unacceptable, as she claimed that she did not scream while giving birth whereas other women did:

“As opposed to the others I did not shout or scream, as a result the staff were very good with me. There were some annoying patients who continuously shouted, screamed and yelled at staff members. They often didn’t allow the doctors and staff to do what they were supposed to do. For example, they didn’t allow the doctors to examine them and eventually the doctors would be mad at them.” (Sahla)

Regardless of the tough behaviour that some women experienced, they eventually stated that they were thankful and grateful for the care they had received. In spite of the fact that these women had negative experiences, they felt very well looked after. They also appreciated the fact that the hospital offered them suitable services for both themselves and their babies:

“It is true that some staff get anxious over the patients, as some doctors offended me but it was nothing serious. I like this hospital very much. In general, the things here were so good. There were some negligence and disregard from the staff’s side, but these are nothing. Every individual will forget it. I prefer this hospital over the private ones as you can get very good care and the baby too.” (Sazgar)

Despite the lack of communication between the healthcare personnel and the women during their labour process, most of the women stated that the staff were competent and skilful in their work whilst only one of them did not believe so:

‘I said to them the baby is coming down and they said ‘no, you are still not ready to give birth’. I was saying that the baby will be delivered immediately, but they said ‘no, your cervix is only 2 fingers dilated’. Then, suddenly I gave birth. They didn’t have the skill to know. During my childbirths, they came after the baby’s head was come out.’’ (Mrwari)

This might be due to the lack of communication between the staff members and Mrwari as she further stated that she did not know why she suddenly gave birth, while staff members may have known why.

4.3.4 Hospital environment

After the completion of the qualitative data analysis, it was found that there was considerable similarity in the issues and concerns raised by the women with regard to the hospital environment. The study found that most of the women highlighted the effects of hospital environment on their labour and birth experience. They reported several concerns that had an impact on them.

4.3.4.1 Unpleasant routine

The data suggested that the women believed that each routine performed during their labour process was an ordinary part of the process of giving birth. These routines comprised vaginal examination or medical interventions such as episiotomy. Although some of the women mentioned that labour progress was monitored by vaginal examination

and they could gain some information on what was going on; some of them expressed their annoyance towards the frequency of these examinations. They also considered these examinations as painful and a nuisance, which added another undesirable aspect onto their overall labour experience. In addition, the women articulated a feeling of shame when they complained about it and they felt hostile and helpless in this regard:

“It is unpleasant when you are surrounded by doctors and staff doing examinations. It is very unpleasant when you are examined by so many doctors. All that doctors! All that examinations! Very unpleasant, indeed. They certainly examine the patients quite often. You also feel uncomfortable when you see all these doors open. Besides, you are with all these women and this is very uncomfortable. All these people are going and coming, they will definitely see you, it is very annoying.” (Hawar)

As a result, the women found themselves in an uncertain circumstance. Initially, this made them feel uncomfortable which eventually evolved into a sense of shame, but at the same time, they thought that these examinations could enable them to know their labour progress. In addition, another key concern that arose from the women’s narratives was the lack of choice in decision-making. Not only did the women complain about the lack of choice in making decisions relevant to their birthing experience, they also argued that their voice was not heard and they described staff members as being unwilling to listen to them:

“Usually, during labour, they [staff] will do lots of examinations in order to know when the childbirth is due. They want to know when exactly is the time for childbirth. So, these things make you very uncomfortable. If you are disagreeing, they will still do the examination.” (Jwan)

Some of the women also believed that the healthcare professionals disregarded the patients' knowledge and were autocratic in their decisions. The quote below reveals how Jwan felt undermined by staff members when she had asked for something and how choices would have been taken away from her:

“You know, here if I even ask for something they will immediately tell me that I do not know better than them. Surely, they will tell you that, they say if we have something we will do it for you. Certainly, they will tell you that. They say you don't have to ask for everything.” (Jwan)

Beside these negative comments some of the women made on the lack of choice they experienced during their childbirth experience, some of them still trusted the hospital. For instance, Rekar mentioned that she wanted to give birth in a hospital that she relied on:

*“When my labour pain started to increase gradually, I went to the maternity hospital in *****. They examined me there but I came to this hospital because we did not trust the other hospital.” (Rekar)*

However, Rekar did not mention why she trusted this hospital over the other hospital, it is a common belief that people generally prefer big hospitals over the small ones (*i.e.*, the hospitals in governorates over the ones in districts). As they believe that they can get better care from experienced staff, better services including efficient emergency department, if something went wrong.

4.3.4.2 Impact of others

As discussed in theme one (Pain and related factors) that some factors contributed to making the birth experience either negative or positive. For instance, some of the women

stressed the importance of having their friends around during their childbirth and this contributed positively. In this section, other factors that had an effect on the women's overall experience will be elaborated.

The data showed that those women who had relatives or friends working in the hospital seemed to receive care and attention from them, while other women did not have that opportunity. The women appreciated the presence of their relatives as they felt secure and thought they were lucky to have someone close providing them with care:

“Not everybody is like me, I have an aunt working here, she is a doctor and was taking care of me. But not everybody has someone here to look after them. Not everybody has that chance to have someone close and look after them.” (Jwan)

The above-mentioned factor acted positively on the women's overall labour experience. Conversely, some of the women mentioned other factors that had a negative effect on their labour such as the impact of unpleasant hospital surrounding. When the women observed other labouring women screaming and shouting while they gave birth it acted as a reminder for the women of what was to face them next. A few women argued that this kind of behaviour assisted in developing a sense of fear in them. In order to avoid facing this distressing stimulus, Jwan preferred to stay at her home until her actual childbirth was imminent. She also described being at home as a relaxing place and without any frustration:

“... I prefer waiting at home rather than at hospital, it is nicer. I don't know, at home you don't have that fear. But here you hold lots of fears; you see all these people screaming and so on. Certainly you will be very frightened. Of course, you will say to yourself that the other women are suffering a lot and this is going to happen to me [giggling] that's why. I don't like to see all these women screaming

and shouting. I would like to be alone because these are acting as stimulators to enhance your fear and panic, certainly. But if you are alone, you aren't exposed to all these noises and you won't be frightened that much.” (Jwan)

Since not every woman in labour had her own allocated staff, either a nurse/midwife or a doctor, the policy of the hospital allowed only one family member or a relative (female) to accompany each woman. However, this made some of the women anxious and they felt in need of more companions. As a result, several women pointed out difficulties in complying with the hospital's rules and regulations which they thought were against their preferences. The main desire of almost all of the women was to be accompanied by more family members. The presence of the companion helped the women in many ways, for example, they acted as a link between the woman and the healthcare professional as they asked questions to the hospital staff or requested what their patients needed. Also, the main role of the family members was to support the women throughout their labour and childbirth and provide them with care and assistance when they needed. Although the women appreciated the existence of a caring companion such as their mother/mother-in-law or sister/sister-in-law, they appreciated when the staff members could also spend more time with them (as discussed in the previous theme):

“They didn't allow, it was really unpleasant, they didn't allow more than one family member. They only permitted my mum to be with me. In the main entrance, they told us that we have to have only one companion. They didn't allow my sister-in-law to come with me, but later on, she hid herself from the staff and went to another room and then she found me. How possible to give birth with only one companion? Each labouring woman should be accompanied by two of her family members.” (Bahar)

4.3.4.3 Hospital layout and services

The women in this study identified particular issues that related to the structure and layout of the hospital and they perceived them as being important in contributing to their childbirth experience. For example, having privacy, receiving responsive examination once admitted and without delays and having more facilities.

Most of the women considered privacy as the most important aspect when they described their labour experience. They stressed that having no privacy during their birthing process, especially during vaginal examination, was a major issue. As mentioned in the previous sub-theme (unpleasant routine), most of the women linked this issue with shame and psychological side effects. Although most of the women did not object to the provided hospital services, in terms of cleanliness and arrangements, they mainly concentrated on their desire for the physical environment of the hospital to provide privacy:

“You know, it would be so nice if every patient had their own room, if possible. This would be so good even in terms of psychological aspects. It is true they say it is childbirth and nobody cares about others because everyone suffering from pain, but I personally wished to give birth in a private room, not in a room with lots of patients. That would be very comfortable, psychologically.” (Jwan)

Once these women were admitted to the delivery ward, they had to wait outside the examination room, where a doctor or two were responsible for performing further examinations and prescribing any necessary medical intervention. The women’s major concern was having no available bed to be examined on during their admission. They complained that they waited for a long time until they had called to be examined. This issue appeared to have an impact on their overall experience. In addition, some of the women

claimed that even in the delivery rooms, after they had been examined and admitted, they could not find any vacant beds to receive care and give birth. Thus, they had to wait until one woman gave birth and then took her place:

“Wallahi, the doctors’ room was very crowded, all those women were there. They couldn’t tolerate waiting because all of them were in pain. Only one doctor was in that room, she was examining all women alone. All those women! It was very uncomfortable while you were waiting and you wouldn’t be examined until it’s your turn. It was a very unpleasant experience I faced there. I was almost fainting, it was so uncomfortable. I wish they could have more staff and doctors there in order to get women examined as soon as possible.” (Hori)

The women recognised some reasons behind the unavailability of beds in the delivery ward. Firstly, they mentioned the surge in admittance of patients and secondly the shortage of staff members which both contributed in developing this issue. In addition, most of the women complained about the limited options and absence of facilities which they considered would be important features in improving their labour experience, if they were obtainable. For example, they stressed the importance of medications and equipment to decrease their labour pain, that they thought would promote a more comfortable childbirth. The women also appreciated having more birthing options such as different birthing positions:

“During my childbirth, I was thinking to give birth in standing position or any other position because giving birth in the current position is very painful. I thought this might be better. But here, we don’t have these facilities; it would be great if we had it.”

Nonetheless, a few women mentioned that the services they received during their stay in the hospital were ‘very good’ and valued the way that everything was organised:

“Personally, I think it was as I expected, the services was very good but some people say ‘it is a shambles’, I have heard that from others many times. Nawalla, for me it wasn’t like that, and there are 3 of my neighbours who have given birth here, and their experiences were the same as mine.” (Mrwari)

4.3.5 Summary

This section presented the qualitative findings obtained from women’s interviews. The findings illustrated in four emergent major themes which were supported by numerous sub-themes. These results enhanced my understanding of the area being studied and were useful in elaborating some aspects of childbirth which was found in the survey. The women talked about several aspects related to behaviour of healthcare professionals and it was of considerable importance to explore the view of healthcare professionals with related topics of childbirth and maternity care. Thus, the next section illustrates the qualitative findings resulted from the interviews conducted with healthcare professionals.

4.4 Findings from the interviews with healthcare professionals

As stated in the previous section (4.3), the women in this study identified several aspects that had an impact on their overall labour and birth experience. In response, research was directed to explore the healthcare professionals’ perceptions of these aspects. This section will explore the concept of how the healthcare professionals perceived their care towards women in labour, in greater detail.

First, this chapter describes the healthcare professionals' characteristics and lastly, several subthemes will be discussed within the context of the resultant themes.

The healthcare professionals in the study comprised nine nursing and midwifery staff including the unit's manager along with five doctors. Each participant's background is shown in Table 4.12.

Table 4.12 Healthcare professionals' backgrounds

No.	Fictitious name	Qualification	Role	Experience (year)
1	Sairan	Diploma in Midwifery	Nursing and midwifery staff	Approximately 2 years
2	Eran	BSc in Midwifery	Nursing and midwifery staff	Approximately 3 years
3	Nazdar	Diploma in Nursing	Nursing and midwifery staff	2 years
4	Nishtiman	Preparatory school in Midwifery	Nursing and midwifery staff	2 years
5	Raz	Preparatory school in Nursing	Nursing and midwifery staff	Approximately 15 years
6	Soz	BSc Nursing	Nursing and midwifery staff	5 years
7	Shawqi	BSc Nursing + Midwifery training	Nursing and midwifery staff	3 years
8	Warda	Preparatory school in Nursing	Nursing and midwifery staff	Approximately 10 years
9	Shawbo	BSc Nursing	Unit manager	8 years (1 year as a unit manager)
10	Dawan	Doctor/MB ChB	2 nd call ⁸ /Permanent	1.6 years
11	Rehan	Doctor/MB ChB	2 nd call/Permanent	1.8 years
12	Parwana	Doctor/MB ChB	1 st call/Permanent	1.5 years
13	Sakar	Doctor/MB ChB	2 nd call/Permanent	1.8 years
14	Hawser	Doctor/MB ChB	2 nd call/Permanent	2 years

⁸ First call permanent doctors refer to those doctors who have less than 1 year experience in the field after their rotation while second call permanent doctors refer to those doctors who have more than 1 year experience in the field.

After data analysis, two main themes each with a number of sub-themes emerged from the data (see Fig. 4.4). These were:

- Relationships
- Difficulties and Challenges

The following conceptual framework presents the major themes and subthemes showing the interrelationship between them. Each theme and its subtheme will be discussed in a comprehensive way supported by a number of quotes taken from the interview transcripts of healthcare professionals.

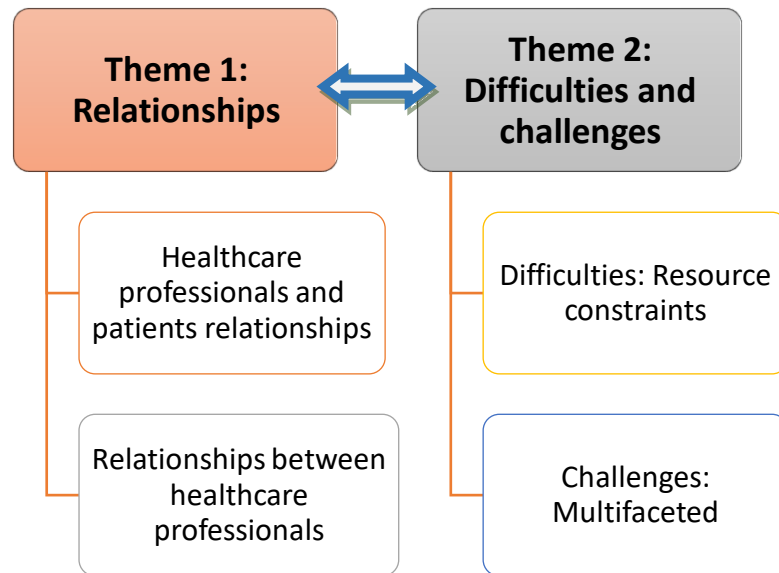


Fig. 4.4 Conceptual framework of the findings from the interviews with healthcare professionals

4.4.1 Relationships

The data analysis of the women's interview data indicated that several aspects concerning staff behaviour and attitude towards them had an influence in creating either a positive or a negative experience for them in their labour process. This concept will be explored within the context of the following sub-themes.

4.4.1.1 Healthcare professionals and patients relationships

The data suggested that the healthcare professionals had different responses with regard to their relationships with patients. They highly valued the importance of having good/positive relationships with their patients. Most of the midwives/nurses described their relationships with patients as ‘good’ and ‘caring’. They stated that it is important to build positive relationships with patients through talking and understanding their needs:

“To me, patients can get half of their treatment just by talking to staff. For example, if now a patient comes and asks me a question, if I answered her not nicely or talked to her with rough speech, she would become uncomfortable, and her condition might worsen. Conversely, the more you talk to her nicely and supportively, the happier she would and it would take her mind off the situation.”
(Warda-Nurse/Midwife⁹)

However, although most of the nursing and midwifery staff acknowledged their positive relationships with patients, some of them expressed concern about some women being uncooperative during childbirth and not listening to staff’s instructions. For example, they mentioned that when they were due to deliver the baby, some women started to move restlessly and backwards which delayed the entire delivery process and tired the baby. Therefore, to try and prevent this, they try to frighten these women by telling them that their baby will be tired or may die:

“We sometimes have some annoying patients; some of them are not staying still during their childbirth, they move their body frequently. So, we cannot control them and deliver the baby and we are afraid that the baby may suffocate. They move their legs, kicking us, not allowing us to do our job; this drives us mad. I personally

⁹ Nurse/Midwife: As there were mixed nursing and midwifery roles among the staff participants, this title is given to those who qualified as a nurse and obtained midwifery training or vice versa.

won't be angry with them but I frighten them by telling them not to do this otherwise their baby will die and it is their responsibility not mine.” (Nishtiman, Midwife/Nurse)

As a result, most of the staff mentioned that, in some cases, they had to be rigid and tough with patients in order to do their work. Eran, one of the midwives, stated that she drew some boundaries between herself and patients in order to maintain a safe working environment for both:

“You can't be friends with them and at the same time you have to be not so tough. Sometimes, midwives have to be firm with patients because they are in a position where they can be confused and frustrated easily. As they don't know how to deal with labour, you have to know how to deal with them. You have to put a boundary between you and them in a way that you will be safe as well as them. At the same time, I don't like to mistreat our patients.” (Eran-Midwife/Nurse)

The analysis revealed that several factors played a major role in influencing the manner used by staff members towards their patients. These factors included shortage of staff, work load and crowdedness (*i.e.*, lots of patients with lots of relatives). One of the participants stated that on some occasions physical tiredness made her react or behave inappropriately with patients. For instance, there were some times she became angry with patients:

“I try to do my best in my work as long as I could, but sometimes if I am too tired and they [patients] are sometimes so annoying, I get anxious and get angry with them, I have to. They are so annoying and you have to talk to them like this, for example, I tell them oh you are so annoying or you are talking too much, these kind of things. There are lots of patients; at the same time there is a lack of staff. If we

had only one patient, we would do our job very nicely and appropriately and there wouldn't be a need to get angry with them.” (Nazdar-Nurse/Midwife)

Regarding the doctors' relationships with patients, the data suggested that they had problems in communicating with patients and most of them highlighted that patients were uneducated and did not understand the doctors:

“My relationship with patients is professional; my only problem with them is that they are uneducated. They cannot understand our words; they don't know the mechanism of labour.” (Hawser-Doctor)

Sakar, another participant doctor, mentioned that doctors focused more on patients considered at risk than on the others. She further stated that they had to shout or get angry with patients in order to make the patients listen to them:

“We don't have time to make relationships with them. Sometimes, we don't even know their names. We mostly focus on risky patients whereas other patients we don't even know their names. You know, our temper here is all the time burning. You may have noticed that we shout all the time, we yell all the time because this is the only way they listen to us, so, you can say the relationship is difficult.” (Sakar-Doctor)

On the contrary, another participant doctor argued that doctors should not allow their emotional behaviour (*i.e.*, impatient or bullying) to be governed by their workload. Parwana, distressed by the way some doctors communicate with patients, mentioned that this behaviour was unacceptable and doctors should be supportive rather than confrontational:

“Generally the relationship between doctors and patients is not so good. I personally become upset and annoyed when I see doctors get angry with patients. In contrast, doctors should be supportive because patients are in pain and we should make them comfortable psychologically. Doctors get angry and they say “we are under pressure of so many patients”, but I don’t see this as an excuse. I don’t know why some doctors are like that. I have witnessed this with my own eyes. I always ask why these doctors are so angry! What is the reason?” (Parwana-Doctor)

The analysis identified that the doctors frequently became angry with patients and did not have a positive relationship with them:

“To be honest, doctors get angry with patients but I haven’t seen the other staff get angry with patients.” (Sairan-Midwife/Nurse)

However, as indicated previously, there were occasions when the nursing and midwifery staff also became angry with patients.

4.4.1.2 Relationships between healthcare professionals

The analysis suggested that the quality of relationships between healthcare professionals were varied and most of them described their relationships as ‘good’ and ‘professional’:

“It is good, thank God; I don’t have any problems with anybody so far. They are good in their work.”(Rehan-Doctor)

Nurses and midwives being cooperative and supportive with each other was another important aspect that was highly valued among them. The participants with less experience in the area expressed their appreciation towards having experienced and skilful staff who had worked for long periods in the delivery unit:

“The staff here are very cooperative and helpful. If for instance, I have a difficult case that I cannot manage by myself, I will call other experienced staff to come and help me in managing the case and delivering the baby. Many times I called X to help me and she did so wholeheartedly.” (Sairan-Nurse/Midwife)

In addition, some participants, including both nurses/midwives and doctors, mentioned that their relationships with some staff were good whilst they were not with others:

“My relationship with other staff is professional. Well, it depends on the person. There are some staff who are respectful but there are others, for example, you ask for something 10 times, then they will reply. Nonetheless, there are some staff with whom I have personal relationships as well as professional relationships. There is mutual respect.” (Sakar-Doctor)

One of the important findings the data showed was that there were some disputes among the healthcare professionals interviewed in this study. The analysis indicated that most of the disputes were between doctors and nurses/midwives. The main reason for these disputes was that the nursing and midwifery staff claimed that the doctors' behaviour was arrogant/ill-mannered. They also said that they felt undermined as the doctors did not listen to their views:

“Our relationships with doctors are good but they don't listen to our views most of the time. Many times we tell doctors that a particular case, for example, is going to be delivered by caesarean section, but they don't listen to us. We know who needs caesareans because we have more experience than the doctors but they dismiss our expertise. In the end, they are forced to accept our advice because there is no other alternative for a viable birth.” (Soz-Nurse/Midwife)

Conversely, other participants, particularly experienced ones, who had worked for a lengthy period in the unit, mentioned that doctors (especially senior doctors) asked for their views and listened to them. Some of them stated that it took considerable time in order to build relationships of trust with the doctors. Also, other experienced nurse/midwife participants mentioned that they do not always listen to decisions made by doctors if they recognise that it is not the right decision:

“Due to the fact that I have been working here for a long time and I have lots of experience, the senior doctors listen to my views, even for a PV [vaginal examination]. I am friends with all of them. Many times senior doctors, not the new ones, have asked me to give my opinions on cases and they have followed my suggestions.” (Raz-Nurse/Midwife)

The analysis indicated that cases were managed in a hierarchical manner. The participants agreed that major decisions should be taken by senior doctors. The nurses or midwives should report their observations to either first call or second call permanent doctors who then must contact their seniors in order to make decisions. This process appeared to affect the patients’ care:

“Our job is to supervise and manage the cases. First call doctors inform us of difficult cases and we inform the senior doctors who decide whether the case should go to theatre or not. We also follow-up the cases; whatever we do has to be done after getting permission from the senior doctors.” (Dawan-Doctor)

One of the doctors expressed the feeling of embarrassment when she talked about the dismissive behaviour of doctors towards nurses and midwives. She furthermore explained that doctors possess a sense of ‘omnipotence’:

“Some doctors feel that they can do whatever they want just because they are doctors but personally I don’t think it is like that. Some feel that being a doctor means that everything is in their control, they have to command, and they have to say this or that. I feel sorry and in my opinion they shouldn’t be like that.”
(Parwana-Doctor)

The data indicated that doctors sometimes exploited their power, making decisions in their own favour, whilst other staff could not do that. Nazdar, one of the nurses, gives an example in this regard:

“It would be natural for husbands to stay with their wives during childbirth. However, only doctors can have spouses with them in the delivery unit. Once, I saw a male doctor accompany his wife during childbirth. She gave birth here but other people are not allowed to bring in their husbands into the delivery rooms. I was so desperate to bring my husband into the delivery room during my childbirth, I told them so many times but they didn’t allow me.” (Nazdar-Nurse/Midwife)

However, the rule of the hospital prohibited male companions to enter the delivery unit; male doctors were allowed to enter the unit due to their authority to access everywhere in the hospital. This policy allowed male doctors to be accompanied by their wives or female doctors to bring in their husbands during labour.

4.4.2 Difficulties and challenges

From the analysis, it was clear that several challenges confronted the healthcare professionals regarding care provision in the delivery unit. The participants identified two main factors that hindered them in providing their patients with quality care. First, the main

focus was on the issues surrounding resource constraints. Second, they frequently discussed the concerns of crowdedness and lack of staff. The next sections explore these aspects in detail.

4.4.2.1 Difficulties: Resource constraints

A common view amongst participants was that limited options and facilities within the context of the hospital weakened the provision of quality care. The healthcare professionals reiterated similar issues that emerged from the women's interviews (as discussed in the previous chapter). These were mainly concerns about limited pain relief options, limited birthing positions and lack of privacy.

Issues related to limited pain relief options were particularly prominent in the interview data. The healthcare professionals argued that two to three limited options were available to relieve the pain associated with labour and birth. The doctors stated that only painkillers such as tramadol and pethidine injections were available for women in labour. Although it was the doctors' responsibility to prescribe medicines for women, the data suggested that they only prescribed these medicines for certain cases. They stated that they only prescribe medications for cases that have medical indications:

“There are only tramadol and pethidine available and these are not so effective to decrease the labour pain very much. We don't have other pain relief measures such as Entonox or epidural analgesia; these are only available in the private hospitals. The only things that exist here are these tramadol and pethidine. We prescribe them for those cases that have efficient contraction in order to increase their effacement. We don't prescribe it for every patient only those who need it. They have to have

indications otherwise we can't give it to everyone because it's limited.” (Parwana-Doctor)

The analysis showed that each doctor had a special account in the pharmacy and they could obtain 10 ampoules of painkillers (five tramadol and five pethidine ampoules) at a time. Thus, they stated that their prescription for them was limited for those cases that had indications. However, the data indicated that doctors prescribed painkillers for those patients who regularly shouted in pain or those who irritatingly asked for pain relief:

“Every doctor has their own share of these injections, for instance, we only have five ampoules of tramadol and five ampoules of pethidine. This is a rule from the hospital administration in conjunction with the pharmacy team. They have their own statistics, for example, for this month that much of pethidine or tramadol will be provided...if we see a patient who keeps on shouting, we prescribe her an injection but we have to make sure that she has frequent contractions.” (Dawan-Doctor)

The data also indicated that although the nursing and midwifery staff could not prescribe the painkillers for women in labour, they supported labouring women emotionally and provided them with reassurance. Soz, one of the nurses, mentioned that, through care and support they endeavoured to reassure their patients, in order to lessen their pain. Also, another nurse commented that some women feel reassured and safer when they were accompanied by a staff member. The next two quotes elucidate this concept:

“We can do nothing about pain relief, we only reassure the patients by asking them to bear the pain as it is temporary and everything will be fine once they give birth.” (Soz-Nurse/Midwife)

“They frequently ask for pain relief and even tell us to not leave them; they feel reassured when we are with them. They say ‘if you are with us, we won’t feel much pain’. So many times I have heard them ‘just give us an injection and kill us’ in order not to encounter the pain.” (Nishtiman, Midwife/Nurse)

Shawqi, another nurse, had concerns about the unavailability of pain relief options and attitudes of doctors towards their request to prescribe painkillers for women in labour. She stated that doctors did not listen to their requests and also highlighted the necessity of pain relief measures for women in labour:

“One day, I told a doctor ‘why don’t you give a certain case a painkiller?’ She said ‘oh you are giving us orders and telling us to give painkiller to the patient!’ Abroad, every patient can get painkillers, if she wants to, but here, they don’t prescribe them for patients; I don’t know why. Even in private hospitals, every patient can have Tramadol but not here. It is not even that expensive, it’s only 3000 ID¹⁰.” (Shawqi-Nurse/Midwife)

In all cases, the participants, including nurses/midwives and doctors, reported that information about the painkillers was not made available to women in labour. They claimed that as a consequence these women request caesarean in order to avoid the labour pain. Whilst the majority agreed that women should be made aware of the available pain relief options, a minority mentioned that women should not be made aware. They considered these women to be uneducated and the hospital environment as unsuitable for this purpose:

“It is difficult to make the women aware of the available pain relief options. They [women] don’t understand, if they know about it, they will just keep asking for it.

¹⁰ ID: refers to Iraqi Dinars (£1.00 roughly equivalent to 2000.00 ID).

Also, it is difficult here because the situation is not fit for the purpose”. (Rehan-Doctor)

Although most of the doctors commented on the necessity of pain relief provision, they simultaneously talked about the requirements for providing women with pain relief such as close monitoring and assessment which needs extra time to be devoted to a woman. They thought that this would be unrealistic to be applied due to the workload involves:

“I am with that to provide patients with pain relief but it is difficult here because, for example, if you give a patient a pain relief measure, you have to be with the patient and monitor her. It is difficult here because in one shift let’s say 15-20 babies will be born, therefore, it is truly difficult. You have to closely monitor the patient and assess her contractions because she cannot push effectively due to the pain relief and thus it takes longer for us to deliver the baby.” (Rehan-Doctor)

Most of the healthcare professionals underlined the importance of safety of mother and baby during childbirth and prioritised it over other aspects of care such as pain relief provision. However, they stated that achieving a positive experience by women in labour during their stay in the hospital is also important but safety was their main concern:

“I care about the safety of the mother and the baby, it is very central of our care. At the same time, we would like them [women] to go home with a positive experience in which they have no complaints about the provided care, but we cannot ensure that”. (Raz-Nurse/Midwife)

The staff members (nurses/midwives and doctors) frequently mentioned the presence of other deficiencies in some services such as inadequate delivery equipment and birthing positions. During analysis I looked at responses to the question: *‘In your opinion, would*

women want alternative positions?’ a similar response was elicited. Most of the staff members stated that most of the women did not request alternative positions because they were unaware of other possibilities of birthing positions. A common opinion amongst the staff members was that they did not disregard the women’s right to make decisions concerning their choice of giving birth. Although they expressed their acceptance of any positions women may choose, they had concerns about difficulties in implementing these requests in the context of a hospital with limited facilities:

“Our patients don’t know if there are other positions for giving birth or not, therefore, they usually don’t ask to give birth in a different position. I don’t mind if patients choose other positions, I just care about their comfort. Also, if they wanted to give birth, for example, by water birth, we don’t have the facilities for that. You know, you have the right to choose, when you have the opportunity and different options.” (Eran-Midwife/Midwife)

Some of the staff members believed that maintaining the privacy of their patients was very important while others considered that women in labour should have a choice to be accompanied by their husbands during their childbirth. The staff members also highlighted difficulties in providing women with these options due to either limited facilities or the rules of the hospital.

4.4.2.2 Challenges: Multifaceted

During the analysis it was identified that a number of issues played an important role in the patients’ care. A recurrent ‘theme’ in the interviews was a perception amongst participants that women generally lacked information about labour and did not know how to deal with their pain during childbirth. All the participants considered this as a barrier in providing

care for patients which they repeatedly encountered. They also stated that if the women were educated, they could better cope with their pain:

“The patients here have no information on labour, they know nothing. They don’t know how to cope with their pain. Another important thing is that they don’t understand what we are telling them. Many times, when I told patients that they still have time until the actual birth, they just kept coming and saying ‘I’m about to give birth’ but it isn’t the case. They don’t understand when we tell them ‘no, you are not in actual labour yet.’” (Nazdar-Nurse/Midwife)

Another interesting finding was that the participants stated that women should obtain information about labour and relevant topics through antenatal visits. They highlighted the importance of having childbirth classes in the health care centres:

“Our antenatal clinics focus on pregnancy not delivery. They advise pregnant women about what to eat, what to do, do not and so on. They check their blood pressure and do blood tests. They don’t give any advice on how to prepare women for labour and delivery”. (Eran-Midwife/Nurse)

Although a few participants valued the role of relatives of patients, most of them had concerns about the presence of many relatives. Their concerns were about the high number of the relatives, and their behaviour towards the healthcare professionals. The participants perceived that having more relatives with patients resulted in preventing the staff from providing patients with the care needed. They stated that relatives annoyed staff members by asking repetitive questions without considering others’ priorities. They also stated that their communication with relatives was ineffective as they mentioned that some relatives were disrespectful:

“Here, the presence of one relative is essential because the staff members are limited and we cannot provide the patients with everything. Thus, it is essential each patient has one relative. Many times, I saw the relatives massaged their patients’ backs and assisted them in admission routines. Nonetheless, our problem with the relatives is that there are too many of them and they sometimes don’t understand us and behave impolitely which makes our work even more difficult.”

(Raz-Nurse/Midwife)

The analysis identified another common view amongst the staff members which was high delivery rate. They expressed their frustration towards the crowdedness of the unit. In all cases, the staff members reported that the hospital could not adequately accommodate all the patients, thus, patient care was affected:

“Our main challenge is to take care of all the patients. On a daily basis, we deliver so many babies and the admission rate is so high, that we cannot provide quality care for our patients. As it’s overcrowded, there aren’t enough beds for newly admitted patients. Sometimes, patients had to wait for 10-15 minutes to get a vacant bed. They waited until a particular case gave birth and then, they could have their own bed to give birth on.” *(Warda-Nurse/Midwife)*

The healthcare professionals identified other factors that hindered them from providing their patients with the care they needed. They stated that issues linked with staff shortage resulted in delays in responding to patients’ requests or providing them with care. However, Shawbo, the head nurse of the unit (*i.e.*, the unit manager), highlighted other obstacles that prevented them from providing quality care for patients. Besides the issues of

staff shortage, she added other problems related to the hospital environment, limited services and low budget:

“We face many difficulties here, from the hospital layout to the staff’s performance. I’m definitely not satisfied with our services because we have lots of deficiencies, for example, we don’t have enough equipment or adequate staff. These issues won’t be solved if we haven’t solved them altogether. For example, if we had staff more than required in all the shifts but if we had other problems like lack of equipment, we wouldn’t be able to provide let’s say the standard care. Therefore, we need to have solution for all these issues together.”(Shawbo-Unit manager)

In addition, the unit manager’s main concern was that authorities did not listen to their requests:

“These issues need to be solved from above, I mean relevant authorities. Even the hospital manager cannot do anything about it. Our main problem is that our voices will not reach the authorities.” (Shawbo-Unit manager)

The data also suggested that most of the nursing and midwifery staff perceived that, despite their hard work, they were unacknowledged. They argued that healthcare providers should be acknowledged either by providing moral or material incentives, in order to make them motivated:

“We just want to be acknowledged by the hospital administration. Sometimes, they don’t even listen to us, for example, if we needed to take a leave, they wouldn’t allow us. They also don’t pay us some incentives, we are so tired here, and they don’t differentiate between us and other staff who aren’t tired or whose work is not

risky like ours. I know our job is humanitarian but we will be motivated if we are acknowledged.” (Nishtiman, Midwife/Nurse)

Despite all the difficulties and challenges all the participants pointed out, they were optimistic that things might improve. Most of them compared the current situation with the past and stated that many improvements had been developed over the last decades:

“I worked here in 2000 for a couple of years, about 2 years, and comparing the situation then and now, it is much better; but we would like to do what is called quality care. I would like this for myself and for the patients.” (Eran-Midwife/Nurse)

4.4.3 Summary

This part of the findings entailed the results obtained from the interviews with healthcare professionals. Clinical and social issues surrounding intra-partum care were explored in this section and it showed how different categories of the healthcare professionals provide care to women in labour and how they manage, behave and respond to requests of women or their relatives.

After illustrating the findings achieved from both the quantitative and qualitative sections, and before commencing to discuss these findings, the subsequent section will present the data integration of all previous data resources (the survey and the qualitative interviews with women and healthcare professionals). The whole study findings will then be discussed in one context (Discussion Chapter).

4.5 Integration of the quantitative and qualitative findings

In the research process, integration denotes the phase or phases where the combination or mixing of the quantitative and qualitative methods occurs (Ivankova et al., 2006). This section combines the findings of both the quantitative and qualitative data from the women and the health professionals in a logical manner to better understand the Kurdish women's experience of labour and birth and the healthcare professionals' perspectives on the relevant childbirth aspects. By doing this, the research questions will be fully answered and a more vigorous and broader picture of the research problem will be developed.

The following subsections present the integrated findings after taking the different methods of data collection into consideration; the survey and the semi-structured interviews with women. It also incorporates the findings from interviews of healthcare professionals, where necessary. This section pays particular attention to whether the findings from different sources support or contradict each other.

4.5.1 Overall labour and childbirth experience

This section shows the women's overall labour and birth experience as this aspect is addressed in both survey and women's interviews. The survey revealed that most of the women were dissatisfied with their labour and birth experiences, mainly referring to the painfulness of labour and childbirth as the core cause of their dissatisfaction. Beside painfulness of labour, the interview data indicated other factors that contributed to their negative experience of labour. In theme one 'pain and related factors', the participants mentioned negative emotions, fear of childbirth, the unexpected way labour unfolded compared with their previous pregnancies, and maternal age. In addition, in theme four 'hospital environment', other factors were highlighted as enhancing their negative

experience. For instances, frequent examination, medical intervention such as episiotomy and suturing, and unpleasant hospital surroundings, including other women screaming and shouting.

Here, it is important to acknowledge that none of the participants (neither women nor healthcare professionals) raised the consequences of FGM as an issue worth considering as a maternity care priority and it will not therefore feature in my subsequent discussions.

The childbirth experience for these women could be described as a bittersweet event, when a mixture of negative and positive experiences occurred for most of the participants. Despite undergoing a painful childbirth and all the negative experiences surrounding it, the survey data demonstrated that most of the women ultimately felt happy about their labour. This finding was confirmed by the qualitative interviews with the main reason behind it being a positive birth outcome. The women linked their happiness with giving birth to a healthy baby and having no postpartum complications; these were seen as the main defining features of a successful birth outcome. They also stated other elements acting as sources of contentment and support, such as the presence of friends and families. The survey and the qualitative interviews support each other in identifying and then clarifying factors that yielded negative or positive experiences during labour and childbirth.

4.5.2 Feeling in ‘control’ and feeling ‘secure’

This section elucidates the notions of feeling in ‘control’ and feeling ‘secure’ when women in the survey were asked to evaluate the statements: ‘I had control during my childbirth’ and ‘I felt secure during my childbirth’. The survey data alone could not explain what women actually meant when responding to these two words in the statements as not

everybody will conceptualise them in the same way. Thus, in the qualitative interviews, women were prompted to clarify what they actually meant by this at the time. Regarding 'control', all the women referred to it as their control of their own behaviour: not screaming, and their power and strength to overcome or cope with pain and difficulties. This could be categorised as 'inner control'. The qualitative findings further supported this in several instances where women used the very limited methods available to them to confront their pain. This could also be linked to the women's lack of knowledge concerning effective coping strategies since targeted facilities (e.g. childbirth-centred education) were not offered in antenatal classes. In addition, none of the women referred to the notion of 'control' as meaning control over what staff did to them, due to the fact that women did not have the choice of being involved in decisions related to their care.

Concerning feeling 'secure', women had distinct interpretations of it. Some of them referred to it as feeling reassured that they were not alone and were receiving continuous support from families and staff. However, others used it to mean feeling safe once they realised that everything went well and that they had given birth to a healthy baby without any problems.

4.5.3 Barriers towards pain relief provision

In this section, the findings regarding pain relief options during labour and birth from all the data sources combined will be explored. In the section of the survey entitled 'awareness of and desire for pain relief', most of the women stated that they wished to be offered options to relieve labour and birth pain. This was mainly because of unavailability of pain relief options to manage their recent labour pain. In the analysis of the women's

qualitative interviews (theme two: pain relief), women reinforced the necessity of making pain relief options available to all women in labour.

Despite the limited availability of pain relief measures such as pain killing medications discussed above, the survey and the qualitative data both demonstrated that women were still unaware of such options. Even if they were aware and requested it, they were not given the opportunity to have pain relief. This is due to the fact that the staff members were selective in terms of prescribing such medications and limited it to those patients who they considered necessary (*i.e.* as medically indicated). However, there was no written guidance or policy in place stating the circumstances in which pain relief may or may not be given. The healthcare professionals (doctors) used their clinical judgement to prescribe pain relief based on the common practice in the delivery unit. This was explained in the analysis of the healthcare professionals' interviews (theme two: difficulties and challenges). In spite of these findings, the healthcare professionals stressed that ideally they should make pain relief options available to women and the women should be made aware about it.

In theme two, in the analysis of the women's qualitative interviews, the women stated that antenatal clinics were ineffective in enriching women's childbirth preparations, including knowledge and strategies for dealing and coping with pain. This was comparable to the questionnaire findings. Additionally, the staff members (theme two) put emphasis on the need for classes in antenatal clinics focusing on labour and childbirth.

In the analysis of the women's qualitative interviews (theme two and four), women on different occasions acknowledged the presence of their relatives, especially when applying natural measures to help relieve labour pain. In contrast, the staff members had distinctly

different opinions about the presence of relatives and perceived them as an obstacle to the provision of care.

4.5.4 Aspects related to staff members

In the survey, women stated that staff devoted enough time to them and their relatives. Conversely, in the qualitative findings (theme three: staff behaviour), women contributed conflicting accounts, complaining about the absence of staff members most of the time, with them only being attentive during the actual birth. This point indicates a limitation of the simple over-arching questions included in surveys and the benefits of following up surveys with interviews giving a greater scope and opportunity for more specific and detailed answers.

The women were not alone during their labour as their family or relatives were with them. The reason they wanted staff to be there was due to do their clinical expertise. Women felt reassured when they were surrounded by staff members. This was emphasised in both the survey (when the staff's skills made the majority of women feel secure) and the qualitative interviews.

The women's interview data showed another contradictory finding to the one obtained from the survey, in that women expressed concern about staff not giving them sufficient information on 'what was happening' or 'what was the staff doing'. However, the healthcare professionals, especially doctors, had different interpretations and blamed women for being 'uneducated' and 'not understanding' their message. In fact, from my own experience, not providing information on matters such as the nature of injections is a common practice.

Theme three in the qualitative findings presented novel and detailed information regarding the relationship between the women and healthcare professionals. The women's perspectives concerning their relationships with staff members were divided into two aspects: 'tough' or 'inappropriate' behaviour and 'good' behaviour. Some of the nurses/midwives and doctors, on the other hand, emphasised the need to appear tough or sometimes use inappropriate behaviour with patients in order to be listened to. They justified these actions by citing the lack of staff and excessive workload. There was, however, a controversy regarding such kinds of behaviour among staff members as some of them were against it as they considered it unprofessional.

Women also complained about the brief nature of communication with the healthcare professionals, if any. The healthcare professionals admitted that this was the case and again rationalised this with the issues of physical tiredness as a result of deficiency of person-power, high number of admissions, and work overload.

The interview data identified the paradox that despite the fact that some women received negative behaviour from staff members, they nevertheless expressed their gratification towards the care they had received. This was confirmed by the survey data when most of the women agreed with the statement: 'I felt very well cared for by the midwife/staff'. In fact, this could be related to that, in the qualitative interview with women, most of them valued the clinical competence of staff members but not the staff's social behaviour or skills.

4.5.5 Facilities

This section presents issues surrounding facility constraints. An element of this section was regarding birthing positions as discussed in the analysis of responses to the survey statement: 'I felt I could have a say in deciding my birthing position'. The women were not offered a choice to decide their birthing positions and they related this to the hospital's limited facilities. The need to provide women with facilities enabling more options for birth was emphasised by women in the qualitative findings (theme four).

Women's negative memories from their labour and birth experiences as discussed in the survey could be related to the following aspects highlighted within the qualitative findings (theme three and four). Issues concerning privacy were of particular significance with staff members also stressing the importance of having privacy in delivery settings. Another issue that was considered as a significant issue in the women's labour experience was the lack of available beds. Both qualitative findings (women and healthcare professionals) reinforced the impact of high delivery rate and insufficient staff members on the provision of care.

4.6 Conclusion

This chapter presented a combination of the entire study findings in order to boost better understanding of the scope of the study. Indeed, the qualitative interviews with women and healthcare professionals elaborated several aspects of labour and childbirth in more detail and significant findings were established to enhance our understanding of how birth is managed in Kurdish settings.

The next chapter will discuss these findings and other important findings in a comprehensive manner and compare them with most recent studies.

Chapter Five: Discussion

5.1 Introduction

This study set out with the aim of assessing how Kurdish women experience labour and childbirth, and whether or not they are aware of options that may exist for relieving pain during labour. It also aims to explore how healthcare professionals (nursing and midwifery staff along with doctors) perceive the many aspects involved in women's childbirth (clinically and socially). As discussed in the preceding integration section, the quantitative and qualitative findings individually and collectively enhance understanding of the scope of the study. Indeed, this was the logic informing the use of the explanatory sequential mixed method strategy.

This chapter discusses the key findings and compares them to findings of other studies in this area, to highlight areas where they concur or contradict each other. The limitations of the study and suggestions for future research will be addressed.

5.2 Overview of findings

The survey findings reveal comprehensive data on different aspects of childbirth which justify the study's focus. In addition, the qualitative interviews facilitate and expand an understanding of the different dimensions of labour and birth from the women's perspectives. This enables the women to describe their experiences individually and thoroughly. The analysis of the women's interviews was first discussed in Chapter Four, Section Two. Several themes (pain and related factors; pain relief; staff behaviour; the hospital environment), each with subthemes, were identified during analysis. Generally, the women in this study regarded their labour and birth experience as very painful and cited

different factors contributing to their overall experience, whether negatively or positively. For example, the behaviour of healthcare professionals towards the women.

However, the findings of the healthcare professionals offered a contrasting insight into the subject with a number of issues being discussed with regard to women in labour. For instance, these professionals often described patients (women in labour) as annoying and uneducated, and complained about them not understanding medical terminology. In some cases staff admitted deliberately frightening patients in order to be listened to.

In the integration section, effort was made in order to bring together all the findings through recognising links and relationships within and between different sources of data. It was discovered that some of the data were complementary while others were contradictory. This process gave a wider field of view and enabled the exploration of multifaceted aspects of childbirth as experienced by Kurdish women.

5.3 Key issues in overall birth experience

As this study focuses holistically on women's experiences of labour and childbirth in a Kurdish setting, it is essential to address the common issues which emerged during the analysis of the combined sources of data. In reviewing the literature, since no comparable study has been found to have been conducted in the country of the current study, studies that have been conducted in either neighbouring, developing or developed countries will be used to support or contrast with the findings. The major recurrent issues that the women in this study experienced and had concern about were pain during labour and childbirth, and the lack of pain relief options. It was discovered that these issues had a profound impact on

the women's overall labour and birth experience. Therefore, this section deals with such issues in more detail.

5.3.1 Pain during labour

The experience of childbirth and the perception of pain is different and unique for every woman. Women who have similar types of births and labour lengths may perceive their overall labour and childbirth experience differently. The childbirth experience has been described as complex and multidimensional (Lavender et al., 1999, Waldenström et al., 1996). At the same time, researchers define the experience of childbirth as individual and unique (Halldorsdottir and Karlsdottir, 1996). Even though the phenomenon of childbirth is a collective phenomenon, it is subjective and personal for those women who experience it (Miller, 2005). Larkin et al. (2009), through their concept analysis of women's experiences of labour and birth, pointed out that although labour and birth experience is defined as an 'individual life event', other interrelated factors influence it. These factors include social and cultural contexts, environmental, policy and organisational contexts.

The current study found that most of the women experienced a high level of pain and described it as the worst aspect of their experience. This finding is consistent with data obtained in a study conducted on 301 women in Kuwait by Harrison (1991). The study aimed to describe the experiences of childbirth of three different groups (Kuwaiti, Palestinian, and Bedouin) of Arab mothers giving birth in Kuwait. The visual analogue scale (VAS) was used to assess their pain. Harrison found that although there were some discrepancies in women's ratings of pain among the three groups, most of the women rated their pain as "unbearably painful". In another study conducted by Abushaikha and Oweis (2004), the majority of Jordanian women who went through labour reported a high level of

pain intensity (≥ 8 on the Numeric Pain Intensity Scale ranging from 0-10). However, it is important to acknowledge that the above mentioned studies (Abushaikha and Oweis 2004; Harrison 1991) were undertaken a long time ago and practices may have changed since then. How women described the pain may also have depended on the timing when the question was asked.

A qualitative study conducted in Iran by Beigi et al. (2010), found a paradox with regard to women's description of labour pain. For instance, some of the women described labour pain as "unbearable and indescribable" while others described it as "sweet pain". It is important to note that these women had a natural childbirth (*i.e.*, without pain relief). This result is in agreement with those obtained by Lundgren and Dahlberg (1998) on nine women in Sweden. Their participants included those women who did not use pain relief options as well as those who used one or combinations of Entonox, Transcutaneous electrical nerve stimulation (TENS), massage, bath and acupuncture. The researchers reported that some participants had difficulty describing their childbirth pain in words, while other participants described the pain as 'terrible' and 'hard' mixed with 'positive' and 'happy'. In general, women graded their labour as a painful experience while in qualitative studies women stated that although childbirth is a painful experience they simultaneously referred it to something rewarding and positive. Nevertheless, none of the women in the current study (in the qualitative part) mentioned their labour pain as 'sweet' or 'happy' pain.

Assessment tools such as the VAS and the Numerical Rating Scale (NRS), or its verbal version, were commonly used in research and in a clinical context to measure pain associated with labour and birth. Authors investigated how women experience and view

assessment strategies of pain during labour. Jones et al. (2015), in Australia, found that women were insightful about the possible inaccuracy of pain assessment measures due to the multidimensionality of pain. Jones and colleagues concluded that *“a woman-centred approach demands pain assessment that matches each woman's preference for mode and timing and captures the multiple dimensions of pain. Women describe the need for an expanding scale to accommodate the progressive modifications of their conception of what is extreme pain”* (Jones et al., 2015, p.708).

Giving birth is a life-changing experience frequently accompanied by feelings of uncertainty which may enhance the women's anxiety levels. Some women may discover that they are fearful of giving birth: this can be caused by numerous factors such as a fear of labour pain, or previous experiences of a painful and difficult childbirth. In this study, women were found to be afraid of childbirth due to its associated pain and the difficulties around it. Therefore, caesarean section was often requested. Shahoei et al. (2011a) reported that the most common reported fear of childbirth among Kurdish women in Iran is the fear of pain of labour and childbirth. Shahoei and colleagues also pointed out that another source of fear was due to the lack of participants' information about labour and childbirth. Another study in Turkey revealed findings that are in agreement with the findings obtained by the current study. Serçekuş and Okumuş (2009) investigated fear factors among Turkish pregnant women. They found that women commonly expressed fears associated with labour and birth pain and procedures that might be undertaken during the labour and birth, for instance, vaginal examination, episiotomy, and assisted deliveries (*i.e.*, forceps or vacuum extraction).

These results corroborate the findings of a review conducted by Saisto and Halmesmäki (2003) who argued that fear of childbirth can emanate from different issues such as biological, psychological, and social factors. These may include fear of childbirth pain, anxiety, lack of support and previous traumatic childbirth experience. This is also consistent with the findings of Størksen et al. (2013) in Norway. Saisto and Halmesmäki (2003) also argued that one of the reasons for requesting a surgical birth was fear of childbirth. This was confirmed by the findings of Fenwick et al. (2010) in two states of Australia.

On the contrary, in Sweden, Hildingsson et al. (2002) found that only a few women wish to be delivered by surgical operation (C/S) and this was mostly related to their personal life circumstances (age, parity and negative obstetric history, social status, and residential area). Findings of Torloni et al. and Serçekuş and colleagues showed that only a minority of pregnant women (Italian and Turkish, respectively) would prefer to give birth surgically without medical indications and their main reason was fear of labour pain and childbirth (Serçekuş et al., 2015; Torloni et al., 2013).

A study conducted in Western Australia by Fisher et al. (2006) found the main factor in alleviating childbirth fear during pregnancy. They mentioned support and positive relationships with midwives as core factors in avoiding childbirth fear. Thus, it is essential that healthcare professionals prepare pregnant women for childbirth and support them in order to overcome potential fears during labour and childbirth.

5.3.2 Pain relief and awareness

As an insider coming from the area of the current study, I was aware that in governmental hospitals women give birth without receiving any kind of pain relief measures, including

non-pharmacological and pharmacological measures such as water births, breathing techniques, injections (pain killers) and epidurals. Despite the fact that a limited range of injections (pethidine and tramadol) were available in the delivery unit of the current study, it was found that not every woman was given the chance to receive them as a means of relieving pain. This was based on the healthcare professionals' (doctors) clinical judgment. In developed countries, some women during labour and birth may avoid any medications or medical interventions, while others may consider all available options in order not to face the pain of labour (Henry and Nand, 2004b). For Kurdish women, when there is no access to pain relief measures in delivery wards, it was of particular importance to know their perspectives on this issue.

Providing pain relief options (for instance, Entonox and epidurals) in the Kurdistan region is a relatively new idea and has been available in only a few private hospitals in recent years. It was important to assess whether Kurdish women were aware of labour pain relief options and also to identify what the obstacles were in providing pain relief options in the governmental hospitals. The findings indicated that the women generally lacked information or were not aware of any kind of pain relief measures to alleviate their labour pain. This result is in line with those of previous studies carried out in developing and low-income countries (India and Uganda) such as Nabukenya et al. (2015), Shidhaye et al. (2012) and Naithani et al. (2011). Naithani et al. (2011), conducted a study on 200 prospective mothers and found that more than 90% of women were unaware of analgesia during labour.

In contrast to the above findings, a study in South Africa concluded that most of the women there (56.3%) were knowledgeable regarding pain relief during labour (Mugambe et al.,

2007). This result is also consistent with the findings obtained by Minhas et al. (2003) in Pakistan, in which 76% of the women had information about labour analgesia (epidurals). However, some studies showed that women were aware of some kinds of pain relief options more than other types. For example, the majority of Pakistani women had information about pain relief injections whereas only a few of them were aware about epidurals in a study carried out by Barakzai et al. (2010). From the studies shown earlier, it is clear that only in developing countries women tend to lack information about pain relief measures.

Women's lack of awareness about labour pain relief options might be due to their level of education as a remarkable number (91 out of 256) of the women in the current study had no history of school level education. This result is comparable with a report on the Kurdistan region's facts and figures published by the Kurdistan Board of Investment (2000), in which the literacy rate among females is stated as 64.2% (illiteracy rate = 35.8%) with an overall population literacy of 74.1%.

In the current study, unsurprisingly, the logistic regression comparing the association between the awareness level of women regarding labour pain relief and educational level of the women showed that there is a statistically significant overall effect of level of education on women's awareness. It was concluded that women with degrees are much more aware of labour pain relief options than those who did not have degrees. Similarly, other studies had shown this association. For instance, Naithani et al. (2011), in India pointed out that the higher educational level, the more knowledgeable women are about labour analgesia.

Nevertheless, it is interesting to note that only a limited number of participants in the current study had knowledge about pain relief options and that they mostly cited friends

and relatives as their main source of information, followed by previous birth experience and healthcare professionals. This result matches precisely with those observed in a study conducted by Mugambe et al. (2007), in South Africa. However, in a study conducted in the UK, it was found that women obtained their information mostly from healthcare professionals and 98% of women read and understood the information provided (Soltani and Dickinson, 2005).

What is surprising is that none of the women in the current study received information from antenatal visits; this is due to the fact that the primary health care centres are more likely focusing on pregnancy related issues rather than labour and childbirth. The logistic regression also showed that there is no statistically significant association between antenatal visits and women's awareness regarding labour and birth pain relief options.

These findings are supported by a study conducted in Erbil primary health care centres by Raof and AL-Hadithi (2011). They reported that pregnant women most commonly discuss subjects related to nutrition and family planning/child spacing during their antenatal visits in health care centres. Other topics discussed include advantages of giving birth in health facilities, breastfeeding and danger signs of pregnancy. They concluded that antenatal clinics provide poor health education. This finding has important implications for developing an extensive educational package incorporating topics during pregnancy, or even prior to it, and covering important subjects related to labour. For instance, explaining the labour process and childbirth preparation classes.

In contrast to the current study's findings, studies conducted in other locations have reported antenatal classes as an effective source of information, alongside other sources of information such as multimedia. Surveys such as that conducted in Australia by Henry and

Nand (2004a) have shown that, concerning intrapartum pain relieving techniques, most of women felt “very well informed” during their antenatal period. It is apparent that in developed countries, such as the UK, there are many means available for potential mothers to obtain information they need related to pregnancy and childbirth. For instance, the webpages of the National Health Service.

5.3.3 Barriers towards pain relief provision

As the majority of the women in the current study were unaware of pain relief options, those who were aware requested their pain to be managed and none of them received any pain relief. Among them, they had different opinions on why their pain was not managed. Some of them had no idea why they were not given pain relief and others claimed that crowdedness of the unit was an obstacle in nurses/doctors providing pain relief options. The data also indicated that these women were left uneducated about labour pain relieving measures and mentioned that staff members know better than them. This indicates that these women consider staff as superior and trusted whatever they did to/for them. These women may consider staff’s training and experience in that field and this could be the reason why they think so. This reinforces the statement of Bluff and Holloway (1994) who said that participants (women in south of England) believed that staff members (including midwives and doctors) “know best” or in some cases know better than they do; this was due to staff’s expertise. Bluff and Holloway (1994) also reported that since participants trusted in staff knowledge and skilfulness, their decisions were influenced by them.

Although the current study found that there were injections available to relieve labour pain, the doctors were selective in prescribing these injections. There was no obvious reason why doctors did not prescribe pain relief injections for those women in need of it or who

requested it. A possible explanation for this might be that doctors wanted to manage all the cases without any additional observation as administering pain killing injections may need further monitoring. An alternative explanation for this is that the staff were much more concerned about the safety of the mother and her baby rather than providing pain relief measures for women in labour. If doctors were keen to provide their patients with pain relief options; they could prescribe such injections for those women who requested it. In return, women could experience childbirth as a joyous moment instead of suffering, since these women instantly talked about their intensity of pain experienced during labour when they were asked about their experience in the qualitative interviews.

These findings from Kurdistan are in contrast to what is recommended by the UK's National Institute for Health and Care Excellence (NICE). Its latest guideline (intrapartum care for healthy women and babies) published in December 2014 recommended that *“healthcare professionals should think about how their own values and beliefs inform their attitude to coping with pain in labour and ensure their care supports the woman's choice”* (NICE, 2014, p.32).

5.3.4 Pain and coping strategies

For many years, researchers investigated the effectiveness of different approaches to decrease the pain experienced during labour and birth. For instance, the impact of acupuncture, birth ball, and massage on labour pain (Taavoni et al., 2011; Chang et al., 2002; Skilnand et al., 2002). In addition, several Cochrane reviews have examined the effects of non-pharmacological or complementary and alternative therapies and pharmacological interventions for labour pain management. It was concluded that most

non-pharmacological measures may work to reduce the labour pain and are safe for mother and baby (Jones et al., 2012; Smith et al., 2006).

The results of the current study indicated that the women employed very limited natural measures as coping strategies. A possible explanation for this might be related to the women having received restricted information on different childbirth-related aspects during their antenatal period. This is in contrast with the findings of Escott et al. (2004) from a study conducted in the North of England. They pointed out that women, during their first pregnancy, can recognise their previous individual coping strategies for dealing with labour pain. Their findings also indicated that even those women who did not attend antenatal classes used various ranges of coping strategies during their labour.

The women in the current study believed that relying on God helped them to ease their labour pain as most of them prayed in order to obtain support from God during their childbirth and that their pain will be diminished. This is discussed in greater detail in section 5.4.2 (Belief in God).

Not surprisingly, in order to experience labour and birth with less or no pain, most of the women in the current study wished to have their pain managed. Likewise, in their study, Kuti and Faponle (2006) clearly have shown that the majority of Nigerian women would greatly value pain relief measures. Shidhaye et al. (2012) also found that the majority of their participants (women in India) desired to learn about different pain relieving techniques. Thus, attention should be paid to incorporating pain relief measures into intra-partum care, since this is a central concern of women in labour.

Despite this finding, these data indicated that few women had concerns about health or side-effects of specific pain relief options, if they were available. They identified problems

of back pain (in case of epidurals) and/or negative effects on their babies. Similarly, James et al. (2012) in India and Barakzai et al. (2010) in Pakistan pointed out that women believed that using pain relief options will cause permanent backache, weakness of limbs, and health problems of the baby.

5.3.5 Satisfaction and birth experience

In general, satisfaction is a broad and multidimensional concept and satisfaction during labour usually relates to several interrelating aspects. It is possible for a woman to be satisfied with some aspects of her childbirth and the care received during it and simultaneously dissatisfied with other aspects (Rudman et al., 2007). Several studies investigated the concept of satisfaction with regard to various issues during labour and birth. These could be categorised as: (i) women's opportunity to be involved in, and in control of, aspects central to them; (ii) be listened to and make decisions about the intrapartum care provided (Christiaens and Bracke, 2007; Rudman et al. 2007; Hodnett, 2002; McCrea and Wright, 2001; Halldorsdottir and Karlsdottir, 1996); (iii) support received from midwives and doctors; (iv) physical environment (Mohammad et al., 2014); (v) having options to choose from, such as positions and pain relief.

The majority of women in the current study reported dissatisfaction with their overall labour. In fact, this dissatisfaction could be related to one or more of the aspects mentioned above. Concerning women's own capacity, the women identified negative experiences with most of its items. For instance, most of them felt neither strong nor capable during their labour and birth and they felt tired. In addition, the majority of them stated that they did not have control. The results of this study showed that women referred to their internal control: their ability to overcome difficulties and cope with labour pain. This finding is in accord

with the findings of a study conducted in Jordan by Oweis (2009); which pointed out that women perceived that they had minimal control during their labour and childbirth and were mostly dissatisfied with different elements of their experience.

Green et al. (2003), found that women were more likely to cite being in control of their own situation (having self-efficacy) than being in control of staff. In their findings, Halldorsdottir and Karlsdottir (1996) reported that women valued the need to be in control of their behaviour and surroundings. They also stated that being in control was associated with being strong during labour and childbirth. Those women who felt in control during their labour, at the same time felt strong. In addition, Goodman et al. (2004) concluded that a central factor that linked to childbirth satisfaction was having personal control. Thus, an important element in intrapartum care is to enhance women's personal control during labour and childbirth which ultimately leads to satisfaction with the childbirth experience.

One of the interesting findings of the current study was that none of the women mentioned their control over what was done or would be done (*i.e.*, no external control). This indicates that Kurdish women are passive recipients of care during labour and were not involved in any decisions that might be crucial to them. This suggests that women did not have opportunities to be engaged in the care provided. It also suggests that healthcare professionals, both midwives and doctors and particularly the latter, are the only decision makers with regard to care provision. This includes when examinations are to be done and how frequently and what treatment is to be done and how. These findings are disappointing and indicate that healthcare professionals should pay attention to women's queries, listen to their views and value their concerns.

Similarly, Hatamleh and colleagues (2013a) noted that Jordanian women were rarely involved in making decisions related to their care, as it is the healthcare professionals' authority to make decisions about different aspects of care. This is further supported by the findings of Mohammad et al. (2014), in which women reported dissatisfaction with regard to their involvement in decision making during their labour and childbirth. In contrast is a national survey of women's experiences of maternity care in England which was published by the Care Quality Commission (CQC) in 2013 reported that the majority of women felt that they were involved enough in decisions about their antenatal and labour and birth care. It was also reported that the proportion of women stating their involvement in care in different stages of pregnancy and labour had increased compared to the 2010 survey (CQC, 2013). In her systematic review, Hodnett (2002) pointed out that being actively involved in decisions about one's care is an essential part of satisfaction in labour and childbirth.

This study found that women were free to eat, drink and move around during their labour unless their actual birth was due. They also could walk, sit, and lie down but during the actual birth the only position they could adopt was the lithotomy position. Although the women linked this to the limited facilities in hospital, this actually might be due to other factors such as policy of the hospital or its standard practice or even the clinicians need to feel in control. Ideally none of these should be the reason for not allowing women to choose the birthing positions they prefer. The model of care and philosophies of healthcare professionals are documented to be among those factors that hinder or facilitate specific birthing positions (Priddis et al., 2012). Tew (1998) in her book, explained how doctors in 1930s in the UK adopted lithotomy positions for their convenience, which had no advantage for women in labour. In Jordan, authors reported that the only common position for giving birth was also the lithotomy position and women were usually restricted in

movement during labour (Shaban et al., 2011). This finding is in contrast with the UK intra-partum care recommendations published by NICE. It recommends that staff “encourage and help the woman to move and adopt whatever positions she finds most comfortable throughout labour” (NICE, 2014, p.22). In developed countries, such as the UK, the majority of women are generally free to move around and have a choice to decide on the position that makes them comfortable during their labour and childbirth (CQC, 2013). Priddis et al. (2012) concluded that upright positions during labour leads to several advantages such as shorter duration of first and second stage of labour, less intervention and increased childbirth satisfaction. However, Priddis et al. (2012) pointed out that increased bleeding which associated with perineal trauma is one of the disadvantages of upright birthing positions.

The study showed that women were concerned about their safety and the safety of their baby. It was noted that these women felt safe and secure after they have given birth as they no longer needing to worry about the unpredictability of labour. They also acknowledged the fact that the presence of their relatives offered them feeling of safety. Similarly, Khosravy et al. (2013) and Shahoei et al. (2011b) found that pregnant Kurdish women in Iran expressed fears with regard to their childbirth, such as fears associated with the wellbeing of their babies. Kabakian-Khasholian et al. (2015) also found that women in Syria and Lebanon relate the process of labour with ‘death’. Other studies in Finland and Australia have shown that women felt fearful about their safety and the safety of their baby (Fisher et al., 2006; Melender, 2002; Melender and Lauri, 1999). In a study conducted among a group of Brazilian women who had given birth for the first time, “fear of death” and “losing the child” was noticeable throughout their birth experience (Nakano et al., 2012). Halperin et al. (2014) conducted a comparative study among Israeli Jewish and Arab

women regarding their birth perceptions. They concluded that the perception of being afraid during labour and fear for their new-born's safety were higher among the Arab women.

This study found statistically significant association between women's own capacity, perceived safety and participation with some demographic variables such as home area and level of education. Thus far, there are no other comparative studies around; therefore, it would be interesting to place these findings into a broader context when relevant studies are published in other locations. Then, it will be possible for other researchers to compare their findings with the current one and this may show differences due to different locations and systems in place of the studies.

5.4 Factors contributing to a positive childbirth experience

Several important themes identified during data analysis were presented in the findings chapter (Chapter Four). The key issues mentioned earlier in this chapter (see section 5.3) are playing a major role in contributing to either a positive or negative experience. For instance, being able to eat, drink or move during early stages of labour were highly appreciated by the women contributed to a positive birth experience.

Many researchers investigated different factors contributing to a positive birth experience. Some authors documented communication, support and a trusting relationship between midwives, or other staff members, and women in labour as factors associated with a positive experience (Attanasio et al., 2014; Nilsson et al., 2013; Lundgren, 2005). Others reported normal labour with healthy mother and new-born, prior knowledge about labour and delivery, socio-demographic factors (age, parity, education and employment status),

involvement in the labour process, strength and ability of one's behaviour towards labour pain, use of pain relieving measures and being able to freely change positions (Karlström et al., 2015; Al Ahmar and Tarraf, 2014; Ahmadi, 2013; Cipolletta and Balasso, 2011; Khaskheli and Baloch, 2010; Hardin and Buckner, 2004; Waldenström, 1999).

The following topics discussed in this section are those aspects that women in the current study considered as important elements of their childbirth, ultimately contributing towards a positive labour and birth experience. Unfortunately, it was found that the women described limited positive elements in their labour and birth experience compared to the negative elements (which will be discussed later in this chapter).

5.4.1 Companionship: family, relatives and friends

Women historically have given birth at home, usually accompanied by other women providing support. Across cultures and in many countries, women began to give birth in hospitals where it was initially considered impractical to receive support during the labour process from other women. However, health policy makers subsequently advocated the benefits of a companion to provide women in labour with the support they need and as a result hospital policies have been reformed. Recently, in many countries, women in labour were allowed to be attended and supported by other women significant to them, such as family members, relatives and friends (Amorim and Katz, 2012). Indeed, this is the case in Kurdish hospital settings where women in labour can be accompanied by (theoretically) one support person. However, in some cases, women bring in additional support persons in. The women in the current study appreciated the presence of their family members, relatives or friends during the labour process. The supporting person could be the woman's mother, sister, mother-in-law, sister-in-law or friend.

In contrast to the findings of the current study, studies in the middle-eastern countries such as Syria, Jordan, and Egypt reported that, in public hospitals, women in labour are not allowed to be accompanied by family members or female relatives. They did however document the need for a companion with women in labour, as it provides many benefits to the labouring woman (Kabakian-Khasholian et al., 2015; Hatamleh et al., 2013a; Khresheh and Barclay, 2010; Sweidan et al., 2008; El-Nemer et al., 2006).

In my opinion, according to the clinical practice of the study hospital, the presence of a supporting person is necessary. This is due to the fact that the current intrapartum care does not provide one-to-one or continuous support for the women in labour. The parturient women receive much physical and psychological support from their female companion. Physical support includes helping women to ease their labour pain by massaging their back, offering help by doing paper work related to hospital administration (such as making a file on admission), communicating with healthcare professionals regarding the progress of labour, gaining information and asking for staff's attention towards their clients. These findings concur with the findings reported by Aduloju (2013) in South-Western Nigeria. Aduloju pointed out that the majority of women reported better coping with labour pain and the whole labour process after receiving back rubbing from their companions. Another study in Indonesia found similar findings with regard to the advantages of companionship (in this case, husband) in providing supportive physical help to women in labour (Rachmawati, 2012).

Psychological support includes supporting women in labour emotionally by keeping them calm, reminding them to have strength to endure the pain and also praying for them to give birth safely. The women, in turn, felt safe and secure with the presence of their family

member or a support person. Other studies described the kinds of support that a companion provides to women in labour. In a study conducted in Jordan by Khresheh and Barclay (2010), where women were given the chance to bring in a female relative (mother or sister), it was found that women experienced childbirth more positively as a result of having a companion. Women reported how they obtained emotional support and encouragement from their relatives by either reading prayers or the Qur'an and holding their hands. They also referred to how the presence of a female relative improved their sense of security. In addition, Kabakian-Khasholian et al. (2015) found that women in three Arab countries acknowledged that the attendance of their family member provided them with psychological support during labour. Women also pointed out that their anxiety level and feeling of fear increases when they are not accompanied by a relative during the labour process.

Several randomised controlled trials in Brazil and Thailand investigated the effects of labour support from a close relative or a companion of the women's choice. They found out that women having support during their labour and birth were more satisfied with their experience (Yuenyong et al., 2012; Bruggemann et al., 2007). Since family members are not allowed to accompany labouring women in most public hospitals in Thailand, a quasi-experimental study was carried out by Chunuan et al. (2009) to compare the outcome of presence of a family member in the first stage of labour in terms of anxiety level, labour pain, satisfaction, duration of first stage of labour and type of delivery. Chunuan and colleagues found that the presence of a family member reduces the anxiety level of women during labour where significant differences were found between the anxiety score of experimental group and control group. Nevertheless, no significant differences were found for other variables.

Conversely, Essex and Pickett (2008) examined the effect of mothers without companionship during labour. They reported that mothers who attended birth unaccompanied were more likely to have a preterm birth, emergency caesarean section and lower satisfaction with life *at 9 months postpartum*. In addition, in South Africa, Ntombana et al. (2014) carried out a study to explore women's views on companionship during labour documented that women with no companions experienced their labour as painful and they believed that their labour could have been 'better' if they had companions.

The current study showed that the women stressed the perceived importance of being accompanied by more than one family member or relative, as they thought that one companion could not provide enough support to them. However, the healthcare professionals were against this (*i.e.*, having more than one companions and their behaviour) and even expressed their discontentment concerning the attendance of family members as they considered them as a barrier in providing women in labour with quality care. They argued that a higher number of companions made the delivery rooms crowded. This is in agreement with the findings of Kabakian-Khasholian et al. (2015) who collected data from labouring women, their family members and staff members (midwives, nurses, and obstetricians) in different public teaching hospitals in three different countries (Lebanon, Syria and Egypt). Kabakian-Khasholian and colleagues reported that although staff members were aware of the evidence supporting labour companionship, they mentioned the expected crowding in labour rooms as a barrier towards allowing companionship. Some staff members showed some "*non-supportive attitudes*" towards labour companions as they believed that companions impede the care provision (p.225).

This study revealed that the healthcare professionals appeared to be annoyed and get angry if a relative frequently asked them to see her patient. Khresheh and Barclay (2010) reported similar findings when, in some instances, minor conflicts occurred between relatives and staff members; consequently the latter viewed relatives as interfering with the care they provide.

Since no male companions are allowed to enter the delivery units in Kurdish public hospital settings, the female companions act as a link between women in labour and their husbands. For example, if a woman needs a blood transfusion, husbands are first contacted to donate or find the type of blood that is needed. In addition, in some emergency cases such as emergency C/S or if a woman wants to consent jointly with her husband, husbands must then be contacted to give consent. Likewise in many neighbouring Arabic and African countries, men are not allowed to attend childbirth. TorkZahrani (2008) stated that as a result of religious and traditional values within Iranian culture, men do not become involve or attend labour and childbirth. Sawyer et al. (2011) reported that women in Gambia are not accompanied by their husbands during their labour due to cultural values. However, Ampofo and Caine (2015) reported that husbands (Ghanaian) were also not allowed to be present at birth due to environmental setting of the hospital (no privacy).

Not allowing men to enter birth units may have its roots in Kurdish tradition, culture and religion, as childbirth is considered as a “woman’s business”. Besides, the hospital environment and its structure (lack of space and privacy) might have an effect on the policy of not involving men in childbirth in the Kurdish public hospitals. Surprisingly, although the current hospital policy that was part of the current study bans men from delivery units, none of the women in this study raised this issue and none of them expressed an interest in

being accompanied by their husbands. Again this might be due to the aforementioned factors and the women themselves nurturing this kind of practice. On the contrary, Sawyer et al. (2011) and Halldorsdottir and Karlsdottir (1996) in the Gambia and Iceland respectively, reported that the women in their studies strongly expressed the need to be accompanied with their partners/husbands during their labour and they believed that having childbirth is a “joint issue” for which husbands should share responsibility.

It is interesting to note that the healthcare professionals (nurses and midwives) in the current study talked about their own childbirth experiences and expressed an interest in adopting a policy that allows women to be accompanied by their husbands in such difficult situations. On one hand, they highlighted the help and reassurance women in labour may obtain from their husbands. On the other hand, they pointed out that men should be aware of what a woman goes through during labour and birth. Participants (women in labour) in another study shared similar views about involving men in labour and childbirth (Kabakian-Khasholian et al., 2015; Sawyer et al., 2011).

5.4.2 Belief in God

Another factor that helped the women to maintain their positive mind-set was their belief in God. The current study showed how women relied on their God/Allah to support and help them during labour and childbirth. This might be due to the fact that Kurdish people are generally believers in Allah (specifically during hard times) and they worship Him as the One who is responsible for making difficult times pass easily. Based on my observations and experience in the field, women usually demonstrate an attitude of surrender to God’s will by praying and reading the Qur’an during their labour; in order to gain his mercy in return and make their labour peaceful and successful. Other studies reported on this topic,

such as Hatamleh and colleagues (2013b) who found that Jordanian women praised the support of Allah in assisting them to adapt and cope with labour and birth pain.

Similarly, other studies documented that having faith in God acts as a factor contributing to a positive experience. For instance, Ahmadi (2013) in her phenomenological study of 22 Iranian women, which aimed to describe positive childbirth experiences, found that belief in God enhances women's childbirth experience. Beigi et al. (2010) and Khalaf and Callister (1997), found that women felt closer to their God during childbirth, and how the use of religious beliefs and rituals such as prayer helped them to cope and alleviate their labour pain. In addition, El-Nemer et al. (2006) pointed out that participants read the holy text of the Qur'an in order to cope with difficult situations they underwent during their labour and childbirth.

Other studies reported the impact of other religions such as Christianity and Judaism on childbirth experience. In Nigeria, Chiejina et al. (2012), noted that there is a significant relationship between childbirth pain perception psychologically and religion (the majority of women were Christian).

Several studies examined the role of culture and religion and their impact on women's pain perception and pain behavior (Callister and Khalaf 2010; Callister et al. 1999). Callister et al. (1999) carried out a study on 60 Mormon and Orthodox Jewish women living in the United States and Canada respectively, found that women (both religions) identified the importance of one's connectedness with God during childbirth. Callister and Khalaf (2010) conducted a secondary analysis of cross-cultural studies from several countries from different continents (Europe, Australia, North, Central, and South America, Middle East, Africa and Asia). They documented that regardless to the religion (Christian, Jewish, and

Islam or even adopting no particular religious faith) women followed, the majority of them viewed childbirth as a spiritual experience and they used their religious beliefs and rituals as coping strategies.

From the studies shown above it is apparent that religion has an impact on how women view childbirth and how they use spirituality as a means of coping strategies.

5.4.3 Competent and skilful healthcare professionals

One of the interesting findings reported in the current study was that women appreciated the skilfulness of healthcare professionals. They felt reassured and secure once they were accompanied by a staff member due to their confidence in the staff's clinical expertise. Several studies documented this issue as an important part of women's childbirth experience. Cipolletta and Balasso (2011) reported that women in Italy considered midwives as very competent and they mentioned that midwives had a central role in making them feel confident and thereby ensuring a positive birth experience. The participants (women who had undergone labour) in the Bluff and Holloway study in England frequently expressed their belief in the competency of professionals (midwives), acknowledging their knowledge and expertise in the field (Bluff and Holloway, 1994).

Other studies linked competency of healthcare professionals to women's satisfaction. A systematic review conducted by Srivastava et al. (2015) identified factors contributing to women's satisfaction with maternity care in developing countries. They pointed out that one of the determinants of women's satisfaction was "*perceived provider competency*" (p.1). They highlighted that women were more satisfied with services in maternity health

services if they perceived that the healthcare professionals were knowledgeable and technically skilled.

Although the current study revealed that the relationships between women and healthcare professionals were sub-optimal (will be discussed in section 5.5), it demonstrated that the women were grateful for the healthcare professionals' clinical ability if not their social behaviour. This indicates that healthcare professionals somehow managed to create a trust-relationship with these women and thus the women praised their clinical competence. Comparably, women in a study carried out in Zambia by Kwaleyela and Kearns (2009) trusted the information given to them by midwives and this made them feel safe. They associated this with the professionals' trainings and experience. They also highlighted the importance of developing a trusting relationship between women and professionals.

5.4.4 Birth outcome: healthy child and mother

As reported earlier the women in the current study felt secure once they have given birth to a healthy child without any maternal complication. This ultimately plays a major role in perceiving the birth experience positively. The results of the current study indicate that women beside all the discomforts they described, felt happy after seeing a child without any anomalies or complications, along with their own well-being. They identified this as the best aspect of their childbirth.

This is in agreement with findings of Ahmadi (2013) in Iran in which they documented that one of the contributing factors to a positive childbirth experience was normal labour including maternal and neonatal health. Women related their happiness to achieving a healthy outcome. In addition, Waldenström (1999) reported that women with a problematic

birth outcome, such as an unhealthy child, assessed their overall childbirth experience as negative. In the US, Attanasio et al. (2014) highlighted that those women who thought they would face complications such as urgent caesarean section during their labour, rated their experience as less positive.

5.5 Factors contributing to a negative childbirth experience

Some issues already mentioned earlier in this chapter as key issues can be categorised as factors facilitating negative experiences during labour and childbirth. It was shown that the women's needs were not fulfilled in several instances. For example, the women described negative experiences with labour pain since there were no, or limited, means available to alleviate the pain. The women also stated fears of childbirth due to its pain. They also highlighted the issues of not being aware of pain management measures and not receiving information during their antenatal period to inform them in advance about the process of labour and coping strategies. As a result these women felt unable to cope with labour pain and had no ability to overcome it. In addition, issues of having no voice in their own care and not being involved in the decision-making process can be considered as factors contributing to a negative experience.

The current study findings indicate that women described several issues related to their childbirth which had a negative effect on their experience. In this section, these negative aspects will be discussed in the light of existing literature, as several studies have identified aspects of women's childbirth which influenced the experience unsatisfactorily.

5.5.1 Aspects related to healthcare professionals

In the current study, women pointed out some aspects which were related to staff members. For instance, as previously mentioned, women appreciated some aspects such as the staff's competency while they had concerns about other aspects. These aspects include unresponsive staff members with negative attitudes, being left alone without continuous support from professionals, lack of communication and insufficient provision of information related to labour progress and/or procedures. These aspects, along with relevant healthcare professionals' perspectives, will be discussed in the subsequent sections.

5.5.1.1 Unresponsiveness and negative attitudes

It is important to note that some of the women in the current study expressed their annoyance with regard to healthcare professionals' attitude towards them. However, the findings also showed that although some of the women felt that they experienced caring behaviour from healthcare professionals, they had observed other women receiving negative or inappropriate behaviour from these professionals. These results are in agreement with findings obtained in a study conducted by Phiri et al. (2014) in Zambia, where some women stated that they perceived welcoming attitudes from healthcare providers while others reported negative attitudes from them. For instance, women complained about the disrespectful behaviour of healthcare providers by shouting at women and perceived this as 'shameful'. These results are also consistent with those obtained in a Jordanian study conducted by Hatamleh et al. (2013a) who reported that most women commented on the negative attitudes from healthcare professionals towards them during labour and childbirth. Women mentioned that they did not experience respect and

politeness from staff who shouted at them and ignored them. Hatamleh and colleagues called this “dehumanised care” as staff members carried out their work without a sense of humanised and individualised care. They documented that several women commented that *“being treated as if they were a machine with no sense of individualized care and a lack of encouragement during labor and birth”* (p.505).

Another study, carried out by Okwako and Symon (2014), explored women’s expectation and experience of birth in a Kenyan public hospital. The authors found that some women reported caring support from staff members while others had concern about the negative attitudes and unsupportive behaviour of staff. Some women described staff as ‘rude’, ‘not understanding’, ‘harsh’ and ‘unresponsive and unsympathetic’. Okwako and Symon concluded that certain factors can influence childbirth experience either negatively or positively. Thus, those who experienced the worst side of these attitudes and behaviours from care providers would have a negative experience.

In contrast with the current findings, several studies in European and Scandinavian countries (England, Italy, Sweden and Finland) reported the mainly positive behaviours of healthcare providers and caring relationships with women in labour (Karlström et al., 2015; Nikula et al., 2015; Cipolletta and Sperotto, 2012; Cipolletta and Balasso, 2011; Gibbins and Thomson, 2001). Researchers in the North of England carried out a qualitative study with eight pregnant women to explore their expectations during pregnancy and subsequent childbirth experience. They found that even though the women felt their labour was different from what they had expected, they all expressed positive feelings regarding their labour and childbirth. It was reported that this was largely due to the positive and caring attitude they had received from their midwives during their pregnancy and labour (Gibbins

and Thomson, 2001). Similarly in an Italian study, participants mentioned that midwives played an important role during their first experience of labour and childbirth. They highlighted midwives' encouragement, kind manners, calmness and responsiveness as important aspects of their experience (Cipolletta and Balasso, 2011). Additionally, in another Italian study, it was concluded that a staff/patient relationship without sympathy and understanding results in a negative experience. Conversely, a humanised relationship leads to a satisfactory birth experiences. Women praised the relationships between them and the midwives and particularly the emotional support provided by the latter (Cipolletta and Sperotto, 2012).

The findings of this study also differed from the findings of Nikula et al. (2015). They conducted a cross-sectional study with 260 new mothers in a postnatal ward in one of the Finnish university hospitals. The researchers found that participants considered midwives' behaviours such as 'giving praise', individualised care, answering questions comprehensibly and treating women with respect as contributing to a positive experience. In addition, the majority of participants (approximately 80%) rated their birth experience as positive. Nilsson et al. (2013) aimed to describe experiences and reflections of childbirth among first time mothers in Sweden. The researchers concluded that "*individualized support to women during labour increases their chances for a positive birth experience*" (p.4).

Thus far, it has been shown that the attitude of most healthcare professionals in this study is in contrast with the attitude of healthcare professionals in developed countries and it is essential to note that there might be several factors behind this. These differences in

practice might be due to the burden of a very busy labour ward on staff's attitude or staffing levels could be a contributing factor in the current Kurdish maternity care settings.

Numerous studies worldwide have shown that a caring attitude of healthcare professionals and positive relationships between them and women throughout the childbearing period is essential in making a positive and satisfactory experience for women. It has also been documented that healthcare professionals, particularly midwives, play a major role in promoting women's self-confidence in coping with fears of labour, its pain and its challenges (Leap et al., 2010; Lundgren and Berg, 2007; Hodnett, 2002). The current findings indicate that current Kurdish clinical practice in intrapartum care with regard to the relationships between professionals and women is not in line with best evidence-based practice. Therefore, it is necessary for Kurdish healthcare professionals to review their attitude towards women in labour and improve their behaviour as giving birth is a highly sensitive moment for any women.

In the current study, almost all of the women stated that the staff's attitude largely depended on the women's behaviour as being quiet and not shouting would lead to receiving more attention and better care. In fact, this might be the reason why these women kept quiet and accepted whatever the healthcare professionals did to them (as discussed earlier in section 5.3). Correspondingly, Ebirim et al. (2012) reported that women in sub-Saharan Africa, mainly in Nigeria, experience labour and childbirth negatively due to the attitude of care providers. They argued that *“childbirth is experienced not as a joyful event but as sad experience due to midwives attitude towards the labouring woman who shout and yell at labouring women especially if she screams cries or complains of labour pain”* (Ebirim et al., 2012, p.223).

With regard to a negative attitude of staff members, the results of this study did not show towards whom these women specifically had concern since most of the women could not distinguish between categories of staff. However, the findings presented in the section of healthcare professionals' views showed that most of the midwives and nurses described caring relationships with women. Yet, some of them believed that they have to be tough in order to be listened to and do their work. Nevertheless, the data suggested that the doctors and some of the nurses and midwives adopted more inappropriate behaviour, such as shouting at or getting angry with patients in order to convey their message. In Italy, Cipolletta and Sperotto (2012) reported that women, on the whole, described their relationships with midwives as positive while some of them stated that their relationships with their gynaecologists were unsatisfactory.

It was shown by the current study findings that numerous factors have an impact on the behaviour of staff members towards their patients. For example, physical tiredness resulting from work load, shortage of staff and crowdedness of the delivery unit (*i.e.*, a large number of patients with lots of relatives). Other studies reported similar factors that hindered healthcare providers from providing an optimal intra-partum care. Sleutel et al. (2007), in their study in the United States entitled "nurses' views of factors that help and hinder their intra-partum care" pointed out several factors that hindered staff from providing professional support. One of the factors that they mentioned was overcrowded and limited facilities. They also noted other factors such as conflict between healthcare providers, outdated practices and ethical and professional decline. Another study conducted in England by Smith et al. (2009), examining the factors that affects the safety in maternity services pointed out that lack of resources, staff shortage and low staff morale along with other factors affect safety in such services.

5.5.1.2 Lack of communication and insufficient information given

The findings of the current study showed that women complained about the lack or brevity of communication they experienced with healthcare professionals. It was also shown that the women felt they were not given sufficient information on procedures and medical interventions. However, healthcare professionals claimed that the brevity of their communication was due to external factors such as busyness of the delivery unit and the lack of human resources. In addition, based on my own experience, it is a common practice for most of the healthcare professionals not to inform women (*i.e.*, no consent obtained) on what procedures or interventions (particularly vaginal examination and rupture of membrane) they are going to do. Grounded in my professional experience, I have not encountered any document/guideline entailing the necessity of obtaining verbal consent prior to any procedures or interventions (non-invasive ones) whereas for invasive procedures the system requires written consent to be obtained. It is important to note that during my undergraduate education in nursing, taking permission and obtaining consent from patients was one of the fundamentals that I learnt and have practiced throughout my professional career.

Similar findings have been reported in several studies in some middle-eastern and African countries. For instance, this finding is in accord with the findings of El-Nemer et al. (2006), in which they reported that communication with Egyptian women in labour either did not occur or, if it occurred, was short and brief. Similarly, the findings from this study are in agreement with Hatamleh and colleagues findings in Jordan as they reported that women did not have a chance to get clarification on information or advice from healthcare providers. They complained about not gaining information from healthcare providers regarding their labour progress. The women indicated that feelings of insecurity emerged

from this lack of information which led most of them to be dissatisfied with the quality and amount of the information they received (Hatamleh et al., 2013a).

Researchers in Zimbabwe reported that there was generally poor communication there between women and healthcare professionals (Murira et al., 2010). Comparably, researchers in Zambia pointed out that women criticised the intra-partum care as healthcare providers did not give information and explanations about what they have done to them. This had a huge impact on the women's labour and birth experience (Kwaleyela and Kearns, 2009). In Zambia, Phiri et al. (2014), reported that women were discouraged from giving birth in birthing centres due to the lack of information on clinical procedures given prior to performing them and the absence of quick responses from healthcare providers.

On the contrary, numerous research in developed countries such as the UK, US, Canada, Sweden and Italy report that women are well-informed during their childbearing period (*i.e.*, pregnancy, labour and postpartum). They also documented the importance of being aware and informed on women's overall labour experience (Attanasio et al., 2014; Cipolletta and Balasso, 2011; Bryanton et al., 2008; Gibbins and Thomson, 2001; Halldorsdottir and Karlsdottir, 1996; Fleissig, 1993).

In some studies carried out in England and Wales, women stated their satisfaction with regard to the amount of information given to them by healthcare providers. It was also reported that women achieved a feeling of being 'in control' during labour and childbirth through detailed information given to them during their pregnancy and labour (Gibbins and Thomson, 2001; Fleissig, 1993). It was clearly shown that having proper communication and receiving detailed information during labour and birth leads to a positive experience. Women in a US study described their positive experience concerning their communication

with their clinicians and the use of an informed consent process. They also reported that they were made comfortable by talking to their clinicians and how clinicians listened carefully to what they said. These women considered these aspects as very important in their childbirth experience. The researchers concluded that the women's reported their positive birth experiences were largely due to these aspects (Attanasio et al., 2014).

In Italy, Cipolletta and Balasso (2011) pointed out that women valued the detailed explanations offered by their midwives and considered this as an essential part in creating a positive birth experience. Likewise, a study conducted in Canada by Bryanton et al. (2008), to identify the factors that influence women's perceptions of a quality birth experience, found that one of the strongest predictors was their degree of awareness of what is happening during labour and childbirth.

The current study findings also showed that besides women valuing if they have been informed and had proper communication with healthcare professionals during labour and birth, some women highlighted the importance of receiving information after they had given birth. The women felt neglected and left alone after they had given birth as they stated that nobody talked to them or was there to attend to their needs. Grounded on my own experiences in the delivery unit, no individualised discussion or de-briefing session is provided for those women who have given birth. However, healthcare professionals (nurses) in the postpartum unit sometimes provide some brief information on breastfeeding and dietary requirement but this is not provided on a one-to-one basis. These findings are in contrast with evidence based practice as most of the developed countries provide women with detailed information and advice after birth in hospital and even postnatally at home.

The CQC in the UK reported that most women felt that they were always given the information and explanation they needed (CQC, 2013).

5.5.1.3 No continuous support: insufficient and unattended

It is important to note that one of the recurring themes in the current study was the issue of shortage of staff and crowded delivery rooms which resulted in women feeling left without the support of healthcare providers. Women's view on staff's sufficiency was divided between the two ends of the spectrum. Some of them stated that there were insufficient staff members to look after them and support them continuously throughout the labour process. However, others stated that there were sufficient staff members around, although they mentioned that they were busy and only attended when the actual birth was due. The women were all in agreement though, about the crowdedness of the unit as they stated that they had to wait for a considerable time in order to be examined on admittance and to find a vacant bed afterwards to give birth. Larkin et al. (2012) conducted a qualitative study in the Republic of Ireland and found that most women associated shortcomings in care (as they often felt unsupported and alone) to the lack of staff and the crowdedness of the hospital wards.

It was shown that relatives of the women in the current study pursued staff to look after their patients. The women were also concerned about the delay in staff members responding to them. Similar findings have been reported elsewhere such as in Kenya and Egypt. For example, Okwako and Symon (2014) pointed out that Kenyan women experienced negligence during their childbirth. They also worried about staff members not being present and not responding to their queries. This is also in line with the findings of Ghani and Berggren (2011), in which they conducted a study of 400 women in

Cairo/Egypt. They examined women's needs during labour and childbirth and found that, besides their other needs, women felt that staff being prompt in responding to their requests or complains was an important requirement during their labour and childbirth.

The women in this study considered the issues of being unattended and staff being unavailable as negatively affecting their childbirth experience. Waldenström et al., (2004), concluded that some aspects of the labour and childbirth of a woman contribute to a negative birth experience. They documented that insufficient time assigned to a woman's individual questions and a lack of support during her labour leads to a negative experience.

The healthcare professionals in the current study were also concerned about the shortage of staff and the busyness of the delivery unit, as a result of which they experienced a high workload. They underlined that these issues affected their quality of care. They also emphasised the importance of sufficient human resources in order to improve the care they provide and to offer more support to women in labour. Other healthcare professionals in different contexts identified the impact of insufficiency of staff numbers on their continuous support provision for women in delivery rooms. Wick et al. (2005) carried out a study in Palestinian West Bank governmental facilities where they documented that midwives claimed their high workloads, due to understaffing and overcrowded units, as barriers to providing adequate care. In addition, a qualitative study conducted with ten midwives in Norway by Aune et al. (2014), reported that participants stated they could not provide a continuous presence for women in labour due to their workload. Gale et al. (2001) also documented that nurses in a Canadian teaching hospital identified insufficient staff as an obstacle to providing adequate support to women during childbirth.

5.5.2 Aspects related to hospital environment

In this study, the women talked about their negative experiences with various issues related to the hospital environment and practices applied in the hospital. These include high stress environment concerns about frequent examinations and issues associated with episiotomy. The following subsections discuss these issues in detail.

5.5.2.1 Hospital environment versus home

This study revealed that although the women praised the cleanliness of the hospital, they raised concerns about the structural aspects of the hospital, such as having no privacy during vaginal examinations. Although, the beds were separated by a curtain (the number of beds was variable in each room, from two to four beds), the women wished to have more privacy during examinations. In addition, some of the staff members highlighted the importance of maintaining the privacy of their patients. Other studies in the Middle-East countries reported similar issues with regard to the lack of privacy. Hatamleh et al. (2013b) reported that Jordanian women had concerns about having no privacy during their labour and childbirth. In Egypt, a study carried out by El-Nemer et al. (2006), reported that no personal privacy was offered to women in labour. Another study in Egypt conducted by Ghani and Berggren (2011) found that women ranked the need of maintaining privacy throughout the labour process (including all procedures) as the highest unmet need (86.5%) for them during labour.

In the UK, Douglas and Douglas (2004) examined patients' perceptions about the built environments of different departments of a National Health Service (NHS) Trust hospital. They found that, in maternity units, women mostly focused on the privacy for themselves and their family members and stressed the need for the built environment of hospitals to

provide patients with privacy. It has been shown that women appreciate having privacy during their hospital stay. The updated version of NICE's intrapartum care for healthy women and babies guideline (2014) recommends that healthcare professionals should "*ensure the woman's informed consent, privacy, dignity and comfort*" during vaginal examination (NICE, 2014, p.27).

This study showed that the women regarded the hospital as presenting a fear factor due to its noisy environment with other women shouting and screaming during their labour and childbirth. Some of the women compared the hospital environment with their home and stated that as a result they stayed at home until their contractions increased in intensity and frequency in order to avoid encountering these fear stimulants from their early stages of labour. A study conducted in Iran on 600 parturient women by Pirdel and Pirdel (2009) aimed to explore the relationships between their pain perception and environmental factors. They found significant statistical relationships between some environmental factors and women's pain perception. In particular, they pointed out that crowded birthing rooms were associated with increasing stress among primiparous women and noise in the delivery unit was associated with increasing stresses among multiparous women.

Studies in Europe and Australia documented the impact of different birthing environments (such as home, birthing centres and hospital) on childbirth experience (Borquez and Wiegers, 2006; Cunningham, 1993). Researchers in the Netherlands, Borquez and Wiegers (2006), compared women's labour and childbirth experiences in two different birthing settings (home and birthing centre). They documented that women in the home-birth group underlined the importance of the comfortable and relaxed environment of the home and they rated their setting higher compared to the birthing-centre group. However, women in

the birthing-centre group put emphasis on availability of medical help and safety. Borquez and Wiegers (2006) also documented that women who had given birth at their homes perceived less pain and wanted less pain relieving medication. However, no difference was documented between the home-birth and birth-centre group with regard to the amount of pain relieving medication they received. Therefore, it is desirable to provide women in labour with a comfortable and relaxing environment that protects their privacy and dignity.

5.5.2.2 Routine

The women in the current study complained about frequent examinations and considered it as one of the factors that contributed to a negative childbirth experience. In addition, although the policy in the Kurdish hospitals advocates the limited practice of episiotomy only when it is clinically indicated, the current study highlighted that the episiotomy rate is still high, as around 44% had undergone episiotomy.

In Jordan, researchers reported that women experience copious interventions during intrapartum care. For instance, they reported frequent vaginal examination, routine episiotomy, amniotomy and labour augmentation. The researchers concluded that these interventions hugely affect women's childbirth experience and that women in Jordan were dissatisfied with their intra-partum care due to these issues (Mohammad et al., 2014a; Mohammad et al., 2014b; Hatamleh et al., 2013b; Shaban et al., 2011; Oweis, 2009).

In Egypt, El-Nemer et al. (2006) reported that each woman experienced a high number of vaginal examinations during labour, ranging from one to eight. They also reported that oxytocin infusions were regularly applied in order to accelerate labour. In Palestine, Wick et al. (2005) highlighted that clinical interventions, such as episiotomy, were most frequently and liberally practiced. Waldenström, (1999), pointed out that several factors

were associated with a negative childbirth experience; for example, medical interventions (labour induction, augmentation and operative delivery).

Chalmers, (2012) examined numerous surveys of women's labour and birth reports in seven countries (the UK, the US, Canada, Lithuania, Azerbaijan, Moldova and the Russian Federation) and found that rates of labour inductions and episiotomy were lower in the UK, the US and Canada compared to the former Soviet countries.

The women in the current study raised concerns about the delay in suturing the episiotomy incision, as they stated that the delay increased their discomfort and they reported that they perceived more pain if the episiotomy incision was left un-sutured for a long time. In her book, Close (1980) reported that women were occasionally left for a long time before having their incisions stitched up. These women referred to the delay in stitching as the worst part of their childbirth and indicated that this facilitated developing apprehension.

The percentage of labour augmentation is high in the current study as the labour of 80.5% women was augmented either by oxytocin infusion or ARM or a combination of both. This might be due to that the healthcare professionals wanting to hasten labour in order to deliver babies in less time. A study in Palestine reported this issue and highlighted that midwives referred to their workloads and over crowdedness as factors for regular oxytocin utilisation in their care (Wick et al., 2005).

These findings are in disagreement with the practices utilised in developed countries such as the UK where NICE (2014) recommends that healthcare professional should conduct vaginal examination only when it is necessary and when it adds essential information to the decision-making process. It also recommends that a routine episiotomy during spontaneous vaginal birth should not be carried out.

5.6 Birth settings and models of care

From the findings presented so far, it is clear that the care provided in the Kurdish maternity services is dissimilar to the care provided by maternity services in developed countries. It has shown that within the current health system there are many shortcomings in the care provided for pregnant and labouring Kurdish women, from the antenatal period, through the intrapartum, to the post-natal period. For instance, in the antenatal period, Kurdish women are not well informed and not prepared for labour and childbirth, as antenatal clinics had no impact on enriching women with important childbirth information.

In the intrapartum, the current study highlighted several issues that concerned the women and healthcare professionals who participated here. As stated earlier in this chapter, both the women and the healthcare professionals underlined the impact of crowded delivery wards on the way care was provided, how women were treated and how healthcare professionals behaved towards them. In fact, many professionals stressed that their tiredness, from having treated many patients, made them behave in a less than ideal fashion.

Therefore, the women in labour were passive recipients of care, they did not have control over the care they received and their voices were not heard. The only decision-makers were the healthcare professionals, in particular, the doctors; and women had no choice in their care. Besides, no information was given and no consent was taken prior to conducting any procedures. The women did not have choice in selecting the birthing position they wanted as the system did not provide such opportunities.

The current study also highlighted that the current Kurdish health system is not providing individualised care for women in labour as a result of the high admission rate. This had an

impact on how these women experience their labour and birth. Although, the system or hospital policy allowed the women to be supported by a family member, this was perceived as not enough by these women. They lacked support from professionals, since to them having more support from professionals would have made them feel secure and reassured.

Based on my professional experience, one of the main reasons for the overcrowded delivery unit in the current study is that, in Kurdistan governmental Maternity hospitals, different categories of cases, from normal to high risk pregnancies, are admitted to the hospital for delivery without any differentiation. Currently there is no policy in place to segregate normal cases from high risk cases. With the current system, on one hand, pregnant as well as labouring women would not be able to make optimal use of the service; on the other hand, healthcare professionals would also be unable to provide high quality care.

This chapter has underlined that the above mentioned issues, in the current Kurdish birth setting, are handled in contrasting fashion to the evidence-based practices in the UK healthcare system which adopts different models of care. For instance, women in the UK are well informed throughout their pregnancy and afterwards, they have their voice and are active decision makers in their care, and healthcare professionals provide supportive care and midwives have autonomy to do their work. Another important aspect explored in this study was the interdisciplinary issues raised by the healthcare professionals (nurses/midwives) including the lack of midwives' autonomy and power relationships between obstetricians and midwives. As mentioned, in developed countries, midwives have the power to control and manage cases without an obstetrician's input, whilst this practice is not found in Kurdish intrapartum settings.

These differences are due to adopting different policies and models of care. For example, in the UK, there are various supported models for receiving women in labour such as the Midwifery-Led Care model where women who are deemed low risk give birth solely with the support of a midwife (Stephens, 2007).

Since this study highlighted that several interventions (episiotomy, vaginal examinations, labour augmentation) are performed frequently, it is important to adopt a care model (such as Midwifery-Led Care) that reduces the usage of these procedures and interventions unless they are clinically indicated. Women find performing unnecessary high levels of interventions unpleasant as their privacy is infringed upon. Simultaneously, staff time is wasted, thus, they cannot establish a personal contact with women and cannot provide them with a reassuring environment. This might be due to the fact that the maternity care is controlled by obstetricians and their philosophy is different from that held by midwives, as the latter advocate normalising childbirth and decreasing the intervention rate. Normalising childbirth also resonates with midwives' research priorities according to a study conducted by Soltani et al. (2016) to examine the research priorities from midwives' perspectives in different countries. They found that promotion of normal childbirth was the main research priority among study participants. However, this priority might be different from Kurdish midwives' perspectives, as the maternity practices and geographical location are different. Several studies reported the advantages of employing a Midwife-Led Care model in reducing the rate of interventions and enhancing maternal and new-born well-being. Discussions on findings from Cochrane reviews reported by Sandall et al. (2013), Soltani and Sandall (2012) and Sandall et al. (2010) reveal that women who received care modelled on Midwife-Led Care were likely to benefit from it. For example, they were less likely to have interventions such as episiotomy and more likely to have a spontaneous

vaginal birth, continuity of care and to feel in control. Overgaard et al. (2012) carried out a study on the effect of birthplace on women's childbirth experiences. The settings of the study were two freestanding midwifery units (FMU) and two obstetric units (OU) in North Denmark. Women in the FMU group reported more positive experiences and satisfaction with care than those women in the OU. In Germany, Knape et al. (2014) examined the association between the presence of midwives and their workload with the mode of delivery. Although the researchers did not find a significant association between the above mentioned variables, they found that those women who were not satisfied with the presence of midwives were twice as likely to have an operative or caesarean section delivery.

In the UK, the NICE guidelines (NICE, 2014, p.7) recommend that healthcare professionals should *“explain to both multiparous and nulliparous women that they may choose any birth setting (home, freestanding midwifery unit, alongside midwifery unit or obstetric unit), and support them in their choice of setting wherever they choose to give birth”*. It also recommends that advice should be given to those low-risk nulliparous and multiparous women that planning to give birth in a midwifery-led unit is mainly appropriate for them as the intervention rate is lower; and the outcome for the new-born is no different compared with an obstetric unit.

The findings of this study raise important issues for consideration for both Kurdish maternity care and professional practice. The Midwifery-Led Care Model offers several important benefits for practice. This model not only proves beneficial for women who go through labour and birth, it also empowers the midwives by promoting their autonomy since they will be the primary care providers. The inferences of the current study appear to help direct healthcare policy makers in identifying strengths and weaknesses of the current

practice and reorganising it in order to achieve positive progress in Kurdish maternity services.

It is important to note that any reforms or changes that need to be taken in any settings or organisations are not a straightforward process. Apart from the financial cost of bringing in more staff and establishing a suitable physical environment with appropriate facilities it faces considerable challenges (social, cultural, logistical and workforce) and is inevitably going to be involved in a long and complex process. Therefore, this has to be addressed carefully.

The first group of student midwives from the College of Midwifery in the Hawler Medical University have recently graduated with a midwifery degree (*i.e.*, are professional midwives) and are now prepared to work in the hospital. It is therefore timely to commence this reform, as this will facilitate and support the process of change, which has already started.

5.7 Strengths, limitations of the current study and suggestions for future research

As discussed earlier, the current study, on one hand, provides an insight into how Kurdish women experience their labour and childbirth. On other hand, it provides an insight into healthcare professionals' perceptions, attitudes and behaviours towards maternity care, in particular, intrapartum care. One of the strengths of the study was that adopting mixed method research strategies boosts validity of the study and reducing any deficiencies linked with conducting one method. This study was carried out using two different methods (quantitative and qualitative) in which resultant data are complementary to each other and the subject of interest is explored more comprehensively. Another strength of the study was

the high response rate of the questionnaire survey. Approaching women face-to-face could be identified as the main factor contributing to this exceptional response rate. Other factors might include the questionnaire being filled out by the researcher when the participants replied verbally. In addition, the women appeared to want their experiences/feelings to be captured if there was a hope that this would lead to service improvement. They happily accepted the invitation to participate in the study and were pleased to talk about their childbirth experience and answer the questions being asked. However, although the research aims have been successfully addressed in the current study, it is important to acknowledge that it has a few limitations.

It is worthy to note that no hospital population data were available, through which the sample data could have been contextualised. This is due to the fact that patient data are not being routinely gathered and analysed by the Kurdish hospital system; and when they are gathered or analysed, findings are rarely published. In fact, it is important to acknowledge that this was a real challenge from the beginning of the research as minimal published data is available on health related topics in the region. In order to gather data (if any) on relevant topics with regard to the study scope, specific governmental Web pages have been searched. For example, the Web pages of ministries of health and planning and directorates of health in the region were searched, but this was only partially successful due to the scarcity of published material. This could be regarded as one of the major unavoidable limitations of the study. One of the limitations was the setting of the current study being limited to one governorate of Kurdistan region, due to time constraints and cost. Although other hospitals in other governorates run under the same organisation (*i.e.*, Ministry of Health), and generally Kurdish people share similar values and norms with regard to childbirth, there might still be some differences.

As mentioned earlier, there are some women who do not go through governmental hospitals to give birth as they choose private hospitals; and the latter employs different system in terms of staff-patient ratio, labour pain relief provision and as a result women may experience labour and birth differently. The focus of the current study was on women who go through governmental system as it is the choice for the vast majority of people, thus, considering private hospitals was outside the scope of my thesis.

No previous studies have been carried out in this area of practice in Kurdistan region of Iraq. The current study formulates the foundation for other research studies in the future as it is the first attempt to explore holistic aspects of childbirth in the region from different angles. Therefore, it is suggested that further studies could attempt to include a wider number of hospitals (wider population) in different Kurdish governorates to explore the childbirth experience from different geographical locations; since the quality of care may vary from one setting to another.

Another limitation of this study is that despite the extensive efforts made to include a wide range of women from different socio-economic background in the qualitative interviews, it was only partially successful in this aspiration, due to various reasons such as difficulty in reaching those women. For instance, distant locations, transportation issues and women's family responsibilities and obligations. Therefore, the women who participated in the second stage of the study were limited to those who were able to take part (*i.e.*, living in proximity to the hospital) and these were mainly educated women. It would be valuable to conduct further research studies that include women from different educational backgrounds.

5.8 Summary

To sum up, this chapter discussed the key findings in light of existing literature. Women in the current study highlighted a mixture of a negative and positive experience during their labour and childbirth. This is due to the multifaceted nature of childbirth; both internal and external factors contributed to either negative or positive experiences. In addition, the women mentioned more negative factors and that is why most of them were dissatisfied with their overall experience. The current findings indicate that most of the elements of the intra-partum care and clinical practice are not fully aligned with the best evidence-based practice and that these should be updated in order to improve the current care provision. The conclusions and recommendations of the current study will be presented in the next chapter.

Chapter Six: Conclusions and recommendations

6.1 Introduction

The study adopted a mixed-methods design in order to enhance our understanding of the Kurdish women's experience of labour and childbirth and to explore the healthcare professionals' views and perceptions relating to the clinical and social aspects involved in women's childbirth. It is to be hoped that by exploring these experiences and acting on the findings, future expectant Kurdish mothers will receive better maternity care throughout the whole pregnancy and labour process.

The findings obtained from the present study have illustrated some important issues that healthcare professionals should be aware of when reflecting on their care provision and which health policy makers should consider in any future reforms of the Kurdish health system.

6.2 Conclusions

The followings are the main conclusions that can be drawn from the current study:

The study has identified that Kurdish women experience labour and childbirth both negatively (regarding certain aspects) and positively (regarding other aspects). In general the results of the current study indicate that several factors affect the birth experience negatively and that these factors need to be minimised. At the same time, factors that promoted a positive experience should be encouraged and reinforced. The main issue that had a negative impact on the women's childbirth experience was labour pain, since there were limited options available to offer pain relief. Almost all of the women desired to have

their pain relieved in any future birth and wished for pain relief options to be available to all labouring women.

The study has shown that women fear childbirth because of the pain involved but also of the threat to their life (*i.e.*, fear of dying). The threat to life is tackled by the healthcare professionals who do their best to ensure that both the mother and the baby survive but based upon the evidence presented here the other factor causing fear - childbirth pain - is yet to be tackled. One of the reasons for women's fear is the current unavailability of sufficient information regarding childbirth in the maternity services (*i.e.*, antenatal clinics). Women are not educated about labour, and are therefore not prepared for childbirth and what to expect. Thus, women need to be adequately prepared and supported for childbirth.

The study has also shown that only a limited number of women were aware of the possibility of labour pain relief. It is necessary that pregnant women should be made aware of the labour pain relief options available to them. Limited pain relief facilities, high delivery rate and attitude of healthcare professionals (doctors) towards pain relief were identified as obstacles in the implementation of pain relief for women going through labour and birth.

The study has revealed that women considered the environment of labour wards as a stress factor for different reasons, such as the impact of other women screaming and having no privacy during examinations. Several factors were shown to hinder the assurance of an enjoyable experience for labouring women, such as, the hospital environment, overcrowded delivery ward and shortage of staff. These issues need to be addressed by authorities and solutions should be offered.

The findings of the study highlighted that women had no external control during labour, their voice was not heard and they were not involved in their own care. It is essential to take measures that enable these women to be active agents and active decision makers in their own care.

One of the factors that contribute to unsatisfactory birth experiences is the frequency of examinations and interventions carried out on almost all women. The women had a major concern about not being informed prior to such procedures and no consent being obtained prior to conducting these procedures. Thus, it is important the number of unnecessary interventions is reduced; adequate information is given in a timely manner and consent obtained in advance of any procedure. The study also underlined the importance of providing individualised care and providing continuous support for women going through labour and birth.

Although there were certain aspects which the women considered as a positive experience (such as technically competent staff), they had a major concern about the behaviour and attitude of healthcare professionals, which many women perceived as sub-optimal. This needs to be improved as women should receive a considerate care that protects their dignity.

There is a hierarchical manner with regard to the way the care is provided, with doctors at the top of the hierarchy. This has led to some differences of opinion between the different categories of staff members. Teamwork should be encouraged to enhance the efficiency of the service and the productivity of the staff. The healthcare professionals complained about being unacknowledged despite their considerable workloads. It is important that workloads are managed properly and healthcare staff are appreciated and rewarded appropriately.

6.3 Recommendations

Grounded firmly within the findings presented in the previous chapters of this thesis, the following recommendations are considered important to reinforce professional practice in maternity services, specifically, intra-partum care in the Kurdistan region of Iraq. These recommendations emerged from the notion that adherence to the best guidelines and evidence-based practice helps promote positive strategies for maternity service improvement and ultimately results in more positive outcomes for those women who are going through pregnancy, labour and birth.

Policy and practice

1. Maternity services need to be seen as user-friendly by providing a homely environment that maintains the women's privacy, listens to them, promotes positive experiences and enhances women's childbirth satisfaction.
2. Provision of labour pain management should be considered as an important and central part of intrapartum care, as it is in developed countries. A policy of labour pain relief needs to be adopted by the MoH and hospital budgets need to have money allocated to cover the provision of suitable analgesics.
3. Authorities and healthcare policy makers should provide clinical settings that offer all essential requirements for the adequate management of labour pain.
4. A suitable working environment should be established, supported by sufficient healthcare professionals, where team work is encouraged and the autonomy and responsibility of different categories of staff are clearly defined.
5. An ongoing evaluation programme should be in place to evaluate care management and professional practice.

6. The MoH should reorganise the health system related to maternity services and establish a national policy and guidelines outlining a standard maternity care framework.
7. Health policy makers should explore the Midwifery-Led Care Model which could provide solutions to the issues existing in the current Kurdish maternity care services.

Education and training

1. Antenatal clinics should provide a central role in preparing women for childbirth and this should become an essential component of antenatal care. For instance, providing childbirth education classes and counselling to pregnant women in order to minimise fear of childbirth. Topics such as coping strategies, explanation of the labour process and the provision of pain relief should be covered in the antenatal period, both theoretically and practically.
2. Mass media such as newspapers, magazines, TV and radio should also play an important role in enriching women with important childbirth information. This could be achieved through contacting national or local media in order to include such information in their health programmes.
3. It would be desirable to establish a unit dedicated to training midwives and nurses in developing and applying scientific, evidence-based pain management techniques for use in labour rooms of public hospitals.
4. At the organisation level, hospital managers should make sure that healthcare professionals, particularly midwives, are well prepared and regularly updated as continuing professional development of midwives is essential for professionals.

Both hospital managers and healthcare professionals need to emphasise the evidence-base nature of their practice.

Research

1. Further research is essential to explore the childbirth experience of those women who live in rural and distant areas or those who are uneducated, since it was not possible to explore the experiences of such groups here in this study. Also, future research could study a wider population of women giving birth in the Kurdistan region (other governorates).
2. As obstetric and midwifery services in the region continue to develop and modernise in line with the recommendations presented in this thesis, research will be necessary to monitor the ongoing development and to assess whether improvements in the service are indeed reflected by improvements in women's perceptions of their labour and birthing experiences.

The conclusions of the current study have shown challenges in the maternity care services and I hope that these recommendations that emerged from this study will guide the officials and health decision makers in enhancing the maternity services by taking positive, prudent steps to reorganise and reform the services in line with those applied in developed countries.

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Appendices

Appendix-A: Questionnaire

I. Socio-demographic characteristics

1. Age..... years old
2. Parity.....
3. What is the highest level of education you have completed?
 - a. No schooling
 - b. Primary school (6 years)
 - c. Intermediate school (9 Years)
 - d. Secondary school (12 years)
 - e. Vocational diploma
 - f. Bachelor degree
 - f. Higher degree
4. Which of the following best describes the area you live in?
 - a. Urban
 - b. Suburban
 - c. Rural
5. Which of the following ethnicity are you belong to?
 - a. Kurd
 - b. Turkmen
 - c. Assyrian
 - d. Other
6. Do you have any medical problems (chronic disease)?
 - a. Yes
 - b. NoIf yes, please mention
7. Did you have any antenatal visits?
 - a. Yes
 - b. NoIf yes, how many visits?

II. Clinical information

1. Gestational age (weeks)
2. Mode of delivery
 - a. Vaginal delivery without episiotomy
 - b. Vaginal delivery with episiotomy
 - c. Vaginal delivery using forceps
 - d. Vaginal delivery using vacuum
 - e. Other
3. Labour was?
 - a. Spontaneous
 - b. Induced by Oxytocin infusion
 - c. Induced by amniotomy
 - d. Other
4. Was labour augmented?
 - a. Not augmented
 - b. Augmented by oxytocin infusion
 - c. Augmented by ARM
 - d. Augmented by oxytocin and ARM
5. Weight of newborn
6. Other notes

III. Labour and birth experience and awareness of pain relief

No	Item	Totally agree	Mostly agree	Mostly disagree	Totally disagree
1	Labour and birth went as I had expected.				
2	I felt strong during labour and birth.				
3	I felt scared during labour and birth.				
4	I felt capable during labour and birth.				
5	I was tired during labour and birth.				
6	I felt happy during labour and birth.				
7	I have many positive memories from labour and birth.				
8	I have many negative memories from labour and birth.				
9	Some of my memories from labour and birth make me feel depressed.				
10	I felt I could have a say whether I could be up and about or lie down.				
11	I felt I could have a say in deciding my birthing position.				
12	I felt I could have a say whether I could eat or drink.				
13	The midwife/staff devoted enough time to me.				
14	The midwife/staff devoted enough time to my relative.				
15	The midwife/staff kept me informed about what was happening during labour and birth.				
16	The midwife/staff understood my needs.				
17	I felt very well cared for by the midwife.				
18	My impression of the team's medical skills made me feel secure.				
19	I felt that I handled the situation well.				
20	I am aware of pain relief options during labour and birth				

Appendix-B: Domains and their items

Domain	Item no.	Item
Own capacity (8 items)	1	Labour and birth went as I had expected.
	2	I felt strong during labour and birth.
	4	I felt capable during labour and birth.
	5	I was tired during labour and birth.
	6	I felt happy during labour and birth.
	19	I felt that I handled the situation well.
	28	As a whole, how painful did you feel childbirth was?*
	29	As a whole, how much control did you feel you had during childbirth?*
Professional support (5 items)	13	The midwife/staff devoted enough time to me.
	14	The midwife/staff devoted enough time to my relative.
	15	The midwife/staff kept me informed about what was happening during labour and birth.
	16	The midwife/staff understood my needs.
	17	I felt very well cared for by the midwife.
Perceived safety (6 items)	3	I felt scared during labour and birth.
	7	I have many positive memories from labour and birth.
	8	I have many negative memories from labour and birth.
	9	Some of my memories from labour and birth make me feel depressed.
	18	My impression of the team's medical skills made me feel secure.
	30	As a whole, how secure did you feel during childbirth?*
Participation (3 items)	10	I felt I could have a say whether I could be up and about or lie down.
	11	I felt I could have a say in deciding my birthing position.
	12	I felt I could have a say whether I could eat or drink.

* Visual analogue scale (VAS)

Appendix-C: Interview Guides

C-1: Interview guide for women

1. Could you describe your experience during labour and birth?
 - What were best/positive aspects for you?
 - What were worst/negative aspects for you?
2. Would you prefer being able to choose your position for giving birth?
3. Did you discriminate between staff (midwives/nurses, doctors, other)?
 - Were there enough staff (midwives/nurses, doctors, other)?
 - Could you tell me your views on staff/patient ratio?
 - How was your expectation? Met or not?
4. Would you prefer to be offered additional help to manage pain levels?
 - Could you tell me your views on pharmacological options?
 - Did you use any of your own ways to manage pain during labour? (massage, meditation, prayer, breath control, herbal infusions *etc.*)
 - Could you tell me what did you get from antenatal visits (especially about labour and childbirth)?
5. Could you explain the staff's attitude towards you and your supporter?
6. During the questionnaire survey, I have asked you some questions about feelings of control and secure during your childbirth, could you tell me what did you mean by these perceptions (control and secure)?
7. Is there something else you want to discuss?

C-2: Interview guide for nursing and midwifery staff

Demographic questions:

1. Area of specialty:
2. How long have you worked in the unit?
3. What is your role in the delivery unit?

Generic questions:

1. Have you faced any difficulties during your care for women in labour? Can you give me some examples?
2. What information is available to women about pain relief in labour?
3. How is the information about pain relief made available?
4. What do women get from antenatal visits?
4. What are the unit's guidelines/procedures on pain relief during labour?
5. What is available on your unit to relieve pain in labour?
6. In your experience do women request pain relief, is there an expectation that pain relief will be provided?
7. Do patients have their own ways of managing pain in labour? (massage, meditation, prayer, breath control, herbal infusions etc.)
8. In your opinion does the hospital do everything it can for the women who are in labour?
9. Is your main concern the safety of laboring women and their children or is it to ensure a good birthing experience for women?

Specific questions which emerged after the quantitative data gathering from postpartum women:

1. Could you describe your degree of autonomy and relationship with obstetricians here in this unit?
2. In your opinion, can women choose their birthing position or the current position (lithotomy) is obligatory for all?
5. Would women want alternative positions?
6. Would they benefit from alternative positions or be placed at risk by it?
7. Would staff feel comfortable with women choosing alternative positions?

3. Could you describe your relationship with women in labour?
4. What is your opinion on staff: patient ratio here in your unit?
8. What ratio would you prefer?
5. Is there anything else you want to talk about?

C-3: Interview guide for unit manager

9. What is your area of expertise?
10. How long have you worked in the unit?
11. What is your role in the delivery unit?
12. Have you faced any difficulties during your work as a unit manager? Can you give me some examples?
13. Are there any guidelines/procedures on pain relief during labour in this unit?
14. Why pain relief medications such as Pethidine and Tramal are kept with doctors in your unit?
15. Could you tell me what are your views on making women aware of pain relief options in advance of labour?
16. Could you tell me your opinion on services provided in this hospital for the women who are in labour?
17. Could you describe your degree of autonomy and relationship with obstetricians here in this unit?
18. Could you describe your relationship with staff here in this unit?
19. Could you describe your relationship with women who are admitted to this unit?
20. What is your opinion on doctor/staff: patient ratio here in your unit?
 - What ratio do you prefer?
 - Have you requested from the authorities (e.g. hospital manager) to supply you with staff?
21. Is there anything else you want to discuss?

C-4: Interview guide for doctors

22. How long have you worked in the unit?
23. What is your role in the delivery unit?
24. Have you faced any difficulties during your care for women in labour? Can you give me some examples?
25. Are there any guidelines/procedures on pain relief during labour in this unit?
26. I have found out that only Pethidine and Tramal are available on your unit to relieve pain in labour.
 - Is there something else?
27. I have discovered that you keep the above medications with you?
 - Why? Is there any guidance for keeping them like that?
28. Could you tell me to whom do you prescribe those medications?
 - Could you tell me about the usage of the medications?
29. Could you tell me what are your views on making women aware of pain relief options in advance of labour?
30. Could you describe your relationship with staff here in this unit?
31. Could you describe your relationship with women who are admitted to this unit?
32. What is your opinion on doctor: patient ratio here in your unit?
 - What ratio do you prefer?
33. Is there anything else you want to discuss?

Appendix-D: Transcript with codes

* 1, Previous childbirth exp.

* 2, Hospital environment

Vs

Home

2 about waiting p. before childb

8. you rushed to come?
9. When I came, exactly, the staff told me what I was worried about it.
10. They told me still it is not the time to give birth.
11. I was waiting for a while and afterwards my childbirth was started.
12. I gave birth normally; both of them were delivered normally.
13. I: Okay.
14. P: But I had sutures and this stuff, for this one too.
15. I: You had episiotomy or tear?
16. P: No, it was tear, I had it during the childbirth.
17. I: OK, how was your childbirth? Was it like the first time?
18. Was it easier or much more difficult compared to your first childbirth?
19. P: Wa'Allah [By God], it was difficult as the first childbirth.
20. Some say that your first childbirth is more difficult and the second childbirth is much better,
21. but it was the same
22. I: There was no difference.
23. P: Yes, indeed.
24. I: You said that you wanted to come to hospital when it is the time for childbirth, why?
25. P: I wanted to be here.
26. and I would like the waiting.
27. To be away from all this.
28. I: Right.
29. P: When I came, I expected that your childbirth is more difficult.
30. and you will give birth at home.
31. I was waiting for the hospital, it is nicer.

* 3, Birth experience

Comment [KIM1]: Knowledgeable about the hospital routine/environment 2

Comment [KIM2]: Previous childbirth experience 1

Comment [KIM3]: ^{Had} Having tear 3

Comment [KIM4]: Childbirth: Difficult 3

Comment [KIM5]: No difference between 1st and 2nd childbirth = difficult

Comment [KIM6]: Tried to avoid waiting time in hospital 2

Comment [KIM7]: Discomfort: Physically - examination ^{frequent} 3

Comment [KIM8]: Hospital environment: undesirable 2

Appendix-E: Initial Framework

No.	Category	Sub-category
1	Childbirth experience	<ul style="list-style-type: none"> - Previous negative experience - Painful experience - Nowhere to deliver - Outcome (healthy child and no maternal complication) - Companion-relatives - Cultural differences: pregnancy and labour (no prenatal education, no pain relief)
2	Hospital environment versus home	<ul style="list-style-type: none"> - Impact of hospital environment (others behaviour frightening) unpleasant routine - Limited options: positions and pain relief - Nowhere to deliver - Comparing home environment
3	Fear of labour	<ul style="list-style-type: none"> - Delaying pregnancy - Fear of childbirth
4	Staff behaviour	<ul style="list-style-type: none"> - Delaying - Attentive once in labour - Sufficient for the labouring women but busy - Shortage of staff and its impact on women's experience - Competent - "tough" attitude towards the women. But should be supportive
5	Examinations	<ul style="list-style-type: none"> - Unpleasant - Not in control/ having no voice - No explanation given
6	Pain relief	<ul style="list-style-type: none"> - Pain relief awareness - Requested it - Barriers to receiving it
7	Prenatal care	<ul style="list-style-type: none"> - Nothing available related to childbirth preparation - No impact on childbirth experience

Appendix-F: Data Matrix

Themes	Participants		
	Jwan	Mrwari	Hori
Birth experience Sub-themes: - pain - fear (negative emotions) - outcome - being alive - staff - previous pregnancies	- Nowhere to deliver (worst part of birth) - Healthy child (best part) - Same as previous labour - Fear of labour: delays pregnancy	- Very tired (other health problems may affect the overall experience) - Pain: uncomfortable - Best part: alive after giving birth	- Painful childbirth - Pain: main concern - Pain affected her to communicate with staff - Waiting for a long time in order to be examined (worst part)
Staff behavior Sub-themes: - not attentive - staff shortage - staff being busy - unresponsive - tough attitude	- Delaying - Attentive once in labour - Sufficient for the labouring women but busy - Competent - “tough” attitude towards the women. But should be supportive	- Not attentive - Sufficient for the labouring women but busy - Incompetent - Tough attitude if pt* is screaming (quiet pt=good attitude) - Pts need supportive care	- Competent staff: trusted them - Staff shortage/not attentive/calling them to come/good behaviour
Hospital environment Sub-themes: - Crowded - Unpleasant routine - Frequent examinations - Limited options - impact of surroundings	- Unpleasant (hospital) reminder of what’s to come/others behaviour=frightening/stimulating/nowhere to deliver - Relaxed (home) - Limited options for birth: positions, drugs - Frequent examinations	- Crowded - Didn’t aware of other birthing positions	- Crowded - Position OK/would like to have other birthing positions
Pain relief Sub-themes: - wishes and desires - Antenatal care - Barriers to receiving it - Non-Pharmacological measures	- Requested it - Barriers to receiving it - Antenatal: nothing available related to childbirth preparation	- Not requested it - Barriers to receiving it - Antenatal: nothing available related to childbirth preparation	- Wishes to have PR - No PR options - Non-Pharmacological: praying - Antenatal: nothing available related to childbirth preparation

Appendix-G: Participant Information Sheet

G-1: Participant Information Sheet-Quantitative part

Research Project Title: “Experience of labour, birth and awareness of pain relief among Kurdish women”

Invitation paragraph

You are being invited to take part in a research project. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read (alternatively I can read it out to you) the following information carefully and discuss it with others if you wish. Ask me if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

What is the project’s purpose?

The journey of having a baby may be similar for all women in terms of physiological details but its meaning to each woman is individual and unique because of the social, cultural, spiritual, emotional and psychological context of her life. Every woman experiences labour and childbirth differently. Although the quality of a woman’s labour and childbirth experience is an essential consideration for health policy makers in developed countries, Kurdish women’s labour and birth experience has, until now, received little attention.

This study aims to assess Kurdish women’s overall experience of labour and birth. It will also investigate women’s awareness of, desire for and barriers to pain relief during labour.

Why have I been chosen?

You have been chosen because you recently went through labour and delivery. Other women in the same situation will also be recruited to the study.

Do I have to take part?

It is entirely up to you to decide whether or not to take part. If you do decide to take part you will be asked to sign a consent form. If you decide to withdraw, you are free to do so at any time without giving a reason and your rights and any services you receive will not be affected in any way.

What will happen to me if I take part?

If you decide to participate you will be asked to answer some questions within a survey conducted by the researcher. It is expected that the survey will last about 30 minutes.

If you feel uncomfortable or distressed during the survey due to having undergone a difficult birth, the researcher will offer appropriate advice and support.

If you find a particular question disturbing during the survey, you should inform the researcher. As a result, the researcher will stop the survey and you will be free to decide whether you want to continue or withdraw from the study.

What are the possible disadvantages and risks of taking part?

This study will take about 30 minutes of your time which will be greatly appreciated. If there are any questions which make you uncomfortable, you can decide to not respond to those questions and terminate the survey any time you feel uncomfortable without having to give a reason. This will not affect your rights and any services you receive.

If a serious clinical issue is identified during the survey, the researcher will react appropriately based on the nature of the issue. For instance, if issues emerge as a result of the behaviour or attitude of health professionals, the researcher will act as an intermediary in order to resolve the problem. In case of apparent malpractice, the researcher will report the issue to the responsible authorities in order for it to be investigated.

What are the possible benefits of taking part?

Whilst there might be no immediate benefits to you, it is hoped that this work will help us obtain a better understanding of how Kurdish women experience their labour and childbirth and how they deal with their labour pain. This information will be used in a constructive manner and aid in improving the provision of care for labouring women in Iraqi Kurdistan health institutions.

What if something goes wrong?

If you have any complaints in the first instance regarding your treatment by the researcher, please contact the research supervisor, Dr. Tony Blackett at the University of Sheffield. His contact details are at the end of the sheet.

Will my taking part in this project be kept confidential?

All the information that you provide us during the course of the research will be kept strictly confidential. Your name will be kept strictly confidential and you will not be able to be identified in any reports or publications.

The following strategy will be taken to ensure the privacy of personal data:

- All your personal information will be kept securely and will be anonymised in any reports or publication. This information will be accessed only by the researcher and her supervisory team.

What will happen to the results of the research project?

Following the study completion, the result of the study is likely to be published by 2015/2016 in professional health journals and conference presentations. In addition, the result of the study is likely to be published in local journals or magazines.

Who is organising and funding the research?

This study is organised by the principal researcher (Kazhan I. Mahmood) with Dr. Tony Blackett and Professor Anne Peat of the University of Sheffield. This study is sponsored by the Kurdistan Regional Government.

Who has ethically reviewed the project?

This study has been ethically reviewed and approved by both the University of Sheffield's Research Ethics Committee and the College of Nursing Ethics Committee, Hawler Medical University.

Contact for further information

In case you wish to obtain further information about the study, you can contact the following addresses:

- Researcher: Kazhan I. Mahmood, College of Nursing, Hawler Medical University, Erbil.
Mobile number: 0750 449 1331; Email: k.mahmood@sheffield.ac.uk
Supervisor: Dr. Tony Blackett, The University of Sheffield School of Nursing and Midwifery,
[Barber House, 387 Glossop Road, S10 2HQ, United Kingdom.](#)
- Phone: +44 144 222 2038; Email: t.blackett@sheffield.ac.uk

Thank you for reading this.

G-2: Participant Information Sheet-Qualitative part

Research Project Title: “Experience of labour, birth and awareness of pain relief among Kurdish women”

Invitation paragraph

You are being invited to take part in a research project. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read (alternatively I can read it out to you) the following information carefully and discuss it with others if you wish. Ask me if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

What is the project’s purpose?

The journey of having a baby may be similar for all women in terms of physiological details but its meaning to each woman is individual and unique because of the social, cultural, spiritual, emotional and psychological context of her life. Every woman experiences labour and childbirth differently. Although the quality of a woman’s labour and childbirth experience is an essential consideration for health policy makers in developed countries, Kurdish women’s labour and birth experience has, until now, received little attention.

This study aims to assess Kurdish women’s overall experience of labour and birth. It will also investigate women’s awareness of, desire for and barriers to pain relief during labour.

Why have I been chosen?

You have been chosen because you recently went through labour and delivery. Other women in the same situation will also be recruited to the study.

Do I have to take part?

It is entirely up to you to decide whether or not to take part. If you do decide to take part you will be asked to sign a consent form. If you decide to withdraw, you are free to do so at any time without giving a reason and your rights and any services you receive will not be affected in any way.

What will happen to me if I take part?

If you decide to participate you will be asked to answer some questions during an in-depth interview with the researcher. The time of the interviews will be arranged depending on your preference and convenience. The length of the interview is estimated to be 45-60 minutes.

If you find a particular question disturbing during the interview, you should inform the researcher. As a result, the researcher will stop the interview and you will be free to decide whether you want to continue or withdraw from the study.

What are the possible disadvantages and risks of taking part?

This study will take up to 60 minutes of your time which will be greatly appreciated. If there are any questions which make you uncomfortable, you can decide to not respond to those questions and terminate the interview any time you feel uncomfortable without having to give a reason. This will not affect your rights and any services you receive.

If a serious clinical issue is identified during the interview, the researcher will react appropriately based on the nature of the issue. In case of apparent malpractice, the researcher will report the issue to the responsible authorities in order for it to be investigated

What are the possible benefits of taking part?

Whilst there might be no immediate benefits to you, it is hoped that this work will help us obtain a better understanding of how Kurdish women experience their labour and childbirth and how they deal with their labour pain. This information will be used in a constructive manner and aid in improving the provision of care for labouring women in Iraqi Kurdistan health institutions.

What if something goes wrong?

If you have any complaints in the first instance regarding your treatment by the researcher, please contact the research supervisor, Dr. Tony Blackett at the University of Sheffield. His contact details are at the end of the sheet.

Will my taking part in this project be kept confidential?

All the information that you provide us during the course of the research will be kept strictly confidential. You will not be able to be identified in any reports or publications.

The following strategies will be taken to ensure the privacy of personal data, audio-recordings and transcripts:

- All your personal information will be kept securely and will be anonymised in any reports or publication. This information will be accessed only by the researcher and her supervisory team.
- Fictitious names will be given to participants during the data presentation and interpretation and in any reports emerging from this study.

- All audio-recordings will be stored in a safe locker and transcripts will be kept securely in the researchers' password-protected computer.
- After the study completion, all audio-recordings of the interviews will be destroyed and only the anonymised transcripts will be stored in the university archives storage.

What will happen to the results of the research project?

Following the study completion, the result of the study is likely to be published by 2015/2016 in professional health journals and conference presentations. In addition, the result of the study is likely to be published in local journals or magazines.

Who is organising and funding the research?

This study is organised by the principal researcher (Kazhan I. Mahmood) with Dr. Tony Blackett and Professor Anne Peat of the University of Sheffield. This study is sponsored by the Kurdistan Regional Government.

Who has ethically reviewed the project?

This study has been ethically reviewed and approved by both the University of Sheffield's Research Ethics Committee and the College of Nursing Ethics Committee, Hawler Medical University.

Contact for further information

In case if you wish to obtain further information about the study, you can contact the following addresses:

Researcher: Kazhan I. Mahmood, College of Nursing, Hawler Medical University, Erbil.

Mobile number: 0750 449 1331; Email: k.mahmood@sheffield.ac.uk

Supervisor: Dr. Tony Blackett, The University of Sheffield School of Nursing and Midwifery,

[Barber House, 387 Glossop Road, S10 2HQ, United Kingdom.](#)

Phone: +44 144 222 2038; Email: t.blackett@sheffield.ac.uk

Thank you for reading this.

G-3: Participant Information Sheet-Healthcare professionals

Research Project Title: “Experience of labour, birth and awareness of pain relief among Kurdish women”

Invitation paragraph

You are being invited to take part in a research project. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask me if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

What is the project’s purpose?

The journey of having a baby may be similar for all women in terms of physiological details but its meaning to each woman is individual and unique because of the social, cultural, spiritual, emotional and psychological context of her life. Every woman experiences labour and childbirth differently. The quality of a woman’s labour and childbirth experience is an essential consideration for health policy makers in developed countries. Therefore, it is worthy to discover how healthcare professionals in Iraqi Kurdistan perceive the care provided for their clients/patients in their labour rooms.

This study aims to assess Kurdish women’s overall experience of labour and birth. It will also investigate women’s awareness of, desire for and barriers to pain relief during labour.

Why have I been chosen?

You have been chosen either because you are one of the staff working in the delivery unit or because you are in a position to influence the quality of maternity care provision. Other staff working in this hospital will also be asked to give their views and opinions to inform the study.

Do I have to take part?

It is entirely up to you to decide whether or not to take part. If you do decide to take part you will be asked to sign a consent form. If you decide to withdraw, you are free to do so at any time without giving a reason and your rights and any services you receive will not be affected in any way.

What will happen to me if I take part?

If you decide to participate you will be asked to answer some questions during an in-depth interview with the researcher. The time of the interviews will be arranged depending on

your preference and convenience. The length of the interview is estimated to be 45-60 minutes.

What are the possible disadvantages and risks of taking part?

This study will take up to 60 minutes of your time which will be greatly appreciated. If there are any questions which make you uncomfortable, you can decide to not respond to those questions and terminate the interview any time you feel uncomfortable without having to give a reason. This will not affect your rights and any services you receive.

If the researcher identifies a serious clinical issue during interviewing (*e.g.* malpractice), the researcher will report the issue to the responsible authorities in order for it to be investigated.

What are the possible benefits of taking part?

Whilst there might be no immediate benefits to you, it is hoped that this work will help us obtain a better understanding of staff views and opinions of labour pain relief and how to deal with women who asked for labour pain relief. This information will be used in a constructive manner and aid in improving the provision of care for labouring women in Iraqi Kurdistan health institutions.

What if something goes wrong?

If you have any complaints regarding your treatment by the researcher, please contact the research supervisor, Dr. Tony Blackett at the University of Sheffield. His contact details are at the end of the sheet.

Will my taking part in this project be kept confidential?

All the information that you provide us during the course of the research will be kept strictly confidential. You will not be able to be identified in any reports or publications.

The following strategies will be taken to ensure the privacy of personal data, audio-recordings and transcripts:

- All your personal information will be kept securely and will be anonymised in any reports or publication. This information will be accessed only by the researcher and her supervisory team.
- Fictitious names will be given to participants during the data presentation and interpretation and in any reports emerging from this study.
- All audio-recordings will be stored in a safe locker and transcripts will be kept securely in the researchers' password-protected computer.

- After the study completion, all audio-recordings of the interviews will be destroyed and only the anonymised transcripts will be stored in the university archives storage.

What will happen to the results of the research project?

Following the study completion, the result of the study is likely to be published by 2015/2016 in professional health journals and conference presentations. In addition, the result of the study is likely to be published in local journals or magazines.

Who is organising and funding the research?

This study is organised by the principal researcher (Kazhan I. Mahmood) with Dr. Tony Blackett and Professor Anne Peat of the University of Sheffield. This study is sponsored by the Kurdistan Regional Government.

Who has ethically reviewed the project?

This study has been ethically reviewed and approved by both the University of Sheffield's Research Ethics Committee and the College of Nursing Ethics Committee, Hawler Medical University.

Contact for further information

In case if you wish to obtain further information about the study, you can contact the following addresses:

Researcher: Kazhan I. Mahmood, College of Nursing, Hawler Medical University, Erbil.

Mobile number: 0750 449 1331; Email: k.mahmood@sheffield.ac.uk

Supervisor: Dr. Tony Blackett, The University of Sheffield School of Nursing and Midwifery,

[Barber House, 387 Glossop Road, S10 2HQ, United Kingdom.](#)

Phone: +44 144 222 2038; Email: t.blackett@sheffield.ac.uk

Thank you for reading this.

Appendix-H: Consent Forms

Appendix-H1: Consent form-Quantitative part (women)

Title of Research Project:		
Experience of labour, birth and awareness of pain relief among Kurdish women		
Name of Researcher: Kazhan I Mahmood		
Contact details: Email: k.mahmood@sheffield.ac.uk		
Tel: 0750 449 1331		
Participant Identification Number for this project: initial box		Please
1. I confirm that I have read and understand the information sheet dated (/ /2014) explaining the above research project and I have had the opportunity to ask questions about the project.		<input type="checkbox"/>
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason and without there being any negative consequences. In addition, should I not wish to answer any particular question or questions, I am free to decline.		<input type="checkbox"/>
3. I understand that my responses will be kept strictly confidential. I give permission for members of the research team to have access to my anonymised responses. I understand that my name will not be linked with the research materials, and I will not be identified or identifiable in the report or reports that result from the research.		<input type="checkbox"/>
4. I agree for the data collected from me to be used in future research.		<input type="checkbox"/>
5. I agree to take part in the above research project.		<input type="checkbox"/>
_____	_____	_____
Name of Participant	Date	Signature
_____	_____	_____
Name of the researcher	Date	Signature
Copies:		
<i>Once this has been signed by all parties the participant should receive a copy of the signed and dated participant consent form, the letter/pre-written script/information sheet and any other written information provided to the participants. A copy of the signed and dated consent form should be placed in the project's main record (e.g. a site file), which must be kept in a secure location.</i>		

Appendix-H2: Consent form-Qualitative part (women)

Title of Research Project:

Experience of labour, birth and awareness of pain relief among Kurdish women

Name of Researcher: **Kazhan I. Mahmood**

Contact details: Email: k.mahmood@sheffield.ac.uk

Tel: 0750 449 1331

Participant Identification Number for this project:

Please initial box

1. I confirm that I have read and understand the information sheet dated (/ /2014) explaining the above research project and I have had the opportunity to ask questions about the project.

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason and without there being any negative consequences. In addition, should I not wish to answer any particular question or questions, I am free to decline.

3. I understand that my responses will be kept strictly confidential. I give permission for members of the research team to have access to my anonymised responses. I understand that my name will not be linked with the research materials, and I will not be identified or identifiable in the report or reports that result from the research.

4. I agree for the data collected from me to be used in future research.

5. I agree to take part in this research project by being interviewed.

6. I agree my interviews to be audio-recorded.

Name of Participant

Date

Signature

Name of the researcher

Date

Signature

Copies:

Once this has been signed by all parties the participant should receive a copy of the signed and dated participant consent form, the letter/pre-written script/information sheet and any other written information provided to the participants. A copy of the signed and dated consent form should be placed in the project's main record (e.g. a site file), which must be kept in a secure location.

Appendix-H3: Consent form-Healthcare professionals

Title of Research Project:

Experience of labour, birth and awareness of pain relief among Kurdish women

Name of Researcher: **Kazhan I. Mahmood**

Contact details: Email: k.mahmood@sheffield.ac.uk

Tel: 0750 449 1331

Participant Identification Number for this project:

Please initial box

1. I confirm that I have read and understand the information sheet dated (/ /2014) explaining the above research project and I have had the opportunity to ask questions about the project.

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason and without there being any negative consequences. In addition, should I not wish to answer any particular question or questions, I am free to decline.

3. I understand that my responses will be kept strictly confidential. I give permission for members of the research team to have access to my anonymised responses. I understand that my name will not be linked with the research materials, and I will not be identified or identifiable in the report or reports that result from the research.

4. I agree for the data collected from me to be used in future research.

5. I agree to take part in this research project by being interviewed.

6. I agree my interviews to be audio-recorded.

Name of Participant

Date

Signature

Name of the researcher

Date

Signature

Copies:

Once this has been signed by all parties the participant should receive a copy of the signed and dated participant consent form, the letter/pre-written script/information sheet and any other written information provided to the participants. A copy of the signed and dated consent form should be placed in the project's main record (e.g. a site file), which must be kept in a secure location.

Appendix-I: Ethical approval

Appendix-I1: Approval from The University of Sheffield



The
University
Of
Sheffield.

The School Of
Nursing
And
Midwifery.

Kazhan Ibrahim Mahmood
1/4/245
Kurdsat Quarter
Sulaimaniyah
IRAQ

**Dean of School
Professor Anne M Peat**

School of Nursing and Midwifery
Barber House Annexe
3a Clarkhouse Road
Sheffield
S10 2LA

17th April 2014

Telephone: +44 (0) 114 222 2055
Email: j.l.gray@sheffield.ac.uk

Dear Kazhan

Re: ERP 133 - Experience of labour, birth and awareness of pain relief among Kurdish women

The panel has approved the ethics application with the following suggested, optional amendments (i.e. it is left to the discretion of the applicant whether or not to accept the amendments and, if accepted, the ethics reviewers do not need to see the amendments):

Remove the following sentences from the patient information sheet (qualitative):

Page 1: If you feel uncomfortable or distressed during the interview due to having undergone a difficult birth, the researcher will offer appropriate advice and support.

Page 2: For instance, if issues emerge as a result of the behaviour or attitude of health professionals, the researcher will act as an intermediary in order to resolve the problem.

Yours sincerely

**Jennifer Gray
Ethics Administrator**

cc Dr. Tony Blackett – Supervisor
Prof Anne Peat - Supervisor

Appendix-I2: Approval from Hawler Medial University



Ethics application

Number...21
Date...16 / 1 / 2014


Researcher name: **Kazhan I. Mahmood**

Researcher affiliation: PhD Nursing Science

I am writing regarding the application for ethical approval for research titled (**Experience of labor, birth and awareness of pain relief among Kurdish women**).

This project has been reviewed by the Ethical committee of research in college of nursing/Hawler Medical University regarding confidentiality and anonymity of participants.

I am pleased to inform you that the ethical approval has been granted by chair's Action for your applicant.


Dr. Badia Muhammad Najeeb
Deputy Chair
College of Nursing
Research Ethics Committee

Hawler Medical University
Nursing College
Date: / / 01

Appendix-I3: Approval from Ministry of Health-KRG

<p>حكومة اقليم كردستان / العراق وزارة الصحة المديرية العامة لصحة اربيل قسم التخطيط شعبة التمريض</p>	 <p>Kurdistan Region Government/ Iraq Ministry of Health General Directorate of Health – Erbil</p>	<p>حكومة تى هەريەى كوردستان / عێراق وەزارەتى تەندروستى بەريۆه بەرايه تى گشتى تەندروستى هەولێر بەشى پلان هۆبهى پەرستارى</p>
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بەروار ١ / ٢٠١٤ زاینی / ٢٧١٣ کوردی / زماره ١٢٤

بۆ/ نه خۆشخانهى
بایهت / راو سه رنج
نماژه به نوسراوى كۆلێزى پەرستارى زماره ٣/٣ له بهرواى ٢٠١٤/١/٥
كه تيايدا داواى هاوكارى و ناسانكارى له نه خۆشخانه كه تان نه كات بۆ مامۆستای یاریده دهر (كهزان ابراهيم محمود) بۆ
نه تجمه دانى توێژينه وهى زانستى له ژێر ناو نيشانى
(Experience of labour, birth and awareness of pain relief among Kurdish women)
له راتان ناگاد ارمان بکهنه وه ، له گه ل ریزدا

د. سامان حسين بهرزنجى
بهریوه بهرى گشتى

دکتۆر
فاخر حاجى رحمان
ياريددهرى بهريۆه بهرى گشتى

بۆ/ نه خۆشخانهى
بایهت / راو سه رنج

وێنه يه ك بۆ /

- نووسینگه ی بهریز بهریوه بهرى گشتى / بۆ زانین له گه ل ریزماندا .
- بهشى پلان / هۆبهى پەرستارى / بۆ زانین له گه ل ریزماندا .

<p>أقليم كردستان اربيل - تقاطع البارزاني الخالد E-mail: info@dohhawler.com</p>	<p>Kurdistan Region Erbil- Barzani Namr Q. Website: www.dohhawler</p>	<p>هەرێمی کوردستان ههولێر - جواربانی بارزانی نهمر نورمال : ٠١٦ - ٢٢٣٨٠١٦ - ٢٢٣٠٤٠٤ - ٢٢٣٠٤٠١ موبایل : ٠٠٩٦٤٧٥٠١٥٦١١٦٢</p>
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