KAMUZU COLLEGE OF NURSING

WOMEN'S EXPERIENCES OF PAIN MANAGEMENT DURING CHILDBIRTH AT BWAILA HOSPITAL, IN LILONGWE, MALAWI

By

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Declaration

I, Isabel Phiri Kachapira, declare that this dissertation on "Women's experiences of pain management during childbirth at Bwaila hospital is entirely my own work. This thesis has not been presented for any award at any University within or outside Africa. All the sources of information that have been used or quoted have been acknowledged and added to the list of references.

ISABEL PHIRI KACHAPIRA

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Signature

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Date

Certificate of approval

The undersigned certify that this thesis is the student's own work and effort and has been submitted with our approval

Signature ----------Date----------

Prof. Ellen Chirwa, PhD

Main Supervisor

Signature ----------Date----------

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Second Supervisor

Dedication

This Dissertation is dedicated to the following people:

1. My late father and mother, Emanuel and Rhoda Phiri who always inspired me to achieve great things in life. Dad and Mum, you will always live in my heart. May your Souls continue Resting in Peace
2. My husband Francis Kachapira, thank you for the enormous support and for believing in me and my sons, Blessings and Alexander, sorry for mostly being busy and not being there for you as you would have wanted me to be.
3. My sisters, Dorah, Yamikani, Tiwalenge and her husband Maclean for their continuous prayers and support.

May God almighty grant his blessings to you all!

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Abstract

Childbirth pain is one of the most severe pains which have ever been evaluated. Most women perceive childbirth pain as the most severe and distressing event of a woman's existence. There are negative effects of unmanaged labour pain on both mother and foetus. Hence, both pharmacological and non-pharmacological pain relief approaches are vital to relieve childbirth pain. However, evidence shows that utilization of pain relief measures during childbirth is very low in Sub Saharan Africa which includes Malawi. Furthermore, women's experiences of childbirth pain and how they cope with pain have not been adequately explored in Malawi. Hence, a descriptive qualitative study was conducted to explore women experiences of pain management during childbirth at Bwaila Hospital. In-depth interviews were conducted with 15 postpartum participants who were recruited using purposive sampling after obtaining clearance from College of Medicine Research and Ethics Committee and consent from participants. Data were audio recorded and field notes were taken to complement the recorded data. Narratives were analysed using content analysis. The findings revealed that women experienced intense pain on their back and lower abdomen during childbirth. Some women did verbalize the pain while others used nonverbal communication. The study also identified aggravating and alleviating factors of pain during childbirth. However, participants were not given any pharmacological pain relief measure during childbirth to relieve them from their intense pain which they experienced. Some participants were only advised on what to do when feeling severe pain. Their pain was not managed according to their expectations hence ending up not to be satisfied with the pain management. As such, recommendations to the nurse in charge to organize Continuing Professional Development sessions for midwives and managers to support with adequate human resource in Maternity have been made.

Table of Contents

List of Abbreviations

COMREC:	College of Medicine Research and Ethics Committee
DHO:	District Health Officer
KCN:	Kamuzu College of Nursing

Operational definitions

Experience: An event, activity or encounter that leaves a lasting impression.

Childbirth: The process of labour and delivery.

Pain management: Pharmaceutical and non-pharmaceutical pain relief measures used during childbirth

Chapter 1

Introduction and Background

Introduction

Labour is a life event that requires a modification in behaviour of an individual within a short period of time. This is due to physiological and psychological changes that occur enormously (Clyburn, Collis, Harries, & Davies, 2008). Although labour experience varies from individuals, it is the most painful experience that women ever encounter in their lifetime (Pirdel & Pirdel, 2015). Almost 94% of women do experience pain during childbirth (Karuga, Nekyon, & Mung'ayi, 2008). The intensity of labour pain may be influenced by cultural background of an individual, previous exposure to pain events, beliefs, moods and the ability of a woman to cope with the pain (Ogboli-Nwasor, Adaji, Bature, & Shittu, 2011).

Pain in labour makes women to feel uncomfortable, sleepless and restless hence it is important to promote comfort and give analgesia to women in labour to alleviate suffering (Bajwa et al., 2010). In addition, severe pain in labour leads to unsatisfied birth experience to most women (Velho, Atherino dos Santos, Brüggemann, & Camargo, 2012). Furthermore, studies have shown that labour pain may bring negative feeling towards future childbirth such that women end up changing their future reproductive goals as they do not want to pass through the unbearable pain again (D'Cruz & Lee, 2014; Faisal, Matinnia, Hejar, & Khodakarami, 2014; Rilby, Jansson, Lindblom, & Mårtensson, 2012). Dangerously, labour pain also brings about respiratory, psychological, cardiovascular and metabolic problems which can affect the mother as well as the baby in utero (Bajwa et al., 2010). Hence, proper pain management during childbirth may assist in preventing all these problems as well as meeting women's satisfaction with childbirth.

However, evidence shows that utilization of pain relief measures is low in Sub-Saharan Africa including Malawi (Bitew, Workie, Seyum, & Demeke, 2016; Jonazi, 2013; Nyirongo, 2013; Obuna & Umeora, 2014). Additionally, little is known concerning women's experiences of pain management during childbirth. Hence, the proposed study hopes to begin to fill the literature gap in Malawi.

Background Information

Historically, pain during childbirth was believed to be a natural phenomenon that should not be interrupted with (Wong, 2009). This belief made provision of pain relief during childbirth to be associated with myths and controversies (Takrouri, 2008). Takrouri further explained that in the past, people believed that God is the one who made this process painful following Eve's disobedience in the Garden of Eden. As such, taking pain relief during labour was as if you are escaping God's punishment (Wong, 2009). According toTakrouri, some people ended up being persecuted while others were even burnt to death because they were giving analgesia to women in labour. As a result, women were conditioned to perceive pain as a natural process and be able to tolerate it (Takrouri, 2008; Wong, 2009).

In addition, Takrouri (2008) reported that in some Muslim communities of Middle East, "Seal" with name of Allah and words of Quran were stuck on the thigh of women during labour to ease the childbirth pain. Furthermore, several methods including primitive use of rings, necklace, sips of alcohol, distraction, and counter stimulation have been used to relieve labour pain (Kothari & Bindal, 2011). Takrouri further reported that Rouzabah in Persia and Cleopatra delivered under the effect of alcohol whereby the Phenix touched the abdomen to split it allowing them to deliver their babies.

However, some people still advocated for childbirth without pain. They consider childbirth's uterine contractions as severe such that interventions to minimize labour pains

should be applied (Takrouri, 2008). Thereafter, Takrouri stated that James Young Simpson (professor of obstetrics in Edinburgh) was the first person to recognize the use of anaethesia in childbirth in 1846. He used Ether but was not satisfied until in 1853 when Chloroform was recognized as one of the anaethesia. Takrouri further reported that later in 1880, Nitrous oxide was also introduced as pain relief until 1970. Furthermore, the use of labour analgesia gained popularity ever since the three famous women, Fanny Longfellow wife of famous American poet Henry Wadsworth Longfellow (1847), Emma Darwin wife of Charles Darwin the eminent Naturalist, and Queen Victoria wife of Prince Albert (1853) accepted and strongly approved the use of analgesia during birth process (Kothari & Bindal, 2011).

In modern era, various pharmacological methods are used as pain relief measures during childbirth. These include; epidural, inhalation (Ether, chloroform, nitrous oxide) and systemic narcotics/analgesics like Pethidine, Morphine, Tramadol and Ketamine (Bajwa, et al., 2010). Despite the pharmacological measures, there are also non- pharmacological measures which are being used as pain relief measures during childbirth. These include breathing exercises, position changes, rocking, massage/counter pressure, visualization, soaking in a bath tub/taking a shower and listening to music (Adams & Bianchi, 2008).

Some women believe that labour pain is a natural event which does not require any medication to alleviate it while others believe that pain relief measures have to be used in order to reduce the pain (Mugambe, Nel, Hiemstra &Steinberg, 2007). Women who believe in pain relief measures for labour pains expect midwives to provide them with comforting measures such as backrubs, assisting with assuming comfortable positions, holding their hands and giving analgesia (Sengani, 2013).

In Sub Saharan Africa, utilization of pain relief measures during childbirth is very low. For example, a study conducted in Ethiopia shows that utilization of non-pharmacological pain relief measures by obstetric care givers was at 40.1% while no pharmacological pain relief measures was given at all (Bitew, et al., 2016). Similarly, in Malawi, Jonazi (2013) and Nyirongo (2013) found that utilization of pain relief measures during childbirth is low. Based on experience, most women in Malawi pass through childbirth without any analgesia being provided to them as pain relief measure. Utilization of non-pharmacological measures usually depends on the nurse to tell the women what to do when they are experiencing painful contractions. It is unlike in developed countries whereby 71% of US women with vaginal delivery utilize epidural as labour analgesia while 57% of Canadian women utilize non-pharmacological pain relief measures during childbirth (Declercq & Chalmers, 2008).

Despite this being the case, research evidence shows that pain during childbirth leads to unsatisfied childbirth experience among most women with normal vaginal delivery (Nilsson, Thorsell, Hertfelt Wahn, & Ekstrom, 2013; Rijnders, et al., 2008; Velho, et al., 2012). Other studies have also indicated that having unsatisfied childbirth experience prompts women to change their reproductive health plans such as lack of willingness to have another pregnancy, taking long to have another child, opting for caesarean section on their subsequent pregnancy and opting for home delivery (D'Cruz & Lee, 2014; Faisal, et al., 2014; Rilby, Jansson, Lindblom, & Mårtensson, 2012). Rijnders, et al. found that 40% of women with unsatisfied childbirth experience opted for home delivery in their subsequent pregnancies because of poor care, of which part of the poor care is lack of attention to pain relief.

Significant evidence shows that those women who receive continuous labour support have short labour, fewer operative deliveries, fewer analgesic interventions and greater

satisfaction (Hodnett, Gates, Hofmeyr, Sakala, & Weston, 2011). In some hospital settings of Malawi, childbirth companions such as family members like grandmothers, mothers, sisters and neighbours of women in labour are allowed into the labour wards to provide support to labouring women. However, the companions are not well orientated on their roles and how they can help to alleviate the pain. Midwives play major supportive roles in alleviating childbirth pain but the problem of midwifery staffing limits their capability to help the women. This study, therefore, aimed at exploring the experiences of postnatal mothers on pain management during labour and delivery at Bwaila maternity unit in Lilongwe, Malawi.

Problem Statement

Most women perceive the pain of childbirth as one of the most severe events they will experience during their lifetime. Therefore, women anticipate the pain with intense fear, panic, and depression. There is scarcity of evidence from the literature that links labour pain to maternal mortality. However, there is significant evidence, which indicates that the support women receive during childbirth reduces the number of interventions and shortens the duration of labour (Banda, 2008; Hodnett, Gates, Hofmeyr, Sakala, & Weston, 2011). Similarly, there are negative effects of unmanaged labour pain on both mother and foetus (Bajwa, et al., 2010). These include respiratory alkalosis due to hyperventilation, foetal acidosis and serious mental health disturbance that interferes with maternal-neonatal bonding. Severe labour pain can also stimulate emotional behaviours such as anxiety and apprehension thereby negatively affecting the woman's psychological experience of childbirth (Bajwa et al., 2010). To this end, effective labour pain management cannot be overemphasized; both pharmacological and non-pharmacological pain relief approaches are vital to relieve childbirth pain.

Midwives play major supportive roles in alleviating childbirth pain but understaffing of midwives limits their capacity to help labouring women or educate their companions. For

example, in Bwaila labour ward based in Lilongwe, Malawi, 32 midwives conducted almost 17 000 deliveries in a year (Bwaila HMIS, 2016). Almost in all these deliveries women experienced labour pain. However, women's experiences of how they cope with labour pain have not been adequately explored in a low income setting. There is limited literature on the phenomenon of experiences of pain management among post-partum women in a Malawian context. This study sought to address this gap in the literature.

Significance of the Study

This descriptive qualitative study will contribute to the body of knowledge concerning labour pain in developing countries as it has highlighted areas of pain management that need to be strengthened. The findings of this study unveiled the effective and non-effective pain relief measures and also the aggravating and alleviating factors of pain during childbirth. These findings will benefit women in such a way that they will understand the effective pain relief measures and be able to apply them and teach others during childbirth. For the midwives, the findings will assist them when giving midwifery care such that effective pain relief measures shall be emphasized and wherever possible to avoid those aggravating factors that have been highlighted by the women such that satisfactory care should be rendered to women during labour. It will also help the midwives when giving health education to women to emphasize on effective pain relief measures. The health education will help to empower women with knowledge on pain relief measures in labour hence assisting them to go through childbirth with minimal pain. The findings from this study may also influence changes in midwifery practice as well as the development of new policies and protocols to support the provision of both pharmacological and non-pharmacological pain relief measures in labour. Finally, findings from this study may also help with more research in the same area.

Research Objectives

Broad objective

The main aim of this study was to explore women's experiences of pain management during childbirth at Bwaila hospital in Lilongwe, Malawi.

Specific objectives

1. To explore women's expectations of pain relief measures during childbirth
2. To identify pain relief measures utilized on women during childbirth
3. To explore women's satisfaction with pain management during childbirth

Chapter 2

Literature review

Introduction

This chapter presents a review of literature that is relevant to the study. It focuses on the type of review done, search engines and search questions used and the actual literature review. Literature review is an important task for a researcher because it provides readers with a background for understanding current knowledge on a topic and illuminates the significance of the new study (Polit& Beck, 2010). It involves a systematic, comprehensive and thorough search of information. This study undertook a narrative type of review in order to critique, summarize a body of knowledge and draw conclusions pertaining to the study topic (Cronin, Ryan, & Coughlan, 2008). Literature review comprised findings from studies conducted by different researchers globally and within Africa in relation to pain relief measures during childbirth.

HINARI, Pub Med, Elsevier Science Direct, Google Scholar, EBSCO host and Bio Med Central (open access) were databases used with search words such as labour pain experience, expectations AND labour pain, expectations AND labour pain management, satisfaction AND labour pain management, pain management during childbirth to search for information. Both published and unpublished studies written in English pertaining to the research topic were reviewed. This was done to gather information addressing pain relief measures during childbirth. The review was guided by study objectives to identify appropriate information related to pain relief measures during childbirth.

Women's expectations of pain relief measures during childbirth

Pain during childbirth is the most intense pain some women may experience in their lifetime. Women are aware of this labour pain and they expect it during labour and delivery

(Kapadia, Parmar, Solanki, & Patadia, 2013; Rachmawati, 2012). It has been highlighted that all information concerning childbirth that women receive from childbirth classes, midwives, doctors, families, friends, media as well as previous experience contributes to the formation of women's expectations (Martin, Bulmer, & Pettker, 2013; Pirdel & Pirdel, 2015). Evidence shows that expectations of pain differ between primparas and multipara. Expectations of pain in primgravidas depend on the reports from others and previous experience in women who have already given birth. Pirdel and Pirdel (2015) support this with their study findings where it shows that multiparas often have different expectations due to previous experience of childbirth as compared to primparas. Furthermore,Fenwick, Staff, Gamble, Creedy and Bayes (2010) identify that previous exposure to childbirth experience may alter women's expectations for future childbirth.

Reports have shown that women describe the pain they expect during childbirth to be very hard and very painful. However, the women further describe the pain to be a productive type of pain that could be overcome (Martin, et al., 2013). Women tend to develop expectations towards their behaviour when labour pain intensifies. Pirdel and Pirdel (2015) reported that women expect to behave badly, lose control, cry, tolerate the intensity of labour pain and give in when labour intensifies. Culture and religion have been identified to influence pain perception among women and also how they react to it. Sengane (2013) found that mothers expect the midwives to value their cultural and religious beliefs when they are in labour. Midwives should know and understand how culture interferes with pain perception because they regularly care for mothers from diverse cultural backgrounds.

Women expect to receive pain relief measures as well as support from midwives during childbirth. Sengane (2013) also supports this in a study done in a public hospital in Gauteng,

South Africa. Results show that women expected midwives to provide comforting measures such as rubbing their backs and abdomen, assisting them to assume comfortable positions, holding their hands and giving them pain relieving medication measures. Sengane further reported that participants expect husbands to be allowed during labour to offer emotional and physical support. The author further indicates that the support person is able to provide the comforting measures and touch that the labouring woman needs. In addition, he is usually able to interpret the woman's needs and desires for staff members. The participants further expect constant presence of the midwife to encourage and console them. They expect the midwives to give them emotional and moral support as well as showing interest, concern, sympathy and empathy. In Malawi, Kumbani, Chirwa, Malata, Odland and Bjune (2012) found that women expect health care workers to explain to them what to do when they are feeling labour pains but it is not done despite being part of the midwives' role. Similarly, a quantitative study done on 151 women at Cecilia Makiwane hospital in South Africa, reveals that 99.3% of the participants believe that staff has an important role to play in helping to relieve pain during childbirth (Mugambe, Nel, Hiemstra, & Steinberg, 2007). This signifies that women trust health care workers to give them more information concerning childbirth.

Another study was done in USA among low and moderate income nulliparous pregnant women. Results show that participants believe that a doctor/ midwife knows everything and what he/she says needs to be done; as such participants expect clinical support from them (Martin, et al., 2013). Martin, et al. further revealed that midwives serve as a source of physical, emotional and information support apart from their technical roles that people expect from them. Additionally, moral support from support person has been reported by participants as their expectation as well. However, participants are not sure as of the roles that support person plays

during childbirth. The results are in agreement with the findings by Sengane (2013) where women expect their husband to be allowed to offer physical and emotional support during childbirth. However, there is no orientation done to the husband in preparation for them to play these roles. This makes the support person to feel that he or she is there for physical support and nothing else.

The findings above show that women develop expectations on pain relief measures based on the information they get from different sources. Literature reveals that women have expectations from both midwives and their support person. There is need to compare these findings with Malawian setting since most of the studies were done outside Malawi.

Utilization of pain relief measures during labour

Pain during labour is inevitable such that almost 94% of women experience pain during childbirth (Karuga, et al., 2008). In India, 88.5% of postpartum women who participated in a study report severe pain experience during labour and delivery while 7.5% experience moderate pain (Hazarika, et al., 2016). Similar results have been reported by Igbo women of Southeast Nigeria in a study done by Obuna and Umeora (2014). The study reveals that 52% of the participants experience severe pain and 40% report moderate pain. This implies that during childbirth, majority of women undergo severe pain and distress that may require some intervention to be applied in order to relieve the pain. Pain might manifest itself as cramping in the abdomen, groin and back. Sometimes women even experience pain in their sides or thighs as well.

Literature shows that women have a positive attitude towards labour pain despite being unbearable. A study done in cape Town, South Africa, shows that women perceive labour pain as

something good because it initiates bonding with the baby. In addition, it acts as a sign for the coming of the baby (Ibach, et al., 2007). Audu, et al. (2007) in Nigeria reveal that duration of labour has an influence on pain perception. Audu, et al. identify that those women who experience prolonged labour complain of severe pain than those without prolonged labour. The authors further state that women perceive labour pains as being severe and distressing such that they want some pain relief to be given to them.

Evidence shows that women react differently to pain during childbirth. However, the components which determine an individual's reaction to pain are not fully understood. Much seems to depend upon the individual pain threshold which also varies according to the individual's psychological and physical state at a given time (Dippenaar & da Serra, 2013). Dippenaar and da Serra further state that cultural, religious and family backgrounds are also factors in setting the pain threshold in individuals. Worry, anxiety, insecurity, fear, ignorance, fatigue, intense heat or cold, poor general physical conditions, malnutrition, starvation, dehydration, continuous pain or severe pain experienced over an extended period are factors which may lower the pain threshold. Across sectional study done in North-eastern Nigeria reports that participants react to labour pain by rolling on the floor, praying, shouting, vomiting, walking up and down and others by being calm (Audu, et al., 2007). This implies that there are different methods that women utilize to communicate feelings of severe pain in labour. As such midwives need to be aware of these methods in order to assist women accordingly during childbirth.

Studies on pain relief reveal that labour pain can be relieved using non-pharmacological and pharmacological pain relief measures. Some of the non-pharmacological interventions which have been reported to be effective include lumbosacral massage, relaxation, immersion in water

and use of cold compress (Jones,2012). Lumbosacral massage involves manipulation of body's soft and it is used to relax tense muscles, soothe and calm the individual. It also helps to relieve pain by inhibiting sensory transmission in the pain pathways or improving blood flow and oxygenation of tissues. Evidence shows that women who experience backache during labour may find massage over the lumbosacral area soothing (Jones, 2012). This is supported by the findings of a study done in Brazil (Rocha, et al., 2015). The study reveals that participants highlight massage as the most relaxing and enjoyable technique used during labour. Relaxation techniques are also other interventions which can be employed for pain relief during labour and delivery. These are mind and body interventions such as listening to music or watching television. It is the practice of releasing tension and maintaining relaxation often carried out in conjunction with focused breathing, meditation and visualization (Jones, 2012).

Fair and Morrison (2012); Fenwick, Staff, Gamble, Creedy and Bayes (2010); Rilby, et al.(2012); Nilsson, et al.(2013) identified control and support experienced during childbirth to be the only significant predictor of childbirth satisfaction among women. To support this, Jonazi (2013) in her study done in Malawi on primparas shows that few participants report a positive birth experience because of reassurance they receive from nurse/midwives as well as being talked to. This shows that supportive behavior of midwives assisted women to evaluate birth experience as positive though their expectations are not achieved. In addition, Rilby, et al. (2012) in a qualitative study of women's feelings about future childbirth report that women who experience inadequate support or are treated poorly by midwives have a negative experience of childbirth hence creating worry and anxiety about future childbirth.

In addition, Nilsson, et al. (2013) in their findings state that women describe presence of midwife or partner as a positive feeling of support. It is further explained that presence of

midwife or partner helps the mothers to cope with childbirth pain. However, a feeling of inadequate support is experienced by the mothers when midwives are not present and do not help them. As such the mothers feel abandoned and it gives them a sense of fear. Nilsson, et al. further identified health care professionals' personal characteristics and emotional expression to affect perception of support. They indicate that health care workers are perceived as happy, cute, lovely, nice, calm, competent, caring and safe most of the times, but sometimes also harsh, stressed, irritable and strict.

In midwifery, the professional goal is to ensure a safe and optimal labour experience with minimal pain and discomfort. Pain relief during labour is desired by many women irrespective of race or creed and contributes immensely to their satisfaction of birth experience. Lawani, Eze, Anozie, Iyoke and Ekem (2014) in their study identify that provision of obstetric analgesia in labour offer women a better childbirth experience. This is also supported by the findings of a qualitative study done on first time mothers in Sweden. Results show that women had negative birth experience despite being supported in labour because of severe pain they experienced (Nilsson, et al., 2013). Hence there is need to offer women labour analgesia such as pethidine during childbirth to create a favourable environment for women which will enable them to have a better childbirth experience. Use of pain relief measures will promote relaxation in the labouring woman and literature shows that the foetus benefits from a relaxed mother as this increases placental perfusion and when the mother is not fearful, oxytocin release is optimized which stimulates uterine contraction. There is evidence from literature that use of pharmacological and non-pharmacological pain relief measures in labour can promote maternal comfort and reduce complications which can arise due to the effects of labour pain on both mother and foetus.

Studies have revealed that utilization of pain relief measures is low as well among health care providers such that not all women who request for labour analgesia during childbirth are given the analgesia (Audu, et al., 2007; Obuna & Umeora, 2014). A cross sectional study was done in north-eastern Nigeria on 255 women. In the study 10.2% requested for pain relief and only 4.3% were given pain relief measure in labour (Audu, et al., 2007). Similar results were reported in southeast Nigeria. Among the 500 women who participated in the study, 38% requested for pain relief in labour. Only 27% received some form of analgesia while 73% did not receive (Obuna & Umeora, 2014). The reason being that they fear foetal distress, it is expensive and that women present late in labour; so it is difficult to give pharmacological labour analgesia when women are in active phase of labour (Lawani, et al., 2014). These results are in agreement with the findings in Ethiopia by Bitew, et al. (2016) where utilization of non-pharmacological and pharmacological labour pain relief measures by obstetric care givers is at 40.1% and 0% respectively. In addition, Bitew, et al.report professional age, qualification, knowledge and attitude of health care professional as factors associated with utilization of pain relief measures among health care providers. In contrast, utilization of pain relief measures is highly reported in developed countries. A study done in USA and Canada found that 71% of mothers in USA and 57% of Canadian women with vaginal birth utilize epidural analgesia (Declercq & Chalmers, 2008). Furthermore, the study reports high utilization of non-pharmacological pain relief measures among Canadian mothers than US mothers.

Evidence shows that utilization of pain relief measures on the women's side depends on several factors such as women's knowledge of labour analgesia, educational level, previous exposure, attitude and beliefs (Almushait & Ghani, 2014; Audu et al., 2007; Lally, Thomson, MacPhail, & Exley, 2014; Nabukenya, Kintu, Wabule, Muyingo, & Kwizera, 2015). Studies

have shown that where women have low level of knowledge concerning pain relief in labour, the utilization is also low. Audu, et al. did a study on desire for pain relief in labour in Nigeria where 255women were interviewed. The results show that only 18% have knowledge on pain relief in labour and only 10% request for pain relief during labour. Only 4.3% are given pain relief during labour. Audu, et al. further reported that 81.6 % of the participants opt for labour pain relief in their next delivery after being taught on the measures. Similarly, a study done at Cecilia Makiwane hospital in South Africa reveals that 56.3% of women know about pain relief in labour and almost 78.8 % of the participants opt for pain relief medication during their anticipated delivery (Mugambe, et al., 2007). This implies that if women are given the right information concerning pain relief measures during labour and delivery by obstetric care providers, they would be able to make an informed decision of utilizing pain relief measures during labour hence increasing the number of women utilizing pain relief measures during childbirth.

Attitude and beliefs of women towards labour analgesia also affect use of analgesia in labour. Those women who believe that labour pain is a natural process and that without pain, one cannot become a mother are less likely to use labour analgesia in labour (James, Prakash, & Ponniah, 2012; Kapadia et al., 2013). The studies further identify that women who believe that the intensity of pain can be reduced or eliminated are more likely to use labour analgesia than those who do not believe in this (Kapadia, et al., 2013; Obuna & Umeora, 2014). Some women believe that taking analgesia in labour will make them feel out of control during labour and delivery (Lally, et al., 2014). Mostly, women are concerned that using analgesia in labour will affect the progress of labour as well as the health of the baby and mother (Hazarika, et al., 2016; James, et al., 2012). Additionally, a study done in India in a medical college hospital found that

most women refuse to take labour analgesia when offered to them as they want to experience natural birth.

Literature shows that majority of women who are offered pain relief measures during childbirth found it to be effective in relieving labour pain. A prospective study done in Nairobi supports this. 22 participants were offered pain relief measure during childbirth and 18 participant reported the pain relief measure to be effective while four participants said it was not effective (Karuga, et al., 2008). Similar results were reported by first time mothers in Italy. Women mentioned taking warm shower, breathing technique as well as changing positions to be helpful in relieving pain during childbirth (Cappelletti, Nespoli, Fumagalli, & Borrelli, 2016). Cappelletti, et al. further found that majority of the women explain a sense of relief given by mobilisation. Despite this being the case, women have concerns in relation to pain relief during labour. Women are concerned that when one is given pain relief measures during childbirth, the baby may be affected, the method will not work, mother-baby bonding will be affected and that the mother will not be able to push or use lower extremities hence leading to caesarean section (James, et al., 2012; Nabukenya, et al., 2015). These concerns if not properly addressed may contribute to low utilization of pain relief measures among women during childbirth.

Women's satisfaction with pain management during childbirth

Quality of care is defined as the performance of interventions according to established standards that are known to be safe, which are affordable to the society and that have the ability to produce an impact on mortality, morbidity and disability (Raven, Tolhurst, Tang, & van den Broek, 2012). Evidence shows that when quality of care at the hospital is perceived to be poor, women are discouraged to come to the hospital for delivery (Kumbani, et.al., 2013; Tuncalp, Hindin, Adu-Bonsaffoh, & Adanu, 2012). In order to improve the quality of care during

childbirth, there is need for an understanding of what quality of care is all about and how it can be evaluated. Quality of care has been described by different models from the health care providers', management and clients' point of view, hence it has been recommended to apply necessary models that are user friendly and relevant to health services in both resourced and poorly resourced settings (Raven, et al., 2012). O'Donnell, Utz, Khonje, and van den Broek (2014) in a qualitative study conducted in Malawi show that definition of quality of care differed from the perspective of mothers as well as health care providers. For the mothers it is linked to personal requirement such as enabling environment, clinical care provision and communication. Being shouted at and being scared are considered to be poor quality care. Similar results are also reported in a qualitative study done in Ghana by Tuncalp, et al. (2012) where women's perception of quality care highlighted key factors such as the importance of information, good communication, attitude and availability of human and physical resource at the facility.

Literature shows that satisfaction with care does not signify that the quality of care is good as it may indicate low or no expectations among women. Women need to be well informed about the care they should expect so that they should have a basis for comparison. A study done by Kumbani, et al. (2012) on women's perception of perinatal care supports this. The results show that participants do not know what type of care they should expect during labour and delivery. As such they view good reception, being respected, being assessed quickly and informed about the findings, confidentiality and privacy as good quality of care. Participants focus on the relationship which they have with their midwives as an important aspect of good quality care. Participants do not comment on the technical aspect of healthcare workers because they do not know what to expect.

Similarly, for those women who have a positive childbirth experience it does not mean that they have received good quality care. Several factors contribute to a positive childbirth experience apart from good quality care. Jonazi (2013) conducted a study on pain management during labour and delivery on first time mothers. The results show that first time mothers are not satisfied with issues of pain management from the midwives. However, some of the participants report a positive birth experience because of reassurance from some of the midwives. Participants in this study have expectations on pain relief measures based on the information they got at the antenatal clinic. As such they are able to evaluate the care they received based on the information they have and conclude that they are not satisfied.

Women need to be well informed about the care they should receive in relation to pain management during childbirth. Information provided to pregnant women during antenatal clinic should cover issues of pain management during childbirth. Health care workers are the reliable source of information on pain relief measures during childbirth hence most women depend on them (Sengane, 2013). The information that women receive from health care workers during pregnancy are of much help during childbirth (Cappelletti et al., 2016). This is probably because women who are well informed are also empowered such that they are able to insist and be given appropriate care.

Pain management during childbirth is among the areas which are considered important in as long as quality care during childbirth is concern. Application of pharmacological and non-pharmacological pain relief measures offers women greater satisfaction with childbirth as such most women would like to be given pain relief measures during childbirth and also recommend its usage by other (Audu, et al., 2007). In Malawi, contrary results have been reported by the two studies which were conducted at two different hospitals (Jonazi, 2013; Nyirongo, 2013). The

results show that participants are not satisfied with the way pain is managed during labour and delivery. Participants complain that they do not receive any pharmacological or non-pharmacological pain relief measures during labour and delivery. Midwives do not offer them any physical support for pain relief. In addition, participants report being not aware of the pharmacological or non-pharmacological pain relief measures which they are supposed to receive.

Barriers to good quality care have been identified by O'Donnell, et al.(2014) in their study. Mothers perceive that lack of autonomy is a barrier to good quality care. Mothers feel they are not involved in decision making regarding their own care. In addition, they feel that midwives are more knowledgeable than them such that they cannot be against what a midwife has said. This makes the participants not to contribute anything towards their care as they feel everything done on them is right.

Conclusion

Literature shows that most women are aware of labour pains and they expect it during childbirth**.** Evidence shows that women experience intense pain as a cramping in the abdomen, groin and back and they react to it differently. Despite the belief that labour should be pain free, studies conducted on use of pain relief measures during labour reveal that utilization of pain relief measures is low in developing countries as compared to developed countries such that majority of women experience intense pain during childbirth. However, most of these studies have been conducted outside Malawi and their main focuses are on experiences of women with care during childbirth in general.

Chapter 3

Research Methodology

Introduction

This section contains a description of the methods that were used to conduct this study. It includes the study design, study population, inclusion and exclusion criteria, sampling methods sample size, study sites, data collection and analysis, trustworthiness of the study and ethical considerations.

Study Design

This study utilized a descriptive qualitative research design to unfold the experiences of postnatal mothers on childbirth pain management. The descriptive qualitative design was selected in order to explore fully the pain management experiences of mothers during childbirth despite the challenge that the results cannot be generalized (Maltby, Williams, McGarry, & Day, 2010). A descriptive qualitative approach emphasizes that the key importance of understanding any phenomena is to understand it from the first person point of view (Maltby, et al., 2010). This will give a clear understanding of how individual women perceive the phenomena around them and how they make sense of this phenomenon. The researcher preferred this method because there was little that was known concerning women's experiences on pain management during childbirth.

Study Setting

This research study was conducted at low risk postnatal ward of Bwaila Maternity Unit in order to maintain the natural setting where the phenomena took place. Bwaila Maternity Unit is one of the units under Bwaila Hospital which is located within the city of Lilongwe. It is one of

the biggest public referral facilities in terms of maternity services in Lilongwe district, with 17000 deliveries per year or approximately47 deliveries per 24 hours (Bwaila HMIS, 2016).

Population and Sample

Study population

A population is considered to be the entire aggregation of cases in which a researcher is interested (Polit & Beck, 2014).The population of this study was postnatal mothers with normal delivery at Bwaila labour ward. The researcher's interest was to understand the phenomenon of pain management during childbirth from the first person's point of view as this gave a clear understanding of how individual women experienced the pain management during childbirth.

Inclusion criteria

The researcher included mothers who were admitted while in latent phase of labour to be assured that the women had adequate time of being under care of a midwife or support person. These mothers gave birth normally at Bwaila labour ward and they were within 48 hours post delivery. Additionally, the mothers had live normal babies, were able to communicate verbally and gave consent to take part in the study.

Exclusion criteria

The researcher excluded from the study postnatal mothers who came as referral cases while in second stage of labour and those who did not deliver at Bwaila labour ward considering that the women had inadequate time of being cared for by midwives of Bwaila labour ward. Those who delivered through caesarean section were also excluded from the study.

Sampling method

Sampling refers to the process of selecting a portion of the population to represent the entire population (Polit & Beck, 2014, p. 177). In this study the researcher used purposive sampling in order to identify postnatal mothers who were capable of providing rich data and were free to express themselves. Polit and Beck (2014) describe purposive sampling as a non-probability sampling method in which the researcher selects participants based on personal judgement about who will give much information about the phenomena of interest. In this study, the researcher picked those mothers who met the inclusion criteria and contributed to the information needs of this study.

Sample size

In qualitative research, sample size is determined based on informational needs. Data saturation is the guiding principle whereby sampling is done to the point at which no new information is obtained and redundancy is achieved (Polit & Beck, 2014, p.286). In this study, the researcher planned to interview 30 participants but saturation of data was achieved after interviewing 12 participants. However, three more interviews were conducted to validate the results; hence the final sample size was 15. Data saturation was reached when participant number twelve gave similar responses to what was already explained by the previous participants. Holloway and Wheeler (2010) argued that the sample size does not influence the importance or quality of the study and that there are no guidelines in determining sample size in qualitative research. Small sample sizes are usually used in descriptive qualitative design due to in-depth nature of the interviews hence sample size may vary from 10 to 30. This is because there will be

no generally agreed upon consensus on the number of informants required as this will be determined by data saturation (Klenke, 2008).

Access and Recruitment of the Study Participants

After obtaining permission from Lilongwe District Health Officer to conduct a research at Bwaila hospital and ethical approval from COMREC, the researcher met the District Nursing Officer and explained to her about the study**.** Thereafter, the researcher was referred to the Senior Nursing Officer responsible for low risk postnatal ward. The Senior Nursing Officer introduced the researcher to the nurse in charge of low risk postnatal ward. Those women who met the inclusion criteria were approached and provided with information about the study (Appendix 1a). They were requested to consent to be interviewed (Appendix 2a). The ones that consented were recruited and interviews were conducted in a quiet room.

Data collection

Permission was obtained from the District health Officer of Lilongwe before data collection (Appendix 4). Data were collected between the 10thof July 2017 and 16thof August 2017. The researcher recruited participants from low risk postnatal ward of Bwaila maternity unit. Participants were interviewed within 48 hours following normal delivery for easy recall as they had fresh memories of their experience. Recruitment was done after participants gave consent to take part in the study.

Data were collected through face to face in-depth interviews using a semi structured interview guide (Appendix 3b) in a quiet room which was identified within low risk postnatal ward. The interviews were recorded using audio recorder. The interview guide contained open-

ended questions in order to allow participants to express themselves fully hence be able to capture the required information. The questions in the guide were based on the objectives of the study.

The researcher developed the interview guide in English (Appendix 3a) and translated it into Chichewa (Appendix 3b) for easy communication with the participants. Each interview lasted between 45 and 60 minutes.

Pre- testing of the data collecting instrument

The interview guide was pre-tested on two postnatal mothers at Area 25 health centre on 29 and 30 June 2017, after seeking permission from the DHO as well as the hospital in charge of Area 25 health centre. Pre-testing aims at determining the length of time it takes to administer the entire instrument package; identifying questions that are not clear and are being misinterpreted, determining the sequence of questions and ensuring that the tape recorder is working satisfactorily. It was through this pre-testing that each step of the research process was evaluated. The interview questions were refined following the pre-test in order to improve the quality of the questions.

Data analysis

The researcher used content analysis method to analyze data. Polit and Beck, (2014, p.306) describe content analysis as the analysis of the content of narrative data to identify prominent themes and patterns among the themes. It involves breaking down data into smaller units, coding and naming the units according to the content they represent, and grouping coded

materials based on shared categories. Data was analyzed using the following steps of content analysis as explained by Elo and Kyngas (2008).

Preparatory phase

In this phase, the researcher strives to make sense of the data (Elo & Kyngas, 2008). Data collection and analysis was done concurrently where the audio recorded interviews were listened to and transcribed verbatim. Field notes were included in the transcripts. Each transcript was re-read and the data was reflected upon to get the meaning behind some words before starting coding. All these assisted the researcher to get immersed in the data hence becoming familiar with the depth and breadth of the data content.

Organizing the qualitative data

The process includes open coding, creating categories and abstraction. Open coding means that notes and headings are written in the text while reading it (Elo & Kyngas, 2008). The researcher read the transcribed data while writing some codes at the margin of the transcripts. The written material was read through again by the researcher, and as many codes as necessary were written down in the margins to describe all aspects of the content. The researcher collected codes from the margins on to coding sheets and categories were freely generated (Maltby, et al., 2010). The purpose of creating categories was to provide a means of describing the phenomenon, to increase understanding and to generate knowledge.

Later on, the researcher grouped the list of categories under higher order headings. The aim of grouping data was to reduce the number of categories by collapsing those that are similar or dissimilar into broader higher order categories (Elo & Kyngas, 2008).

Finally, abstraction was done whereby the researcher formulated a general description of the research topic through generating main categories (Elo & Kyngas, 2008). Each main

category was named using content characteristics words. Categories with similar events and incidents were grouped together as sub-categories and sub-categories were grouped as main categories. Demographic data of the participants were analyzed manually.

Trustworthiness of the Research

Trustworthiness refers to the process of evaluating the quality of data and the findings. In this study, trustworthiness evaluation was based on the scientific rigor criteria used in qualitative methodology identified by Lincoln and Guba (1985), which assess the credibility, dependability, conformability, and transferability of the findings (Polit & Beck, 2014, p.323).

Credibility

Refers to the confidence in the truth value of the data and its interpretation as judged by an external reader (Polit & Beck, 2014). In order to achieve credibility in this study, there were repeated interviews at different time points until data saturation was reached. The interviews were lasting 45-60 minutes in order to provide adequate time for participants to think and give a response and to build trust and rapport with the participants.

Dependability

Dependability of the study means that the data has to be stable over time and over conditions (Polit & Beck, 2014). This means that the study should be able to give the same results if it were to be repeated with in a similar context.The researcher ensured dependability in this study by doing Code-Recode strategy where by the researcher coded the data twice in between two weeks. The results from the two coding were compared and contrasted for

similarities and differences respectively. This helped the researcher to gain deep understanding of the data patterns and to improve the presentation of participants' narrations.

Confirmability

Polit and Beck (2014, p.323) describe confirmability as the objectivity and neutrality of the data that is the potential for congruence between two or more independent people about the data's accuracy, relevance or meaning. Such being the case, during data management, another person was asked to verify the coded categories to ensure that all information was captured and well coded. Additionally, the report incorporated the participants' expressive language, presented as direct quotes from the transcribed data to provide evidence of the research findings. Lastly, the research supervisor also went through the emerging categories and the entire set of raw data together with the researcher throughout the process of data analysis. This was done in order to ensure a true representation of data.

Transferability

Transferability refers to the extent to which the findings from the data can apply to other settings. This was achieved by providing sufficient descriptive data in the research report for readers to evaluate the applicability of the data to other context (Polit & Beck, 2014). The researcher provided a thick description of the research methodology and the research context so as to enable someone interested in making a transfer to reach a conclusion about whether transfer can be possible or not.

Ethical Consideration

To ensure that human beings are protected, ethical principles, informed consent, privacy, confidentiality, beneficence and anonymity guided the study.The proposed study was submitted to College of Medicine Research and Ethics Committee (COMREC), for ethical approval before data collection. The researcher got permission from Lilongwe District Health Officer (Appendix 4) where the study took place. The researcher also explained to the participants about the purpose of the study for them to understand (Appendix 1b). Furthermore, the researcher assured the participants that the information will be kept safe and nobody will access it apart from the researcher herself. In addition, participants' names were not used in this study; instead codes were used to ensure anonymity. There was a consent form where participants were asked to sign if they have agreed to participate in the study (Appendix 2b). In order to ensure autonomy in this study, no participant was forced to take part in the study and if they decided to withdraw in due course, they were free to do so. In addition, participants were informed that no punishment of any kind will be given for refusal to participate.

Conclusion

This chapter described the research design and method of the study. It included the description of the research design, population, sampling method, data collection method, data analysis method and ethical considerations.

Chapter 4

Presentation of findings

Introduction

This chapter describes the findings of a study conducted at Bwaila hospital in Lilongwe District. The findings have been presented to achieve the following objective of the study: explore women's expectations of pain relief measures during labour, identify the pain relief measures utilized on women during labour andexplore women's satisfaction with pain management during childbirth. The findings of the study have been presented in the following main categories: desire for pain relief, labour experience, contentment with pain management and barriers to quality care. The identified sub-categories include: escaping pain, support, nature of pain, relief measures, satisfied, not satisfied, inadequate midwives and midwives attitude (see Table 2 for the main categories and sub-categories). Demographic data were reviewed to identify the characteristics of the participants and have been presented first in this chapter (Table 1).

Table 1: Characteristics of Participants

Demographic characteristics	**Frequency**
Age (years)	
Less than 20	2
20-35	10
35 above	3
Religion	
Christianity	13
Islam	2
Marital status	
Married	14
Single	1
Education level	
Secondary	7
Primary	8
Occupation	
Housewife	6
Employed	1
Business	8
Tribe	
Chewa	6
Ngoni	4
Lomwe	3
Yao	2
Parity	
Primpara	4
Multipara	9
Grandmultipara	2

Table 2: Main categories and Sub-categories

Main Categories	**Sub-Categories**
Desire for pain relief	Escaping pain Support
Labour experience	Nature of pain Relief measures
Contentment with pain management Barriers to quality care	Satisfied Not satisfied Inadequate midwives Midwives attitude

Women's expectations of pain relief measures during childbirth

Participants were asked on their expectations of pain relief measures including their expectations of receiving pain relief from the midwife and support person. In response to these questions, participants mentioned different expectations which they had in relation to pain relief measures. Desire for pain relief emerged as the main category under this objective.

Desire for pain relief

The responses from the participants revealed that women had expectations as regards to pain relief in labour. The participants mentioned that they expected to be treated with love and compassion by the midwives as well as support person. The study findings revealed that participants expected care such as being given medication for pain relief, support and advice on what to do when they were feeling much pain during childbirth. Escaping pain and support were sub-categories under this main category.

Escaping pain

The study findings showed that most participants expected to deliver immediately upon reaching the hospital. As the labour pains intensified, some participants expected to be relieved from pain by being given pharmacological pain relief measures. However, though they expected these pain relief measures, participants were not specific of what type of medication they were expecting to receive. Furthermore, participants were not sure whether medications for pain relief during labour were available or not. Some participants felt like the midwife could assist them with other measures such as labour augmentation and caesarean section so that they should deliver fast and escape the pain. The following narrations are what the participants said:

I expected that the midwives, after seeing that we are in pain, will be able to help us, for example, giving us medication that reduces the pain, or advising us on what to do when we are feeling much pain such that we should escape the pain of childbirth (Participant No.1, Para 6, 37 years).

The other participant said:

I expected that they will give me an injection to lessen the pain so that I won't feel pain during labour (Participant No 3, Para 3, 25 years).

In contrast, some participants described the context of pain to be associated with a desirable outcome such that they just expected to have the baby by the end of pain. As such, some participants did not have any expectations neither from the midwife nor the support person. The reasons being some participants believed that those who usually receive medication during childbirth have a medical problem but as of them they did not have any. Some participants did not know that a midwife can do anything to relieve labour pain especially primparas. One participant said:

I did not expect much from the midwife because this is my third time and all along, I have never been told of ways that can relieve my pain, so I did not expect anything else since I didn't know that the midwife can help me in any way 'speaking with emphasis',(Participant No. 11, Para 3, 25 years).

Another participant said

I was expecting to have my baby in my hands by the end of the pain (Participant No 2, Para 1, 22 years)

Support

The study findings showed that most participants expected to receive support from a midwife whenever they were feeling much pain. The participants explained that they expected the midwife to check on them and address their concerns while offering psychological as well as emotional support. Additionally, the women expected the midwives to communicate to them about their progress of labour and advise them on ways to reduce pain. One participant said:

I expected to be attended to by the midwife when am feeling pain. I also expected her to listen to my concerns and examine me and talk to me on the progress of labour until delivery (ParticipantNo.10, Para 3, 23 years).

In this study, participants seemed not to be aware of the roles of the support person in labour pain management. The findings showed that only few participants expected psychological support from the support person. Most participants appeared to rely much on midwives to provide both pain relief and emotional support. Majority of the participants thought the support person has nothing to do with their pain but they felt the support person was there for physical support. Some participants were wondering to see that their support persons were assisting them to relieve the pain. One participant stated:

I expected them to call the midwife for me whenever I needed the midwife since in my situation, I could not be able to do that myself. I expected them to give me words of encouragement, like "it is okay, you will be fine" (Participant No 11, Para 3, 25 years).

The other participant said:

To help in carrying my baby if I would have delivered with difficulties and that I would not be able to carry the child myself. Also, since there is theft in these places, they were supposed to help secure my things and my baby while am doing laundry work (Participant No. 12, Para 4, 36 years).

Pain relief measures received by women during childbirth

Participants were asked to indicate the pain location and how they were communicating to others about their pain. They were also asked what factors aggravated or alleviated their pain. Participants were asked to explain if any pain relief measures were utilized during childbirth, and to report the effectiveness of the interventions. From the information that participants gave, labour experience emerged as the main category.

Labour experience

Under this category, there were two sub-categories: nature of pain and relief measures. Nature of pain will be presented first followed by relief measure.

Nature of pain

The study findings showed that all participants in this study reported to experience pain during childbirth. Some participants experienced the pain more than expected especially primgravidas. The findings further indicated that participants felt much pain on the back and lower abdomen. However, close to delivery, much pain was felt around the birth canal. The study findings further showed that participants were able to use verbal and non-verbal communication to let people know that they were in great pain. While some participants reported that they were groaning, crying and rolling whenever contraction comes, others were telling

people around them that they were in pain. The following extract states what the participants indicated:

I was feeling much pain on my back and lower abdomen, it was like the lower abdomen and the back was pulling each other (Participant No 4, Para 3, 27 years).

Another participant stated:

I was crying and screaming while mentioning the names of those who were around me. But there was nothing they could do to me apart from encouraging me to persevere (Participant No 5, Para 2, 24 years).

The study findings also identified some factors which aggravated and others which alleviated the pain that participants experienced during childbirth. The participants reported aggravating factors which include: ambulation, full bladder, vaginal examination, full rectum, crying and the environment whereby the midwife is not offering any comfort to the client. One participant said:

When I want to pass stool or urine, when walking around, lying down on my back, lying down sideways, when a midwife does vaginal examination, the pain was so intense (Participant No 7, Para 1, 18 years).

Another participant said:

When a midwife was doing vaginal examination, it aggravated the pain. Frequency vaginal examination which was done on me was increasing the pain hence I did not like it (Participant No 5, Para 2, 24 years).

Another participant said:

Some nurses were not so caring to a woman in pain, not even encouraging you, or saying anything that can be of comfort. So this also increased pain sensation (Participant No 12, Para 4, 36 years).

Participants also reported alleviating factors to pain during childbirth which includes: backrub, positioning, frequent urination, rupture of membranes and presence of a midwife. This is illustrated in the following excerpt:

In my opinion, the effective way which reduced the pain was when I was advised to lie down sideways without doing anything that can cause more pain. In addition, gently massaging/stroking the area where there was pain and urinating regularly could reduce the pain as well (Participant No 1, Para 6, 37 years).

The other participant said:

Walking around was decreasing my pain, if I empty my bladder, I could feel some relief from pain. During the time my membranes ruptured, I felt some relief from pain as well (Participant No 15, Para 2, 27 years).

The study findings showed that some participants believed that labour pain is a natural process that no one can interfere with. They also believed that for somebody to deliver a baby you need to feel pain otherwise without pain one cannot deliver normally or will have some complications. In this case, the women believed that taking some pain relief medication means that one will have prolonged labour as the contraction may cease and this may delay the coming of the baby. The responses showed that some of the participants did not believe that they can pass through labour and delivery with minimal pain. Some participants also believed that experience of severe pain during childbirth is associated with prolonged use of depo provera and

also they related the pain with sex of the baby. The following narratives were stated by the participants:

The midwife could not take a great part in reducing the pain; they also wait until you are due to deliver. There is nothing that can be done on labour pains (Participant No 14, Para 3, 23 years).

The other participant said:

It was not the right time to inject me with pain relief medication because doing so would have caused some complications, considering that one is not supposed to be given medication during labour. Maybe the pain could temporarily stop, but during delivery, you could feel great pain once the effect of the injection has stopped (Participant No 6, Para 2, 24 years).

Relief measures

The study findings showed that participants did not mention of receiving any pharmacological pain relief measure from the midwife. However, most participants utilized non-pharmacological pain relief measures which they were told or explored by themselves. Few participants were done backrub but most participants were advised on diversional therapy like ambulation, deep breathing exercises and frequent bladder emptying. Some of the participants were told to endure the pain such that nothing could be done. Participants were able to describe those pain relief measures which they felt were effective or not effective in reducing pain during childbirth. Those measures which the participants mentioned as effective in reducing pain include: sleeping in lateral position, deep breathing exercise, massaging and backrub, frequent

urination and strongly holding to something hard. These measures were relieving the participant from intense pain as such they tend to like them. One participant stated:

After assessing me, the midwife just said my cervix was still dilating as such I needed to urinate frequently and walk around to facilitate descent of the baby. There was no pain relief measure given to me apart from these advices (Participant No 15, Para 2, 27 years).

Another participant said:

When I was in pain, I slapped myself on the back and on my thighs. The pain would subsidize a little rather than doing nothing. Lying down sideways reduced the pain than lying down on the back (Participant No 06, Para 2, 24 years).

Ambulation was mentioned by some participants to be not effective in reducing pain during childbirth. However, most participants liked ambulation because it helped them to deliver fast as it facilitated the descent of the baby. Ambulation relieved the participants from intense pain faster unlike with sleeping in lateral position which made the pain to cease for so long hence prolonging the delivery time. As such, most participants liked those methods that lead to their fast delivery of the baby. Few participants also did not like the instruction of frequent bladder emptying because they were not in a position to walk and when they went to urinate, the urine was not coming out. The following extract is what one participant said:

Walking around helped me to deliver fast but it was not effective as a pain relief measure to me because it was increasing the pain. I liked the method of walking around because it helped me to deliver fast as it was facilitating the descent of the baby. I did not like the sleeping one because it was interfering with the descent of the baby and also the labour pain was taking time

to resume which I felt would make me to take a longer period before delivery (Participant No 03, Para 3, 25 years)

Women's satisfaction with pain management during childbirth

Participants explained their views on pain management provided to them during childbirth. Furthermore, participants narrated their satisfaction with the pain relief measures and their suggestions to improve quality of pain management during childbirth. Two main categories of contentment with pain management and barriers to quality care were identified on this objective.

Contentment with pain management

This category was identified from the views of participants on pain management they received. This category was followed by two sub-categories namely: satisfied and not satisfied.

Satisfied

The findings of this study show that participants describe the care as satisfactory when the midwife was comforting them with words of encouragement during labour. One participant narrated that she was given analgesia during repair of perineal tear such that she did not feel pain.

The nurse has been of great help according to her profession and call of duty, but not that she could do anything to reduce the pain. Whether the nurse was around, or not, the pain was still there. Yes … am satisfied first because I have safely delivered my baby and second, the midwife was very helpful with encouraging words; so these words were comforting me (Participant No 10, Para 3, 23 years).

Another participant said:

I could say I was taken good care of because when you are delivering you don't know of what will happen to you. As it happened with me, I had a perineal tear. The midwife was able to repair it without me feeling much pain. I was given injection to the site for me not to feel pain (Participant No 15, Para 2, 27 years).

A few participants were not able to give any information about their views on the pain relief measures which they received. They felt a midwife is well knowledgeable than them so they felt everything done to them was good. One participant said:

Since the midwife knows everything, following what she is telling you is so helpful rather than doing what you know. So everything that was done on me was good (Participant No 05, Para 2, 24 years).

Similarly, another participant said:

No, there was no reason, they did everything the way it was supposed to be done, I could not command them. It is not possible to have your own fantasies of how things should be done because if you have left your home and come to the hospital, then you are supposed to listen to what the doctor is saying, even though you have your wishes, it cannot be possible (Participant No 09, Para 8, 38 years).

Not satisfied

Unsatisfactory care was described by participants whenever the midwife was not available for them and that they did not receive the care they deserved. For example, that they

lacked pain relief medication despite experiencing pain. In addition, the health care providers' bad attitude towards the client was also not good for the participants.

The study findings revealed that most participants were concerned that some interventions or advice given by the midwife were less supportive; regardless of that, participants accepted them without any complaint. Participants also reported that they were not given any pain relief medication to lessen their pain. Some participants felt that may be there was no medication for them to be given to relieve their pain at that particular time. Another participant, a primparas, was denied water when she asked for it during labour and delivery. One participant complained that the midwife was not there for her as it was required to assess her and know the progress. The following were the narratives form some of the participants:

I did not receive much help from the nurse regarding the ways to reduce my pain, nothing like coming around and encouraging me. I am not satisfied because most of the things, I was doing them myself, even my baby was delivered without any assistance from midwife, it is the fellow women in the ward who helped me deliver my baby (Participant No 11, Para 3, 25 years).

Another participant stated:

Mmmh, when we arrived we heard that we were supposed to be assessed every hour by the midwife, a thing which did not happen to me. I was just groaning with pain up until I asked my support person to go and call the midwife to come and assess me. I would have loved to be assessed frequently to know my progress. The midwife's presence provides some relief and knowing your progress keeps you fine psychologically (Participant No 15, Para 2, 27 years).

Barriers to quality care

Inadequate midwives

Inadequate midwives came from most of the participants and they described it as a contributing factor to unsatisfactory care during childbirth. Most of the participants complained that there were few midwives in relation to the number of patients present at that particular time. Participants observed that a midwife was not with them most of the times as she was busy attending to other clients. In this case, one midwife was attending to more than one patient hence compromising quality care. This deprived other clients to receive the type of care which they deserved**.**

They were supposed to be encouraging me that when it's time to deliver or when I deliver, I will be relieved of pain….The midwife failed to constantly encourage me because of the work load that was there since we were many of us against few midwives. But overall, they helped me (Participant No 01, Para 6, 37 years).

Midwives attitude

Some participants identified midwives' attitude as compromising quality care in pain management. The participants complained that some midwives did not want to be told what to do whenever they were doing their work. This made participants not to voice out their concerns in relation to pain. One participant said:

I think it just depends on the heart of the person that you have found that time. For my case, I think I was just unlucky that the person I met was not so kind as they ought to be (Participant No 11, Para 3, 25 years).

Based on participants' experiences of pain management, they came up with suggestions. Most participants suggested the presence of the midwife at all times during childbirth so as to give them comfort. Participants further requested the midwives to treat them fairly with love and passion. Participants further suggested that the support persons should be oriented on their roles during childbirth rather than them sitting idle. They also suggested the availability of medication for pain relief so that they can be given during childbirth although other participants doubt its availability. In addition, participants requested women to utilize the non-pharmacological measures as well as listen to midwives' advice. One participant stated:

The support person should not be so quiet, but should be able to cheer you up when you are in pain, but encourage you with words and give you morale, without shouting at you. From the hospital staff, they should help us with a loving gentle heart, show affection and encouragement now and then. It is not about the medication that can reduce the pain, but their caring attitude. The care that they show us makes us feel loved and helped (Participant No 11, Para 3, 25 years).

The other participant said:

Slapping on the back and on the buttocks lessens the pain sensation. Of course the pain doesn't go completely but it reduces. Giving you an injection so that you don't feel much pain, of course I don't know whether somebody had ever been given this injection but am just thinking. This hospital is big and during delivery, there are a lot of women, however, I would have loved if every patient has her own doctor attending to her. But since the number of patients is always more than the doctors around, this cannot be possible (Participant No 06, Para 2, 24 years).

Conclusion

This chapter focused on the description of research findings. The main categories and sub-categories were described. The main categories include desire for pain relief, labour experience, contentment with pain management and barriers to quality care. Each of the main categories was described with their sub-categories.

Chapter 5

Discussion of findings

Introduction

This chapter discusses the findings of the study. The discussion is done in line with the purpose and the objectives of the study, which was exploring women's experiences of pain management during labour and delivery at Bwaila maternity unit in Lilongwe. Although the issues were presented individually in the previous chapter, they are inter-related and participants frequently commented on their experiences of pain management during childbirth. As a result of these interrelationships, some of the issues have been combined because they could hardly be presented separately from each other. Major findings will be discussed according to four major categories identified in this study which are: Desire for pain relief, labour experience, contentment with pain management and barriers to quality care.

Finally, the researcher will address the limitations of the study with recommendations and implications of the results for midwifery education, research and practice.

Desire for pain relief

Escaping pain

This study found that almost all women expect to experience pain during childbirth; as such majority of the women expect to be given pharmacological pain relief to lessen their pain. However, some women were concerned that pain medication could have adverse effects. In previous work from Sub Saharan Africa and Northeastern America, similar findings were reported (Jonazi, 2013; Martin, et al., 2013; Sengane, 2013). James, et al.(2012); Mugambe, et al.(2007); Nabukenya, et al. (2015) found that women were concerned that taking

pharmacological pain relief measures during labour will have an effect on the baby and mother. Studies acknowledge that pharmacological pain relief measures if not properly administered can cause complications to the fetus and neonate. For example, sedation leads to birth asphyxia (Chikuse, Chirwa, Maluwa, Malata, & Odland, 2012).

However, women in this study were not specific as to what type of pharmacological pain relief measure they were expecting to receive. This made them not to be sure whether medications for pain relief during childbirth exist or not. Some participants were just mentioning injection but they were not able to mention the name of the medication. It is unlike with other studies done in Pakistan and South Africa where women were able to mention the type of pharmacological pain relief measure they would expect to receive like injection e.g. Pethidine or epidural analgesia after they were told by their doctors and midwives (Barakzai, Haider, Yousuf, Haider, & Muhammad, 2010; Mugambe et al., 2007).

The findings of this study also indicate that some participants expected a fast delivery to be conducted on them so that they should escape the intense pain they were feeling. Others were opting to go for caesarean section in a way of escaping labour pain. This is in agreement with the study findings in Iran where results showed that fear of childbirth pain was the reason most primgravidas requested for caesarean section in normal pregnancy (Faisal et al., 2014).

Support

In this study, women also reported that they expected to receive support from the companions. They expected the presence of the midwife at all times which offers them emotional support and also to be shown love and respect as well as to be advised accordingly whenever they are feeling pain. This study findings are in agreement with what Sengane (2013) reported in

a study done in a public hospital in Gauteng, South Africa. The results revealed that women expected midwives' presence to offer them emotional and moral support as well as communicating to them in a polite way. Sengane further revealed that participants expected to know their progress and receive guidance from the midwives.

Similar findings were also reported by Goberna-Tricas, Banus-Gimenez, Palacio-Tauste and Linares-Sancho (2011) in their study where women want to be treated with tender loving care during childbirth as they go through a lot of pain. In Malawi, Kumbani, et al.(2012) found that women expect healthcare workers to explain to them what to do when they are feeling labour pains. Adams and Bianchi (2008) identified the importance of communication during labour and delivery. The study reported that informing women about the progress of labour and plan of care helps to ease anxiety. After each assessment as labour progresses, it is very important to update the woman on the fetal status as well as cervical changes. This is in agreement with the findings of this study whereby participants expected to be assessed frequently by a midwife as well as to be told about their progress of labour.

Results from this study indicated that participants expected much support from the midwife and not the support person. They gave the reason that through their experience, they hardly see or hear a support person helping in reducing labour pains. This study findings are in agreement with other studies done in South Africa (Mugambe et al., 2007; Sengane, 2013). This could be due to lack of knowledge concerning what care they should expect from the support person when they experience pain during labour and also the support person did not know what care to provide to their client when they are feeling labour pain. Similar findings were identified among primparas women who reported the perceived roles of birth companions which include physical support like; caring for the woman during labour and delivery in the absence of a

midwife, to receive the baby after delivery and to observe every activity during labour and delivery (Kungwimba, Malata, Chirwa, & Maluwa, 2013). Literature shows that when a support person is well oriented on their roles during labour and delivery, they are able to provide the comfort measures and touch that the labouring woman needs. In addition, they are usually able to interpret the woman's needs and desires for staff members (Kungwimba et al., 2013).

In Brazil, evidence shows that companion's emotional support offers women much satisfaction than any other non-pharmacological pain relief measure (Gayeski, Brüggemann, Monticelli, & dos Santos, 2015). The study further shows that the companions do assist with application of non-pharmacological measures like manual massage and focused attention. This is in contrast with the findings in this study where companions were not oriented on their roles when they enter the labour room; as such they just wait to keep the baby when it is born as highlighted by participants in this study. Hodnett, et al. (2011) reported the importance of continuous support during labour as those women who had continuous one-on-one support during childbirth were more likely to experience labour pain for a short period of time. Hodnett, et al. further revealed that with continuous one-on-one support, women are also less likely to use labour analgesia during their intrapartum period or undergo cesarean delivery, or deliver a baby with low APGAR scores at 5 minutes. In addition, they cannot report negative feelings about the childbirth experience.

Labour experience

Nature of pain

Pain during labour is part of the natural complex system that keeps the uterus contracting and relaxing and keeps the baby moving and protected (Lothian, 2008). Factors that influence a

woman's experience are the intensity of labour pain, the length of time that labour lasts, the environment in which she gives birth and the support that she receives from her companion or care giver. This study found that every woman experienced pain during childbirth. Almost all women experienced much pain at the back and lower abdomen. This was outlined by one participant in this study who narrated that the pain was like the lower abdomen and the back were pulling each other. Tournaire & Theau-Yonneau (2007) reported that uterine contractions are felt as back pain because the nerves that supply the uterus also supply the skin on the lower back or lumbosacral area. Dippenaar and da Serra (2013) stated that pain in the lower abdomen seems to be related to the activity in the upper uterine segment and is present when labour is progressing well. Dippenaar and da Serra further stated that pain in the back is related to tension in the lower uterine segment and the cervix. In normal labour, slight back pain may be experienced only at the start of a contraction. However, backache is common in posterior position of the vertex and when there is uncoordinated uterine action particularly when the cervix is abnormally resistant.

During childbirth, women may move around, massage the back and perhaps groan in response to pain of a contraction. In the process of making themselves comfortable, the movement also keeps the progress of labour. These actions help to ease the pain as well as facilitate the process of labour and delivery (Lothian, 2008). Lothian further stated that the baby's turning and movement through the birth canal is facilitated by the movement and position change of women in response to the pain. Every time the woman moves, the diameter of the pelvis changes, the baby gets enough room and is gently pushed into the pelvis and through the birth canal. It was also highlighted in this study that some participants liked ambulation because it assisted them to deliver fast though it was not effective in reducing pain. Ambulation allows

for descent of the presenting part and also to relieve the intensity of pain when the woman's focus is diverted (Dippenaar & da Serra, 2013).

The study findings also showed that participants in this study experienced severe pain when ambulating than sleeping in lateral position. This is different from what the study done on primparas in Egypt found. The study reported that primparas who utilized upright positions experienced less abdominal and lower back pain in active phase of labour and also higher satisfaction as compared to those who utilized recumbent position (Al-Seady, Fadel, EL-Gohary, & Marzouk, 2017). The study further recommended that maintaining upright position such as walking, sitting, standing, kneeling and squatting should be encouraged during first stage of labour. However, the study was done on primparas only unlike with this study where it included primparas, multiparas and grand multiparas whom their pain experience differs.

The findings of this study revealed some factors which aggravate and alleviate pain during childbirth. A vaginal examination which is usually carried out when assessing the progress of labour is an important part of midwifery care. However, some participants in this study reported feeling of severe pain during vaginal examination and that it was frequently done. Similar findings were reported in studies done in Egypt, Palestine and Jordan where women complained that vaginal examination was done frequently on them and that they were feeling severe pain during the procedure (El-Moniem & Mohamady, 2016; Hassan, Sundby, Hussein, & Bjertness, 2012; Muliira, Seshan, & Ramasubramaniam, 2013). Pain during childbirth is part of the normal physiological process which is influenced by psychological, spiritual and cultural factors hence the experience of undergoing vaginal examination can cause further pain in labouring women (Muliira et al., 2013). Pain reported during vaginal examination is also associated with inadequate skills of the examiner (Hassan et al., 2012). However, some

interventions were identified that can make the experience of vaginal examination more comfortable which include: judging the necessity of vaginal examination, using sensitive woman centred care, managing pain distress associated with vaginal examination, giving sufficient information of the procedure to the women, increased communication and treating the women with courtesy and respect (Muliira et al., 2013).

The findings in this study revealed that women believed that pain during labour is a natural process that should not be interrupted. This was illustrated by women who expressed that they had no expectations of receiving relief from pain or being offered pain management during childbirth. This just shows that majority of women were not aware that pain management is one of their needs that is supposed to be addressed during childbirth (Iravani, Zarean, Janghorbani, & Bahrami, 2015). Similar findings were also reported by Mugambe, et al. (2007). Sengane, (2013) found that women who believe in pain relief measures for labour pains expect midwives to provide them with comforting measures unlike those women who do not believe in pain free labour.

Relief measures

Each woman's labour is unique such that some women need little or no pain relief and others find that pain relief gives them better control over their labour and delivery. In this study, participants did not receive pharmacological pain relief measures from the midwife despite their complaints of feeling much pain. Participants were only offered some of the non-pharmacological pain relief in the form of advice. Participants were advised to ambulate, sleep in lateral position, empty the bladder frequently and do deep breathing exercises. This is in tandem with women in Canada where more than half of the women utilize non-pharmacological pain

relief measures and in contrast with US women who utilize pharmacological pain relief such as epidural (Declercq & Chalmers, 2008).

Lack of pain relief measures in labouring women can have physical and psychological effects on maternal and neonatal health outcomes. It can lead to stress which is associated with prolonged labour and negative birth experiences which can lead to postpartum depression. The findings of this study are similar to the results of studies done by Jonazi (2013); Kungwimba, Malata, Chirwa, and Maluwa (2013); Nyirongo(2013) which indicated that participants did not receive any pharmacological intervention during labour and that majority did not benefit much from non-pharmacological pain relief. The results are suggesting that most women might be suffering throughout the process of labour without any pain relief measure which is unfair treatment to the labouring mothers and they might be suffering the consequences of labour pain silently. This experience can eventually negatively affect the participant's decision on their future reproductive goals because of lack of pain relief measures. In this case, the importance of having a hospital delivery cannot be valued.

It is documented that although severe pain is not life threatening in a health labouring woman, it can have psychological consequences which can have adverse health outcomes. The pain of labour can be associated with catecholamine release which could in turn be accompanied by increased cardiac output, peripheral vascular resistance and increased oxygen consumption (Ogboli-Nwasor et al., 2011). Literature suggests that postnatal depression may be more common when analgesia is not used and pain during labour has been correlated with development of post-traumatic stress disorder which can be prevented if pain relief measures are employed (Bajwa et al., 2010). Mostly, utilization of non-pharmacological pain relief measures during childbirth also depends on the midwife telling the women what to do when they are

experiencing a painful contraction. Most of the non-pharmacological pain relief measures are cost effective, they do not have side effects, they allow improved sense of patient control and they do not need full time presence of the midwife (Almushait & Ghani, 2014). The findings are in agreement with another study done in Ethiopia which showed that there was no utilization of pharmacological pain relief measures among obstetric care givers and only 40.1% utilize non-pharmacological pain relief measures. Similar results were reported in Indonesia and Nigeria whereby no method of pain management was offered by health professionals (Rachmawati, 2012; Lawani, et al., 2014). In contrast to the findings of this study, a study done in Brazil showed that most of the non-pharmacological methods such as warm shower, changes in position, birth ball and breathing technique were applied by the nurse /midwife (Gayeski et al., 2015). The reason for such findings in the Malawian setting could be lack of established guidelines on pain management during childbirth in public hospitals and hospital setup.

In this study, it was identified that midwives were instructing women to do some of the things they did not like. Women were told to ambulate despite them being not capable of doing that. It is recommended that despite the availability of severe relaxation techniques and pain relieving measures, the woman is the one who should choose the relaxation technique or pain relieving measure which is suitable for her. The woman is the active subject during childbirth hence she needs to exercise her autonomy and self-control during labour and delivery. Similar findings were also reported by Rocha, et al.(2015) in a study done in Brazil where mothers were told to do a lot of things which they did not like.

In Nairobi, Kenya, majority of women who were offered pain relief measures during childbirth reported that the measures were effective in relieving the pain and few women reported that the pain relief measures that were offered were not effective. This also applies to

the findings of this study whereby women reported some of the non-pharmacological pain relief measures like massage, bladder emptying and lying in lateral position to be effective and others not. Massage has been reported by many women as the most relaxing and enjoyable technique used during childbirth (Rocha, et al., 2015). Tournaire & Theau-Yonneau, (2007) reported epidural analgesia as the most effective way of reducing pain during labour. However, in the same study, Morphine and Pethidine have been reported to have a sedative effect and limited analgesic effect. The sedative effect makes it harmful to the unborn baby.

Contentment with pain management

Satisfied

Women usually come again to the health facility for delivery whenever they are satisfied with the care they received. However, for women to be satisfied with the care they receive, they need to know what to expect in terms of pain management when they come to the hospital. This will help them to compare the care they have received to what was expected and be able to take note of the difference. The findings of this study showed that participants did not know what to expect in relation to pain relief during childbirth. Participants in this study were satisfied with the care they received just because the midwife was coming around and offering them some words of encouragement. This finding supports what Bazzant and Koenig (2009) found in their study where health care providers' empathy had a great effect on women's satisfaction with care.

Literature indicates that for women to be able to rate the quality of health care received, they need to understand what quality means and how it can be evaluated (Raven, et al., 2012). The participants in this study lacked this understanding of what quality means in relation to pain management. However, the results are similar to what O'Donnell, et al., (2014) found on good

quality of care where from the mothers perspective it was linked to personal requirement such as enabling environment, clinical care provision and communication. But in this study, O'Donnell, et al. looked for general quality care provided during childbirth unlike in the current study where it was specific for pain management during childbirth. Contrary results were found in South Africa where women were able to describe the quality of pain management received during childbirth (Mugambe et al., 2007). Nevertheless, women in this study were well informed by their midwives on pain relief measures during labour hence they had the basis for comparison.

The participants in this study did not comment much on the technical skills of the health care providers in relation to pain management. It might be because the participants were not informed in advance on what to expect from the health care providers on pain management during childbirth. As such they were grateful for whatever care was given to them during childbirth. Delvaux et al., (2007) observed similar findings in their study where most women were satisfied with the care they received during childbirth despite low technical quality of midwifery care and unfavourable personal support given to them. This is contrary to results from developed countries where women are able to rate the quality of pain management received during childbirth because they are well informed antenatally and they know what to expect during childbirth (Rocha et al., 2015).

Not satisfied

Participants in this study highlighted areas that they were not happy with during provision of care. The participants identified inadequate midwives, inadequate care and midwives' attitude as negative experience of care.

Participants in this study wanted to have a midwife available when they were in labour and during delivery. This did not happen to majority of the participants because of inadequate midwives as compared to the number of clients which results in one midwife attending to more than one client. Women's perception of staff as being unhelpful and uncaring by not offering comfort or being absent contributed much to women's dissatisfaction with pain management in this study. Wild, Barclay, Kelly and Martins (2010) found that when women are left alone, they are reluctant to seek care in their subsequent pregnancies. Similar results were also reported in a study done in Sweden where women felt they were not properly assisted because of midwives workload as they had to simultaneously assist multiple women in labour (Rilby, et al., 2012).

Similar results were also reported in two studies where by women complained that midwives were spending little time with them during first stage of labour and that there was no support from midwives because they tend to have coexisting responsibilities towards more than one woman in labor, spend large amounts of time managing technology or keeping records, and begin or end shifts in the middle of women's labour (Almushait & Ghani, 2014; Hodnett, et al., 2011). Adams and Bianchi (2008) recommended that the most favourable staffing for a labour and delivery unit is one nurse to one client. However, this might not be possible in most of the maternity units; hence, choosing when to be at the bedside, demonstrating caring, effective attitude and being fully present when in the room are very important. Midwifery tasks can be clustered to provide longer periods of physical and emotional presence.

Participants in this study complained that they did not receive pain relief measures as expected from the midwives which made them not to be satisfied with the quality of pain management during childbirth. In addition, some participants also complained that they were told to do some of the things which were not effective in relieving labour pain as such they did not

like them. Literature suggests different non-pharmacological measures which women can utilize during labour without requiring full presence of a midwife considering that pain management is an essential element of care to be offered during childbirth. There is need for the midwife to explain properly to women on how these measures work to relieve pain during childbirth so that they can understand and be able to practice during childbirth. These findings differ with those in South Africa where women were able to rate the services received in relieving labour pain as fair and good (Mugambe, et al., 2007).

It has been revealed in this study that one participant was denied water after she asked for it. There is the traditional belief that when a labouring woman takes water, the contractions will stop. Kungwimba, et al. (2013) in her study also came up with similar results where participants complained that they were denied water while in labour by their companions. Romano and Lothian (2008) recommended that eating and drinking during labour provides essential nutrition and energy for the labouring woman. Labour is tough, as such a woman requires calories and adequate hydration for her health hence the need to encourage them to eat and drink during labour. In addition, labouring women preferred to eat and drink rather than fast. There is no evidence to suggest that labouring women should be restricted food or fluids, as such women should be offered a meal and fluids when in labour. Intake of food and fluids during labour is an important aspect of physical care. Women are encouraged to be taking sips of fluids and light foods as needed during labour in order to prevent dehydration and provide energy to the labouring woman (Dippenaar& da Serra, 2013).

Lack of fluids in a labouring woman can lead to dehydration because there is already loss of fluids through sweat as labour progresses which needs to be replaced through fluid intake. This implies that this participant was not well managed in terms of fluid intake because she was

deprived of this during labour and delivery. This might affect the woman psychologically hence increasing the perception of pain which later affects the neonate (Dippenaar & da Serra, 2013). The midwives should therefore ensure that all labouring women are provided with food and fluids during labour and should not interfere by restricting basic nourishment to women in labour

It has been revealed in this study that some participants failed to voice out their concerns in relation to labour pain because of midwives' attitude. Attitude of health care workers are an important aspect of care. This is because women value how they are treated when they come to the hospital for care. Usually, women do not like to be shouted at whenever they are feeling labour pains; they would love to be talked to in a polite manner and with respect. Women in labour also prefer midwives to be approachable. Chanza, Chirwa, Maluwa, Malata, & Masache, (2012) also reported similar findings in their studies done in Malawi. Evidence shows that midwives' attitude determines women's desire to seek maternity services at the hospital in their next deliveries. This is supported by the studies done in Malawi and rural Tanzania where health care workers who used abusive language, showed no tolerance and had hostile behaviours prevented women from using health facilities for delivery (Chanza, et al.; Mrisho, et al., 2007).

Displaying positive attitudes of midwives during provision of labour and delivery care can improve working relationship with labouring women and is essential for better maternal and neonatal outcomes. A good working relationship between the labouring woman and midwife enhances relaxation and the woman feels supported in a strange environment. The quality of the relationship which women have with their care providers is a key determinant of whether they have positive birth experience or not.

Limitations of the study

There are two main limitations of this study. Firstly the use of purposive sampling which enrolled participants on the criterion of ability to articulate their experience does not guarantee that all voices were sufficiently heard. Secondly, this study being a qualitative one, its findings cannot be generalized.

Recommendations

The recommendations have been made to the in-charge of Bwaila labour ward and the hospital management which controls the resources available at the hospital. It is hoped that these recommendations will be implemented.

Literature indicated different reasons that made health care workers not to provide analgesia to women during labour. Among the reasons is that health care workers thought that it is not necessary to provide the analgesia during labour since labour is a natural process (Lawani et al., 2014). Another study also indicated that knowledge of health care workers is associated with utilization of pain relief measures during labour (Bitew et al., 2016). It is against this background that recommendation has been made to senior managers of the facility to organize CPD sessions for health care providers in maternity to make sure they are reminded of pain and pain relief measures during childbirth.

Managers should support the maternity unit with adequate human resources for them to be able to offer psychological and emotional support to labouring women. Significant evidence shows that those women who receive continuous support during labour have short labour, fewer operative deliveries, fewer analgesic interventions and greater satisfaction (Hodnett, Gates, Hofmeyr, Sakala, & Weston, 2011).

Midwives should include extensive community mobilization and client education during antenatal care on pain relief measures during childbirth to provide the public with knowledge on the benefits of pain relief in labour and rule out any misconceptions. Evidence shows that utilization of pain relief measures on the women's side depends on several factors such as women's knowledge of labour pain relief measures, educational level, previous exposure, attitude and beliefs (Almushait & Ghani, 2014; Audu et al., 2007; Lally et al., 2014; Nabukenya et al., 2015). Furthermore, these studies showed that where women have low level of knowledge concerning pain relief in labour, the utilization is also low.

The companions need to be oriented in advance on the non-pharmacological pain relief measures that they can apply to assist in alleviating pain during labour. Studies have shown that companions are good at applying some of the non-pharmacological pain relief measures such as massage, focused attention as well as emotional support in the absence of a midwife (Gayeski et al., 2015).

Midwives working in a labour ward should communicate all assessment findings and interventions to women during childbirth. Adams and Bianchi (2008) identified the importance of communication during labour and delivery. The study reported that informing women about the progress of labour and plan of care helps to ease anxiety.

The nurse managers of the labour ward should facilitate the compilation of protocols on how to manage pain during labour for the midwives, the women and their support person and have them pasted on the walls in labour ward. Availability of protocols will help to facilitate the proper implementation of services which include pain management during labour and delivery.

Implications of the study

These study findings have implications on midwifery education, midwifery practice and research.

Midwifery education

Pain management during childbirth should be intensified during training of midwives at different training institutions. There is need to emphasize much on the areas highlighted in this study so that midwifery practice should be improved.

Midwifery practice

Midwifery practice will benefit from this research study in that the recommended strategies will improve midwifery practice at different hospitals. This research has highlighted areas of pain management that need to be strengthened. As a result of this improvement women will be motivated to come to the hospital for delivery with the improved quality of services.

Nursing research

The research can be replicated in other hospital settings to make transferability of the findings possible. Some hypotheses can be formulated from the findings and be tested to add to the knowledge base in midwifery practice.

Conclusion

This study has assisted to explore on how women experience pain management during childbirth at Bwaila maternity in Lilongwe. The study has managed to come up with the experiences of women with pain and pain management during childbirth particularly at Bwaila hospital. It is very essential to note that what women expected for pain management during childbirth is not what they got during their experience of childbirth.

The study identified that during childbirth, participants have expectations that their pain will be reduced by being given pharmacological pain relief. Participants also expected to be supported by the midwives when they were feeling much pain. However, participants expected minimal support from their support person. It was also revealed that participants in this study felt severe pain during labour; however, they did not receive any pharmacological pain relief measure as expected. This made the participants not to be satisfied with pain management during their childbirth. Hence all stakeholders involved in midwifery practice should work together in an effort to improve the quality of services in all maternity units.

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Appendices

Appendix 1a: Information Letter to Postpartum Women (English)

Study title: Women's experiences of pain management during childbirth at Bwaila hospital. **Investigators**: Isabel Kachapira (Kamuzu College of Nursing) and Prof. Ellen Chirwa (Kamuzu college of Nursing). **Contact details of study principal investigator**: Isabel Kachapira, Kamuzu College of Nursing, P.OBox415, Blantyre. Cell: 0999650971 or 0882273918. Email: kachapira2016isabel@kcn.unima.mw. **Study sponsor**: United States Agency International Development (USAID), World Learning Malawi Scholarship Programme, P.O. Box 30733, Lilongwe.

Dear Madam

My name is Isabel Kachapira, pursuing a Masters Degree in Midwifery at the University of Malawi, Kamuzu College of Nursing. As part of my studies, I am conducting a research project on "*Women experiences of pain management during childbirth at Bwaila Hospital*". The aim of the research is to explore the experience of postnatal mothers on pain management during labour and delivery. The purpose of this letter is to request you to participate in this research.

Your participation will involve answering questions concerning pain management in labour through an interview. The interview is expected to take 45-60 minutes of your time and it will be conducted at the time that is suitable and convenient to you and in a quiet place for privacy and to avoid disturbances. Furthermore, you may wish to know that your participation in the study will not have any reasonably foreseeable risks or discomfort to you, however, in case you experience any physical or emotional harm please forward your concerns to the researcher.

I also wish to inform you that you will not have any direct benefits from the study for your participation; however, the study findings will assist in the identification of best ways to

assist women with pain management during labour. Be informed that no reports in this study will identify you in any way and your information will be kept confidential and will only be accessed by the researcher and those people directly involved in the research. In addition, you will not be asked your name during the interview; instead, numbers will be used.

Your participation in this study is voluntary. You may choose to participate or not, or to withdraw from the study at any time. Your refusal to participate or withdrawal from the study will not have any penalty or negative effects on the services that you are receiving from the health workers at this facility. Should you agree to participate in this study, I will ask you to sign a consent form or put your thumb print on the space provided in order to indicate that you have voluntarily accepted to be interviewed.

The study and its procedures have been approved by College of Medicine Research and Ethics Committee (COMREC), and Bwaila Hospital authorities. Should you require any further information regarding the study or your rights as a study participant you are free to contact me on 0999650971/ 0882273918 or you may raise your concerns to COMREC Secretariat, P/Bag 360, Chichiri, Blantyre 3, Telephone number 01 989 766.

Thank you for taking your time to read this information letter.

Appendix 1b: Information Letter to Postpartum Women Translated in Chichewa

Kalata yolongosola zakafukufuku wa amayi omwe angobereka kumene

Mutu wa kafukufuku: Zokumananazo pa zadongosolo la kachepetsedwe ka ululu pobereka kwa amayi omwe angobereka kumene pa chipatala cha Bwaila.**Wopangitsa kafukufuku**: Isabel Kachapira (Kamuzu College of Nursing) and Prof. Ellen Chirwa (Kamuzu College of Nursing).**Mwini kafukufuku**: Isabel Kachapira, Kamuzu College of Nursing, P.OBox415, Blantyre. Cell: 0999650971 or 0882273918. Email: kachapira2016isabel@kcn.unima.mw.**Wopereka thandizo lopangira kafukufuku**: United States Agency International Development (USAID), World Learning Malawi Scholarship Programme, P.O. Box 30733, Lilongwe.

OkondekaMayi

Ine dzina langa ndi Isabel Kachapira, ophunzira wakusukulu ya ukachenjede ya Kamuzu Koleji ndipo ndikupitiliza maphunziro anga a uzamba. Ngati mbali yamaphunziro anga, ndikupanga kafukufuku amene mutu wake uli "Malingaliro komanso zokumananazo pa zadongosolo la kachepetsedwe kaululu pobereka kwa amayi omwe angobereka kumene pa chipatala cha Bwaila. Cholinga cha kafukufukuyi ndi kufuna kudziwa zomwe amayi amakumana nazo komanso malingaliro awo pa dongosolo la kachepetsedwe ka ululu pobereka. Ndalemba kalatayi kukupemphani ngati mungatengepo mbali mu kafukufukuyi.

Mukavomereza kutengapo mbali, muyenera kuyankha mafunso amene mutafunsidwe ndi opangitsa kafukufukuyi. Mafunso amenewa akutengerani mphindi zosachepela 45 komanso zosapitilira 60 ndipo afunsidwira pamalo achinsinsi kuti anthu ena asamvenawo komanso kuti musasokonezedwe. Dziwaninso kuti palibe vuto lirilonse limene mutalipeze chifukwa chotenga

mbali mukafukufukuyi ndipo mukadzakumana ndi vuto lirilonse musadzazengeleze kuwaziwitsa opangitsa kafukufukuyi.

Dziwaninso kuti palibe phindu lirilonse limene mutapeze potenganawo mbali mu kafukufukuyi koma mayankho anu adzathandiza kupeza njira zoyenera kuthandizira amayi pa dongosolo la kachepetsedwe ka ululu pobereka. Muli ndi ufulu odziwa zotsatira za kafukufukuyi ngati mungakondekutero. Mayankho anu onse akhala a chinsinsi komanso adzawerengedwa ndi okhawo okhuzidwa ndi kafukufuku ameneyi. Palibenso amene aziwe kuti mwayankha mafunsowo ndinuyo chifukwa nambala igwiritsidwa ntchito m'malo mwa dzina lanu.

Dziwani kuti simukukakamizidwa kutenga mbali mukafukufukuyi ndipo mutha kusankha kuvomera kapena ayi komanso ndinu ololedwa kutuluka mukafukufukuyi nthawi iliyonse mungafune. Simukhala ndi mulandu uliwonse mukatero komanso chisankho chanu sichisokoneza chithandizo chimene mukuyenera kulandira pachipatala pano munjira iliyonse .Ngati mwavomera kutenga mbali mukafukufukuyi, mukupemphedwa kuti musayine kapena kudinda ndi chala chanu pa fomu la chivomelezo limene mutapatsidwe ngati chidzindikiro choti mwavomera kutenga mbali mukafukufukuyi mosakakamizidwa.

Kafukufuku ameneyi wavomelezedwa ndi komiti imene imayang'anira za kafukufuku yotchedwa College of Medicine Research and Ethics Committee (COMREC) komanso ndi oyang'anira chipatala cha Bwaila. Ngati mungafune kudziwa zambiri zokhuzana ndi kafukufukuyi ndinu omasuka kufunsa mafunso pogwilitsa ntchito manambala awa: 0999650971 kapena 0882273918. Mutha kupelekanso mafunso ndi madandaulo anu ku komiti iyi: COMREC Secretariat, P/Bag 360, Chichiri, Blantyre 3, ndipo nambala yawo ya telefoni ndi iyi: 01 989 766.

Zikomo kwambiri powerenga kalatayi.

Appendix 2a: Consent Form for Postpartum Women (English)

Study title: Women's experiences of pain management during childbirth at Bwaila hospital. **Investigators**: Isabel Kachapira (Kamuzu College of Nursing) and Prof. Ellen Chirwa (Kamuzu college of Nursing). **Contact details of study principal investigator**: Isabel Kachapira, Kamuzu College of Nursing, P.OBox415, Blantyre. Cell: 0999650971 or 0882273918. Email: kachapira2016isabel@kcn.unima.mw. **Study sponsor**: United States Agency International Development (USAID), World Learning Malawi Scholarship Programme, P.O. Box 30733, Lilongwe.

I have read or have had another person read the information to me and have understood the content of the information. I have also understood the aim of the research, its procedures and the expected duration of my participation. I have been given an opportunity to ask questions about the study where necessary. I understand that the information I will give will be kept confidential and will only be accessed by the researcher and those people who are directly concerned with the study.

I understand that I will not have any direct benefits for participating in the study but that the findings of the study will assist in identifying best ways to assist women with pain management during labour. I know that I do not have to suffer any injury nor harm during the research process and that the information I will give to the researcher will not be used against me in future. I also know where to complain if my rights are violated during the study. I am aware that participation is voluntary and that I am free to withdraw from the study at any time without being penalized.

I voluntarily agree to participate in the study.

Participants signature……...Date……

Participant's thumbprint (if illiterate)……...Date ……

Signature of witness (if participant illiterate)……...Date…….

Researcher's signature…….Date…….

THANK YOU FOR TAKING PART IN THIS STUDY!

Appendix 2b: Consent Form for Postpartum Women Translated in Chichewa

Chivomelezo cha amayi womwe angobeleka kumene

Mutuwakafukufuku: Zokumananazo pa za dongosolo la kachepetsedwe kaulul upobereka kwa a amayi omwe angobereka kumene pa chipatala cha Bwaila.**Wopanga kafukufuku**: Isabel Kachapira (Kamuzu College of Nursing) and Prof. Ellen Chirwa (Kamuzu College of Nursing).**Mwini kafukufuku**: Isabel Kachapira, Kamuzu College of Nursing, P.OBox415, Blantyre. Cell: 0999650971 or 0882273918. Email: kachapira2016isabel@kcn.unima.mw.**Wopereka thandizo la kafukufuku**: United States Agency International Development (USAID), World Learning Malawi Scholarship Programme, P.O. Box 30733, Lilongwe.

Ndawerenga, kapena munthu wandiwerengera uthenga umene uli pa kalataiyi ndipo ndamvetsa zones zimene zalembedwa. Ndamvetsanso cholinga cha kafukufukuyi ndim'mene atapangidwire komanso nthawi imene nditatenge kuyankha mafunso ndikavomera kutenga mbalimukafukufuyi. Ndapatsidwa mpata ofunsa mafunso okhuzana ndi kafukufukuyi pamene sindinamvetse. Ndamvesetsa kuti mayankho anga akhala a chinsinsi ndipo adzawerengedwa ndi anthu okhawo amene ali okhuzidwa ndi kafukufuku ameneyi. Ndamvetsa kuti palibe phindu limene nditapezemukafukufukuyi koma kuti zotsatira zakafukufukuyi zidzathandiza kupeza njira zoyenera kuthandizira amayi pa dongosolo la kachepetsedwe ka ululu pobereka.

Ndikudziwa kuti palibe vuto lirilonse lodziwika limene nditakumane nalo mukafukufukuyi. Ndadziwitsidwanso kumene ndingathe kupeleka madandaulo anga ndikakumana ndi vuto lirilonse lokhudza kafukufukuyi. Ndikudziwa kuti sindine okakamizidwa kutenga mbali mukafukufukuyi komanso kuti nditha kusiya kutenga nawo mbali mukafukufukuyi nthawi ina iliyonse popanda mlandu uliwonse.

Mosakakamizidwa, ndikuvomera kutenga mbali mukafukufukuyi.

Sayini ya otenga mbali mukafukufuku……..

Tsiku……..

Chidindo cha chala cha otenga mbali mukafukufuku (ngati saakutha kulemba)…….

Tsiku……..

Sayini yamboni (ngati otenga mbali mukafukufuku saakutha kulemba)……..

Tsiku……..

Sayini ya opangitsa kafukufuku…….

Tsiku……

Zikomo potenga nao mbali mu kafukufuku ameneyi

Appendix 3a: Interview Guide (English)

SECTION A: Demographic data

Date of interview……..Participant's number……

Starting time…… Finishing time……

Section A: Demographic Data

1). How old are you?

…….

2) What is your religion?

a) Christianity [ ]

b) Islam [ ]

c) Others (specify)……

3) What is your marital status?

a) Married [ ]

b) Single [ ]

c) Divorced [ ]

d) Widow [ ]

d) Separated [ ]

4). How far have you gone with your education?

a) Tertiary level [ ]

b) Secondary level [ ]

c) Primary level [ ]

d) I have never been to school [ ]

5) What is your tribe?

……

6) What is your occupation?

a) House wife [ ]

b) Civil servant [ ]

c) Business lady [ ]

d) Others (specify)……..

7) What is your parity?

…….

Section B. Expectations of pain relief measures during childbirth

Could you tell me about your expectations of pain relief measures during childbirth?

Probes

What type of preparation or care were you expecting from the midwife?

What did you expect from the support person?

What type of pain relief measures did you expect to receive during childbirth?

Section C. Pain relief measures received during childbirth

Now I want to ask you about pain relief measures that you received from the midwife.

Which part of your body did you feel much pain during the labour process?

How did you communicate the pain that you felt to the people surrounding you?

What things do you think increase your pain sensation, and what kinds of things reduced the pain sensation?

Could you please tell me about pain relief measures and advice provided to you by midwife during childbirth?

Probe

Which pain relief measures were effective? Why?

Which pain relief measures were not effective? Why?

Which pain relief measures did you like most? Why?

Which pain relief measures did not you like? Why?

Section D- Views on the quality of pain management received during childbirth

Now I would like to ask you about your views as regards to quality of pain management during childbirth.

Could you tell me your views on the quality of pain management provided during childbirth?

Were you satisfied with the pain relief measures you received? Why?

Were there other pain relief measures you wanted which were not provided by midwife? Mention them?

What do you think made the nurse/midwife not to provide those pain relief measures to you?

What pain relief measures would you recommend to be given to women during childbirth?

Thank you very much for your participation

Appendix 3b: Interview Guide (Chichewa)

Mafunso a kafukufuku

Tsiku la kafukufuku…….Nambala ya otenga mbali mukafukufuku…….

Nthawi yoyambila……Nthawi yomalizila……..

Gawoloyamba: Mbiri ya amayi amene alimukafukufuku

1)Kodi muli ndi zaka zingati?

……

2) Kodi ndinu a chipembezo chanji?

a) Chikhirisitu [ ]

b) Chisilamu [ ]

c) Zina (tchulani)……

3) Kodi muli pa banja?

a) Inde ndili pabanja [ ]

b) Ayi sindinakwatiwe [ ]

c) Banja linatha [ ]

d) Mwamuna anamwalira [ ]

e) Tinasiyana [ ]

4) Kodi sukulu munafika nayo pati?

a) Koleji [ ]

b) Sekondale [ ]

c) Pulaimale [ ]

d) Sindinapiteko ku sukulu [ ]

5) Ndinu a mtunduwanji?

……..

6) Kodi muli pa ntchito?

a) Ayi sindigwira ntchito [ ]

b) Inde ndimagwira ntchito [ ]

c) Ndimapanga bizinesi [ ]

d) Zina (tchulani)…….…….

7) kodi mwaberekapo kangati?

……..

Gawolachiwiri. Njira zochepetsa ululu zomwe amayi amayembekezera kulandira panthawi yomwe ali muululu.

Kodi munali ndi chiyembekezo chotani chokhudzana ndi ndondomeko yochepetsa ululu panthawi yomwe mimba imawawa?

Mafunso otsatira

Kodi mumayembekezera thandizo lotani kapena chikonzekero chotani kuchokera kwa anamwino panthawi yomwe munali kumva ululu kwambiri?

Nanga mumayembekezera zotani kuchokera kwa okuyang'anirani pamene munali kumva ululu kwambiri?

Kodi ndinjira ziti zochepetsera ululu zomwe mumayembekezera kulandira panthawi yomwe munali kumva ululu?

Gawolachitatu: Njira zochepetsa ululu zomwe munalandila muli m'matenda ofuna kubereka

Tsopano ndikufuna ndikufunseni njira zochepetsera ululu zomwe munalandira muli m'matenda kuchokera kwa anamwino.

Kodi ndi gawo liti la thupi lanu lomwe ululu umanveka kwambiri panthawi yomwe munali mmatenda?

Kodi munafotokoza bwanji kwa omwe anali pafupi nanu zaululu omwe munalikumva?

Kodi ndi zinthu ziti zomwe munaona kuti zimaonjezela kamvekedwe ka ululu? Nanga ndiziti zomwe zimachepetsa kamvekedwe ka ululuwo?

Kodi ndinjira ziti/malangizo zochepetsera ululu zimene munalandira kuchokera kwa anamwino panthawi yomwe munali mmatenda?

Mafunsootsatira

Nanga ndinjira ziti zomwe munaona kuti zina kuthandizani kuchepetsa ululu? Chifukwa chiyani?

Kodi ndinjira ziti zomwe munaona kuti sizinakuthandizeni kuchepetsa ululu? Chifukwa chiyani?

Ndinjira ziti zomwe inu munazikonda? Nanga ndi chifukwa chiyani munakonda njira zimenezo?

Kodi ndi njira ziti zimene simunazikonde? Nanga ndichifukwa chiyani simunazikonde?

Gawo la chinayi: Malingaliro pa ndondomeko zochepetsera ululu panthawi yomwe amayi ali m'matenda obeleka.

Tsopano ndikufunsani zamomwe mwaonera pankhani yakachepetsedwe ka ululu munthawi yomwe amayi ali m'matenda obereka

Fotokozani za malingaliro anu pa zaululu omwe mwamva ndi ndondomeko zochepetsera ululu zomwe mwalandira panthawi yomwe munali m'matenda?

Kodi ndinu okhutitsidwa ndithandizo lomwe mwalandira zokhuzana ndi kuchepetsa ululuwa matenda?

Tchulani njira zina zomwe mudakakonda anakakuchitirani anamwino zochepetsa ululu wa matenda zomwe sizidachitike?

Mukuganiza kuti ndi zifukwa zotani zimene anamwino sanaperekere chithandizo chimenechi?

Kodi ndinjira ziti zomwe mukuganiza kuti zingathandize amayi pochepetsa ululu munthawi yomwe ali m'matenda?

Zikomo kwambiri potenga nao mbali pakafukufuku ameneyu

Appendix 4: Approval Letters

In reply please quote NO DZH/MALAWI,
Lilongwe District Health Office
P.O. Box 1274
Lilongwe
Malawi

Ref. No.:
Telephone No.: 265 726 466/464
Telefax No.: 265 727817
Telex No.:
E-Mail. lilongwedho@malawi.

COMMUNICATIONS TO BE ADDRESSED TO:

6th April, 2017

The In-charge, Bwaila Hospital
The In-charge, Area 25 Health Centre

Sir/Madam

PERMISSION TO CONDUCT A PILOT AND RESEARCH STUDY IN LILONGWE

Approval has been granted to the bearer of this letter:- Isobel Phiri Kachapira (Mrs), to conduct a pilot and research study at Area 25 Health Centre and Bwaila Hospital respectively.

" Postpartum women experiences and perceptions of pain management during childbirth at Bwaila Maternity Unit. "

Any assistance rendered would be appreciated.

LILONGWE DISTRICT HEALTH OFFICE

Dr. Et Rambiki Kajawo SR
DISTRICT MEDICAL OFFICER

CERTIFICATE OF ETHICS APPROVAL

This is to certify that the College of Medicine Research and Ethics Committee (COMREC) has reviewed and approved a study entitled:

P.05/17/2187 – Postpartum women experiences and perceptions of pain management during childbirth at Bwaila hospital, Lilongwe district by Isabel Phiri Kachapira

On 19th June 2017

As you proceed with the implementation of your study, we would like you to adhere to international ethical guidelines, national guidelines and all requirements by COMREC as indicated on the next page

L Alfazema

Dr. L. Alfazema-Chiuzeni- Vice-Chairperson (COMREC)

Approved by College of Medicine
19 JUN 2017
(COMREC)
Research and Ethics Committee

19/6/17
Date