

OSLOMET

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Silent Labour

**Expressions and management of labour pain in Fort Portal,
Uganda**

**Master's Degree in International Social Welfare and Health Policy
OsloMet – Oslo Metropolitan University
Faculty of Social Sciences**

This thesis explores expressions and management strategies for labour related pain in the region of Fort Portal, in Uganda. The study was developed within a qualitative framework and the data was collected with the use of semi-structured interviews. The participants in the interviews were all women working in the public health sector in the region. Foreign volunteer midwives and local health providers that worked in at least two of the public health centres in the area were interviewed. The analysis divided the data in common themes in three main areas: motherhood, pain expressions and pain relief. This thesis has the goal to contribute for a better understanding around those topics. By doing so, it adds to the discussion around the best ways of accessing quality of care.

OsloMet – Oslo Metropolitan University , Faculty of Social Sciences
Oslo 2018

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Acknowledgements

I have very clear in my memory that day, in the middle of all the turbulence, when I thought about giving up.

I want to say thank you to the people that help me keep going.

I would first like to thank my mother, Mônica, and my father, Fernando, who were able to motivate me and support me even from the distance.

I want to say thank you to my partner, Nebojša, for being by my side in all the difficult moments.

A very big thank you to professor Randi Wærdahl who adopted me under her supervision and taught me so much in so little time. This thesis would not be possible without our long meetings, when she shed light on things and made me see the path.

I also want to thank all staff from OsloMet that were always accessible helping my research happen. Thank you to the people from the charity Knowledge for Change, specially Louise Ackers, James Ackers-Johnson and Allan Ndawala, for receiving me in Uganda and providing the structure I needed while staying there and doing the interviews.

Finally, I am thankful to all the women that agreed on talking to me and made this thesis happen.

I dedicate this work to my sister Gabriela Jansen Vieira.

Fieldnote 26.09.2017

I was allowed to be in the room and observe while a delivery was happening. Two British volunteers (one midwife and one student of medicine) and two local nurses are attending the woman who is delivering a baby.

The woman delivering has a "poker face" as if she is making an effort to hide the pain.

The grandmother of the woman delivering was with her hand closing the woman's mouth while telling her to push.

There was a discussion between a British volunteer midwife and a local nurse about cutting (episiotomy - I also had the impression that it is something used routinely). The locals want to do it without informing the woman, they say it is better if they don't say anything because if they do she will be anxious. Then the British volunteer says she would want to know if people were about to cut her and asked the local nurses if they wouldn't want to know, to what they answered "no". In the end they do tell the woman, but while they are cutting already (not as if she has any choice). It is not like the woman has a chance to understand what is happening and what they are doing to her or even less have an opinion about it. They cut her with no anaesthetics (not even mention of pain relief).

Excerpt from interview with Ugandan Midwife Four

Me: But then when you go to the C-section you get the epidural ?

UMF: Yeah.

Me: So you don't feel a lot of pain?

UMF: When it is after one day, or if it is in the morning, in the evening you are already feeling the pain.

Me: But the pain from the surgery, not labour pains...

UMF: You don't feel anything, because of the anaesthetics.

Me: That's the only case you give anaesthetics to women here, is if she has a complication, right? If she has to go to a C-section.

UMF: Yeah.

Me: You don't give any type of pain relief just for the labour pains?

UMF: No.

Preface

The idea for this Master Thesis started as a very different one and it developed during the in-field research to become what it is presented here. In the Research Market organized by the Oslo Metropolitan University it came to my knowledge that there was a partnership with the University of Salford, in the UK, that has research programs in Uganda happening for several areas. Those programs happen through the charity Knowledge for Change (K4C), that has an office in Fort Portal. One area that called my attention was the one on respectful care in maternal health. Researches in that area happen in connection with the WeCare project developed by K4C. I saw a possibility of working with a theme that was always one of my interest; that of obstetric violence. This thesis started, then, to explore the applicability of the term obstetric violence in the Ugandan Context. I stayed in Uganda for two months to do my research. The limitations for obtaining my data and the inputs coming from observation lead me to narrow my topic. While on the field, doing observations in the maternity wards, there was something that called my attention for being different than what I am used to from the reality of my country (Brazil), but also most countries in the west. Pregnant women in the ward, including women in active labour, seemed much quieter than I would expect for such situation. They would seldom make loud noises, or even noises at all, and having the attendant that is there with the woman covering her mouth at the time of delivery seemed like something normal. I decided then to explore women's expressions and management of labour pains and how those can be linked with quality of care and maternal health outcomes.

Oslo

2018

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Summary

Maternal health is being considered as a highly important international issue at least since the year 2000. That was when the UN's General Assembly implemented the United Nations Millennium Development Goals, with the aim of reducing maternal mortality. The highest rates of maternal mortality and morbidity are in the areas where most of the women don't have access to health facilities for antenatal care, postnatal care and delivery (World Health Organization 2016). It is understood that those services are essential for increasing maternal health (Adam et al. 2005, Bale, Stoll, and Lucas 2003, Paxton et al. 2005, Campbell, Graham, and Lancet Maternal Survival Series steering group 2006, Piane 2008). The phenomenon of women not attending to a health facility and getting skilled health care for delivery can be explained in many ways: transportation issues, not enough offer, or pressure from a next of kin (Bohren et al. 2014). Another of the factors identified by researchers for non-attendance of mothers at health facilities is the decision making of the mother herself. That can be related to a perception of quality of care, disrespect or abuse (Bowser and Hill 2010). Labour pains are an important part of becoming a mother, conflicting perceptions of those between mother and health worker, or poor management, could affect the whole experience of delivery and the future decision of looking for skilled maternal services. To give women the type of care they will accept is important to understand their demands. Based on this perspective, the present study has the intention to explore the experiences and management of labour pain, in the context of Fort Portal, Uganda. The research was developed in connection with the WeCare program from the British charity Knowledge for Change. The data collection was made with semi-structured open-ended interviews with Ugandan mothers and health workers and with foreign volunteers in maternities of the municipality. A thematic analysis was then made identifying important aspects around the topic. In the end, this study intends to contribute for a better understanding of the matters of motherhood, pain in labour and the use of pain relief in the eyes of the women from Fort Portal, Uganda.

Keywords: maternal health, labour pain, pain relief, Uganda.

Introduction

According to the World Health Organization (WHO 2018), around 830 women die every day from causes related to pregnancy and childbirth. Those deaths could be avoided if these women had access to skilled maternal care. Going through something natural as it is pregnancy and childbirth should not be such a big life threat. Researching topics related to maternal health is important to create understanding on why becoming a mother can be so dangerous for women and how to change that. I developed my research with the help of the WeCare project from the British charity Knowledge for Change, active in the public health sector in Fort Portal, Uganda. I travelled to Uganda and was the start of an eye-opening journey that I will share now in this thesis.

I went to Uganda with the idea that I was going to explore the applicability of the concept of obstetric violence for the country. I planned on talking to pregnant women and mothers about the services they receive in the health centres and try to understand how satisfied they are with those services. I imagined defining all types of disrespect and abusive practices starting from them, drawing from their perspective and their idea of how maternal health services should be. My first days of observation around maternity wards and my first fieldnotes reflected that topic I had decided on for my master thesis. Later, I understood I wasn't up to the task of addressing such a broad topic. Language limitations excluded my access to most of the users of the health services where I was working in the area. That, added to a limited amount of time for data gathering in Uganda, made me rethink my project.

One thing that popped to my eyes since the beginning when arriving to the country was Ugandans relationship with pain and that became even more clear, and strange to me, after I watched women delivering their babies. My own observation and conversations I had with other foreign people made my curiosity grown bigger around women's expressions of pain while in labour. The situation I found myself in and this phenomenon calling my attention led me to narrow my topic.

The idea I have of women in labour is based on what I learned from TV shows, movies, novels and experiences of other people around me. To me, a woman in labour is a woman who is going through a very painful moment and expresses that pain by shouting or crying. I always thought of the delivery of a child as being loud. It is a loud moment, and, in my understanding, a woman is given the freedom to be loud because it is known that she is going through a painful

experience. I received that same impression from the views of the foreign volunteer midwives I interviewed in Uganda. They come from a culture where labour is loud, and women are allowed, and even expected to express that pain by crying or screaming.

While doing observation at maternity wards in Fort Portal and even being present in the room in the moment of the delivery I was puzzled with a different reality than what I would expect. Most of the women labour silently around the hospital and in the moment of delivery, many times, the people accompanying the woman at the hospital hold the mouth of the mother-to-be while encouraging her to push the baby out. Those observations found an echo in what I learned the foreign volunteer midwives noticed as well. Something that, after having done the interviews, I found out to be the normal, and sometimes expected, called my attention and the attention of the volunteers as something odd.

In this introduction I will present the background for this thesis. I will talk about maternal health and the numbers that define the status of it worldwide. I will provide then specific information about Uganda and the maternal health there. This study will then be placed when I talk about its relevance. I follow explaining the aim and main questions of this research and finish with the limitations.

Background: Let's talk numbers

The World Health Organization produces reports that show a picture of the global burden of disease. For understanding the several health threats that cause mortality and morbidity worldwide the WHO report uses the DALY measure. DALY stands for Disability-Adjusted Life Year, "the DALY is based on years of life lost from premature death and years of life lived in less than full health" (World Health Organization 2008, 2). These reports are very interesting for, among other things, showing what are the main causes of healthy years lost around the globe.

When studying the global burden of disease and the DALY measure I understood that maternity related health issues play an important role for increasing that burden (World Health Organization 2008). It is not a surprise that maternal and infant health are found in the United Nations goals for development. What one can also learn when studying the DALY report is that the burden related to maternal and infant health is heavier for low-income countries. That will be further confirmed by more specific studies that show the big differences between groups of countries concerning maternal and infant mortality and morbidity (Adam et al. 2005).

More research on the matter of maternal health is still important, especially in the context of a low-income country, where the problem is bigger. I will take some space now to talk about numbers and give a global picture of maternal health. I will then bring the focus to Uganda, where this research took place.

Maternal Health

Maternal health figures as an important issue addressed by the United Nations Millennium Development Goals adopted in 2000 by the international community, represented in the UN's General Assembly (United Nations 2000). The Development Goal 5 aims on "Improving Maternal Health" and is divided in two targets: 5A "Reduce by three quarters, between 1990 and 2015, the maternal mortality ratio", and 5B "Achieve, by 2015, universal access to reproductive health" (United Nations 2015). The operationalization chosen for measuring the achievement of these goals was the UNICEF-WHO indicators on "maternal mortality ratio" and "Proportion of births attended by skilled health personnel" (Millennium Project 2006). Goals 5A and 5B were complementary, since many studies showed a connection between a woman's access to reproductive health and her health outcomes (Adam et al. 2005).

Between 1990 and 2015, the maternal mortality ratio decreased by 44 percent. Although the maternal health picture looks better, the goal of 75 percent reduction for maternal mortality was not achieved. Furthermore, there is a big disparity between developed and developing countries in how much each one advanced towards the MDG 5 (Unicef 2015). This inequality is well expressed by Adam, who presents the numbers from 2005 in a condensed manner:

"Each year more than 500 000 women die during pregnancy or childbirth and more than 4 million babies die in the first 28 days of life, accounting for 38% of mortality in children aged less than 5 worldwide. The contrast between countries is stark. Of every 1000 children born in Africa and South East Asia, 44 and 38 die in the neonatal period, respectively, compared with four in high income countries. A similar gulf exists for maternal mortality, with rates in sub-Saharan Africa more than 2.5 times those in Asia, which are in turn more than 20 times those in developed countries." (Adam et al. 2005, 1)

Nowadays, 99 percent of the maternal deaths occur in developing countries, the mortality is higher in rural and poorer areas, where women have less access to skilled health care or health centres with proper structure to deal with complications in pregnancy (World Health Organization 2016).

After the Millennium Development Goals, in 2015, the international community has adopted the Sustainable Development Goals. In the new agenda, the goal is to “by 2030, reduce the global maternal mortality ratio to less than 70 per 100,000 live births” (United Nations 2017). In order to achieve such a goal, it is important to understand why there is so much inequality in maternal health around the globe. The maternal mortality ratio is still getting to 14 times higher in developing regions than what it is in the developed ones, and “only half of women in developing regions receive the recommended amount of health care they need” (United Nations 2017).

There is one feature that deepens the issue of achieving the Sustainable Development Goal for maternal health. Most efforts made to improve maternal health relied on broadening the accessibility to skilled birth attendants. That has been improving and the coverage is extending with time (World Health Organization 2018). Although the number of women delivering in health facilities with access to health providers has gone up, studies have been showing a disconnection between that phenomenon and the decreasing in maternal mortality (Campbell et al. 2016, d'Oliveira, Diniz, and Schraiber 2002). That shows a need to a change of focus; from quantity to quality, from the clinical perspective to the user perspective (Hanefeld, Powell-Jackson, and Balabanova 2017).

Uganda

“Every day, 15 women die in Uganda from pregnancy and childbirth-related causes, 94 babies are stillborn and 81 newborn babies die. This equates to 69,5701 deaths each year due to complications during pregnancy, childbirth and in the first month.” (Kigozy 2017, 3)

Uganda is part of a group of countries that is trying to bring more women to deliver in a health facility. Having most of the population located in rural areas, one of the problems the country has been facing is the low rates of women searching for maternal care in a health centre. Uganda was placed, by the World Health Organization (WHO), as one of the countries where the risks of maternal mortality is higher, with a maternal mortality ratio of 343 per 100000 live births (World Health Organization 2015). Many of the leading causes of maternal deaths can be avoided when the woman gets access to a health care facility in time; assuming the woman will be provided with the right level of obstetric care. Most of the health facilities in Uganda that can offer a better quality obstetric care are concentrated in the urban areas, making it harder for women in the rural areas to receive proper care (Sawaya, Rother, and Thede 2014). Efforts are in place to try to increase the access of women to health facilities for childbirth, antenatal

and post-natal care. There are many barriers, some of them are related to experiences of disrespectful care or abuse when using a facility (Bohren et al. 2014). The progress in the country to achieve the MDG and SDG goals concerning maternal health is slow to achieving universal access to reproductive health and stagnant to reducing the maternal mortality ratio (Development 2013).

Uganda has its fertility rate as high as 5.6 births per woman (World Bank 2016) and a high population growth rate of 3.3% per year (World Bank 2017). This leads to an expected population doubling time of 24 years and an expected population of more than 80 million people for 2050. Although the population is on the growth and the mortality rates have decreased (specially due to a successful strategy against the huge HIV epidemic the country was facing (Slutkin et al. 2006)), mortality remains relatively high (BakamaNume 2010, 115).

The population in Uganda is very diverse in terms of wealth, culture and ethnicity, with around 56 recognized ethnic groups: “the Bantu account for 67% of the population, the East Nilotic account for 12%, the Western Nilotic account for 15% and the Central Sudanic account for less than 5%. Other ethnic alien minorities including Banyarwanda, Sudanese, Congolese, Kenyans, Arabs, Europeans and Asians account for 1%” (United Nations Development Programme 2005, 3). This feature can affect the relationships and communication between people; them being from a different cultural background. With that in mind it is possible to imagine that such a diversity may affect the relations between pregnant woman and maternal health provider; if they are from different ethnic groups. Studying the perceptions around labour is important in such an environment; where there is the need of improvement in the access to safe pregnancies and deliveries, and where socio-cultural aspects might affect how a woman experiences and accepts professional health care when they are going through the process of becoming mothers (Atekyereza and Mubiru 2014).

A demographic and health survey made by the government of Uganda in 2016 showed that more than 78 percent of women, on average, had their deliveries attended by skilled care providers (UBOS and ICF 2017, 22). That is a relatively high percentage compared with neighbour countries in Sub Saharan Africa. That also shows an improvement in the access of health facilities for delivery, which could mean the efforts put in making women search for skilled health care when pregnant had some success. However, the data currently available shows a maternal mortality ratio that is still very far from the Sustainable Development Goal 3

of 70 deaths per 100 000 live births. That brings the attention to the issue of the quality of care these women receive when they do decide to search for skilled maternal care.

Many things could be playing a role here jeopardizing the delivery of care that is of high quality and can prevent maternal deaths. Structural problems are an example, such as facilities understaffed, lack of quality in the training for health staff, among others. Cultural aspects and lack of a good communication between mother and health care provider can also be a reason (d'Oliveira, Diniz, and Schraiber 2002, Pickles 2015, CLADEM and CRLP 1998), and that is the aspect this thesis is looking into. This study will then try to understand Ugandan women experiences of labour pain, their beliefs around it and the way they manage those pains. Together with the type of care they get considering the pain they are going through and the way the health care providers manage labour pains. By doing so, I hope to contribute to the great picture of the mechanisms of health care delivery.

Relevance of the study

Many studies show the importance of obtaining skilled birth attendance and having access to higher-level health facilities and obstetric care in case of complications to prevent maternal mortality (Adam et al. 2005, Bale, Stoll, and Lucas 2003, Campbell, Graham, and Lancet Maternal Survival Series steering group 2006, Paxton et al. 2005, Piane 2008). Many reasons are highlighted to explain the low attendance of labouring women in some areas in developing countries. Those vary from lack of transportation, costs, influence of others, traditional believes, among others.

Furthermore, there is solid evidence showing the relation between the search for a facility for delivery and women's perceptions on quality of care or disrespect and abuse (Bohren et al. 2014). The Ugandan health development plan (UMH 2015) underlines that most of the barriers to the utilization of social services in the country are originated on the demand side, they enumerate the following reasons: "decision making inability for women, household financial status with women having to rely on their spouses, lack of transport, among others" (UMH 2015, 18).

In this context, the way labour pains are dealt with when a woman decides to reach for skilled maternal services can affect the experience of giving birth and the future choice of delivering in a facility. As Bowser and Hill put it:

"Growing evidence for the negative impact of disrespect and abuse in facility-based childbirth on skilled birth care utilization across a range of countries is reviewed

including recent qualitative and quantitative studies that suggest disrespect and abuse may sometimes act as more powerful deterrents to skilled birth care utilization than other more commonly recognized deterrents such as geographic and financial obstacles.” (Bowser and Hill 2010, 3)

The Millennium Development Goals era had the efforts focused on making women search for skilled health care for antenatal and delivery with the goal of minimizing maternal mortality and morbidity. There was progress, and the number of women going to antenatal visits or delivering with the aid of a skilled birth attendant went up worldwide. In despite of that, the fall in mortality and morbidity indicators didn't follow the rise in skilled birth attendance in every country. That could be an indicator that it is important to access the quality of the care in addition to the quantity of care (Campbell et al. 2016, 2193). It can then be inferred that the quality of care offered by health care providers will affect the coverage of skilled maternal care; influencing women's choices of searching for those services when pregnant and at the time of delivery. Besides that, care of bad quality will affect negatively the maternity health even when women are covered.

“The problem does not lie only in access to hospital delivery or resources since avoidable deaths and serious complaints about quality of treatment occur in cities—where most births take place in hospital and in relatively well resourced facilities.” (d'Oliveira, Diniz, and Schraiber 2002, 1681)

Again, we are reminded of this reality, which is also the one of Uganda. Government surveys show the percentage of women having access to skilled maternal health providers on the rise, but the maternal health doesn't show the same pace of improvement.

Cultural dimensions of pain

It is recognized the existence of at least seven dimensions for pain which health care workers should be aware of when accessing and dealing with patients' needs (Silkman 2008). The sociocultural dimension is one of those and stands for the way a person's cultural and social background is going to influence in the experience and expression of pain. The sociocultural dimension may affect the understanding of how much pain a person is going through because of different ways of showing pain. Since there is not an accepted accurate method to measure pain, the communication between health care provider and patient is very important for the identification and treatment of that pain. Although it is understood almost every person feels the pain the same way, the way they express it and respond to it varies according to their sociocultural background (Carteret 2010).

It is important, then, to understand the different ways people have for expressing pain and establishing a good communication so that the health care provider can understand the level of pain of a certain patient. Besides, it is important to understand how the patient's sociocultural background is going to affect the patient's perceptions on pain medication because that will help define what is the best option for managing that pain (Carteret 2010).

In this thesis, by looking at women's expressions and management of labour pain in a given area, I am also exploring the effect their sociocultural background has in their experiences of pain. I am looking into the way they express the pain, but I am also exploring the reasoning behind their behaviour and the way it affects not only the expression of the pain but its management. This type of information is essential when building people centred care and care that is of quality, respecting the person's culture without hindering the clinical quality.

Pain and quality of care

Pain will be a part of a woman's journey when becoming a mother, and it can manifest itself in many ways. While some types of pains are going to be considered normal, other types will be avoided or fought against. In the case of labour pains, even if it could be said to be consensus that those are normal pains, depending on the context, the way they are experienced, expressed or managed is going to be different. Some women couldn't imagine delivering their babies without the aid of pain relief, some don't even know about the existence of pain relief for labour pains, and yet some won't see the experience of delivery without the pains of labour as acceptable.

Unfortunately, labour pains are not the only types of pains present in the experience of delivering a child for many women. Studies show that physical abuse happens too often to labouring mothers. "This includes being slapped and pinched; being stabbed with scissors; rough handling; being hit with instruments such as a ruler; being 'hit between the buttocks'; being denied pain medication when medically indicated, such as when performing episiotomies or after Caesarean section deliveries;" (Pickles 2015, 9). The access women have to pain medication is of interest for this study. Deliberate refusal of pain relief has been defined as one type of obstetric violence (d'Oliveira, Diniz, and Schraiber 2002). It can be explained in some situations as a way the health personnel uses to punish women if it is understood they did something that is socially not accepted.

The understandings about labour pains, what they are for, how to deal with them and how the woman going through them is treated, can be linked to maternal health in two ways. First

influencing the choice of the woman to search for a health facility for delivery. In this case, a different understanding between mother and health personnel of what are and how should labour pains be dealt with, might affect the decision of a woman to go for specialized care for delivery; if the woman perceives her needs are not being met. A second case is how the perceptions around labour pains could affect the quality of care by itself, in the occasions a woman goes to a health facility for delivery. In this situation, different understandings around the topic could jeopardize the communication between woman and health worker, leading to a failure of giving proper care; or, in a subtler case, it could make the woman perceive the experience of delivery as a bad one, leading to trauma.

This study intends to put some light in a specific feature of the problem of maternal health, namely the management of labour pains. Better understanding of the experiences and perceptions around labour pains for Ugandan women can help in the effort of shaping maternal services that are more respectful considering the reality of the country and the point of view of these women. Besides, it is useful to understand how labour pains are managed, not only by the women themselves when coping with the pain or in a more private scenario, but also by the health care provider when a woman searches for a health centre to deliver the baby. That can add to the existing knowledge and help in the search to understand if there is any gap between women's expectations around labour pain and what they experience when reaching for a health facility. In this way, finding out more possible reasons why women, even when having the access to one, choose not to use a health facility for delivering their babies. Also understanding what could be improved in relation to pain relief in the maternity services.

By developing this research, the intention is to contribute to the debate to understand what the more efficient measures can be to achieve the Sustainable Development Goal on maternal health. More specifically, this study explores women's expressions and management of labour pains in the region of Fort Portal; those pain being natural or due to any needed minor medical procedure. Furthermore, I use the information learned to originate a discussion on the best way of achieving quality of care.

Research aim and questions

Giving birth is a cultural phenomenon, it is surrounded by cultural beliefs and practices, and those can affect the health of the woman and the baby (Atekyereza and Mubiru 2014, Kyomuhendo 2003). To be able to help women to have better experiences when giving birth is important to understand the perspective of these women and their expectations. Even if

someone's belief is that health professionals will know better what a woman who is giving birth needs, her expectations must be considered so the communication between health professional and mother can occur and the health care can reach the mother with efficacy.

Pain in labour is a matter discussed in the realm of obstetric violence and respectful care. Pain in labour can be caused by the labouring process itself, with the contractions and the dilation, or it can be caused by some type of intervention that might be needed; as it is the case of the episiotomy. Nowadays there are analgesics that can be used to help the woman to cope or to get rid of both types of pains during labour. And it is the understanding of those who try to fight obstetric violence, of those who defend the importance of respectful care, that the woman should be able to decide for herself how the pain should be dealt with. That belief is part of the construction of the concept of quality of care.

As explained in the previous section, the problem of maternal health has been accessed and is being dealt with from a positivist perspective. The efforts being made are towards the number of facilities out there and the number of women having access to those facilities getting higher. The world has been seeing improvement in those numbers, but the real goal is to improve women's health, and that is not necessarily following the increased numbers. To fill this gap is important to look for understanding and we need to investigate things that will be harder to measure with the use of numbers. A qualitative research is helpful to add another dimension to the matter and help explain why the numbers don't add up. Why is women's health not improving as much as expected when there are more health facilities, more health personal and more women delivering with skilled birth attendants?

I went to the field to try to understand what is happening. I came to Uganda and what I found there was silence. The silence of the maternity wards and the silence of labours called my attention and I wanted to understand what it meant, and how its connected to maternal health.

This study tries to understand how labour pains are expressed and managed in the municipality of Fort Portal, Uganda. Besides that, I try to get explanations on why expressions and management of labour pains are a certain way. In the search for those understandings I went through interpretations of the importance of motherhood for women and how those can influence the delivery, including delivery services and all related to labour pains.

Quality of care is being accessed in many ways, but looking at it from the user perspective is something relatively new (Hanefeld, Powell-Jackson, and Balabanova 2017). This study is looking to the matter from an insider-outsider perspective and bringing in the explanations of

Ugandan women, who are in the centre of this. By doing that the aim is to add to the existing knowledge with different inputs, with information that's been produced with the use of layers of interpretation. Choosing a qualitative approach allowed me to use the "clash" between the outsider and the insider points of view to produce questionings and possible clarifications.

My research question is "How are labour pains expressed and managed in Fort Portal, Uganda?" and it is based on it that I developed my interview questions and built my data. Under this broad inquiry there are more specific questions that lead the construction of data for this study, those are:

How do Ugandan women express labour pains and what is the reason behind it?

How are labour pains managed in Uganda and why are they managed that way?

How understandings of the importance of motherhood for women affect the way pains are expressed and managed?

For the analysis of the data generated there was one question leading the discussion, which was:

How the perceptions and management of labour pains in Uganda affect the quality of care?

This question has the goal to make the link between the users' perspective and the health care services they have access to.

By answering those questions, I have the goal to unveil the reality of women in the area studied and demonstrate the complexity behind this one aspect of pregnancy and labour. When doing so I hope to find some of the things that might influence people's behaviours and how can health services be shaped in a way that women in the area will accept. I believe that would help achieving improvements in women's health.

Limitations

Every study has limitations that can be of several types. Giving information about those limitations works for me as part of my effort to be clear. My goal when writing is to disclose information about any aspects that might have influenced this study at some level. I believe the strongest limitation I found when doing my research was related to language. I found myself many times thinking about communication between the different people I encountered in Uganda while I was there for my data collection. I bring a part of my fieldnotes where I expressed my concerns:

“ON CONSENT: The British volunteer nurses or midwives try to inform the mothers to be of what they want to do and ask if they are ok with it; but I am not sure the communication works, because they speak English and many people here [in Fort Portal] don’t understand [English] but agree with things anyways.” (Fieldnote 26.09.2017)

“Something that always brings me some concern when being in Uganda, in the health facilities observing how things go between local health workers, patients and volunteers is the communication. It’s about dealing with people’s lives and health and most of the patients don’t speak English [which is the language used by the volunteers].” (Fieldnote 20.10.2017)

Uganda was a British colony in the past. Therefore, English is considered an official language in the country. However, a big part of the population from the setting where this study was conducted doesn’t speak it. I expressed concern with the communication between foreign volunteers and patients on my fieldnotes, but that were communication challenges I faced myself for collecting my data. One can think that could be easily solved because all the work done by me for my research and by the volunteers in the health facilities happens side by side with local staff. But in the busy environment of a maternity ward, most times there is no space for translations

This issue limited the amount of people that could be accessed without the use of a translator. Besides, that was also a selecting factor that brought more educated and more well-off people as sources of data, given the fact that those are the people who can express themselves better in English. One interview was made with a Ugandan technician at a health facility and the aid of a midwife was needed for communication purposes. Since the language used for this study is not the mother tongue of part of the people interviewed, nor of the interviewer, that can be considered a limitation because it might affect the understanding from both sides.

Another limitation I would like to mention was a limitation of resources. Because this whole research was auto financed, the resources were a limitation factor for this study. I had a timeframe of two months to work in Ugandan, with no possibility of extension of this period or another trip back to the country. Personal matters forced me to interrupt the research I was conducting in Uganda for around one week exactly in the middle of the period I had in the country, and that also affected the process. There were no resources available for hiring translators and that enhances the effect of language limitations mentioned above. The topic would benefit from further research on the matter in the same area. I hope to bring a new perspective that should be further explored by future studies.

Finally, there are limitations attached to the nature of the study. There are many issues that could arise from the use of face to face interviews for the generation of data. The fact that I can be connected by the respondents with the organization that worked for this research as gatekeeper could affect the answers given, or me being a foreign white person can affect the relationship I build with the Ugandan informant. The way the informants picture me will end up shaping the information they will give me. That is a downside of the interviews if compared to other methods of research (as observations, for example) (Harding 2013, 22, Bryman 2012, 494).

Any type of methodology chosen for a research will come with its advantages and disadvantages, and the latter may count as limitations to that research. Some criticize the use of qualitative researches saying it is difficult to replicate, has problems of generalization or transparency; although it is arguable if those are limitations or problems (Bryman 2012, 406).

When sitting for a semi-structured interview, the researcher is taking some time and having a conversation with the respondent in an environment in which many non-verbal things will play a role. The researchers actions during an interview can influence the session, and actions of interviewees can also be taken into account as part of the data (Corbin and Strauss 2015, 38).

Another thing to be aware of is the risk of creating bias when creating a rapport with the respondent in order to have a successful interview, a strategy to balance the creating of this relationship against the risk of bias is to keep the focus on the respondent by extracting information and views from the respondent without giving out much personal information (Harding 2013, 35). Related to the same problem there is the awareness not to lose track of the context when coding the data gathered at the interviews (Bryman 2012, 578). Also, keeping one's biases in mind when interpreting the data is important, yet there is no guarantee that biases can be overcome.

Structure of the thesis

I am going to start by exploring a couple of concepts that were important for the context from which this research surfaced, the questions of the interviews were created, and the data was analysed. In the next chapter I will elucidate the discussions around quality of care, obstetric violence, respectful care, over and under medicalization and pain. Those concepts were key for the development of this study and they will be used in the analysis of the data in the findings and discussion chapter. On the third chapter I will disclose the theoretical journey I have been through when developing this project and explain how it affects the way this research took

place. The fourth chapter will provide the practical information about the methodology I used. Following that is the findings and discussion chapter where I will talk about what I learned with this study. Finally, on the last chapter I will present some concluding remarks and perspective on what actions should follow this study.

Contextualizing labour pains and maternal health

This thesis focuses in one of the many aspects that can influence maternal health, namely experiences and management of labour pains. In this chapter I will contextualize this, inside the broader picture. I will talk about the definition of quality of care and the importance it has for increasing maternal health. I will bring the focus to one of the features of a quality care; care being people-centred. Finally, I will show how this feature relates to the management of labour pains. I will bring in concepts developed in the realm of obstetric health care, namely respectful care, obstetric violence and under vs. over-medicalization. All those are related to the content of the care given and to the effort towards providing care that is of quality.

Although the main ideas building those concepts can also be applied to other areas of medicine and health services, they are here linked to obstetric issues. The health personal addressed is the one working with maternity services: obstetricians, nurses, midwives, etc. The patient is the pregnant woman and the baby. This brings a specific characteristic to the discussion; although the main focus is to achieve optimal health for woman and baby, the main health “issue” providers have to deal with is not a disease but something natural. It comes to the discussion the extent of medicalization that should be accepted not to turn something natural into a pathology. The discussions that construct these concepts work to find the ideal border between the medical authority and women’s autonomy over their own bodies.

Quality of care

“Due to focused global advocacy, many countries have made progress in increasing the proportion of pregnant women who give birth in a health facility. However, this increase in coverage often has not translated in the expected reduction of maternal and newborn mortality and stillbirths. This is due to inadequacies in the quality of care provided in health facilities.” (World Health Organization 2018)

Following efforts to improve the health care that is provided and health outcomes, many institutions and agencies came up with a definition of quality of care. This is also a consequence of a focus shift emerging from a growing understanding that it is not enough to offer a bigger number of hospitals and have more people going to health facilities; quality is as important as quantity for improving health.

The definition I will use for this thesis is the one from the World Health Organization, which is “[quality of care is] the extent to which health care services provided to individuals and patient populations improve desired health outcomes” and to consider care to be of quality it

“must be safe, effective, timely, efficient, equitable and people-centred.” (World Health Organization 2018). I am going to focus on the last characteristic, people-centredness. For the possibility of providing care that is safe, effective, timely, efficient and equitable at least two things must happen: people must choose to utilize health services and health providers must understand people’s needs. Considering that, people-centredness becomes the first thing to be looked at.

According to the World Health Organization, applying people-centredness to health care is “providing care that takes into account the preferences and aspirations of individual service users and the culture of their community” (World Health Organization 2018). This definition brings at least two realities to be considered: the one of the individual and the one of the community of which this individual is a part of. To be able to offer care that is people centred it is important to understand the local society so that care will respect the local culture and have better acceptancy. At the same time, the care offered must be individualized, with the understanding that one person is different from another and, therefore, has different needs and expectations.

Assessing quality cannot rely only on the medical knowledge. Quality in care has many features: clinical quality, perceived quality, quality of the process, responsiveness and quality as a social construct (Hanefeld, Powell-Jackson, and Balabanova 2017). In all these features the user perspective is very important, and for most of them it is essential. Quality must be assessed from both the provider and demand sides; besides, it is important to look at what lies in the middle affecting how provision meets demand. Efforts have focused on the provision side and only recently have started shifting the attention to the demand applying people-centredness (Hanefeld, Powell-Jackson, and Balabanova 2017).

The challenge is to offer health care people will accept, shaping services to people’s perceptions of quality, without affecting the clinical quality. So, of course the clinical quality is important, but it won’t stand alone to improve health outcomes. Receiving care is often a process, not a one visit to the doctor, and many things can affect that process. People must understand how the care they are getting when they go to a health centre is making them better.

People centredness comes to help close the gap between the perceptions of quality and the actual quality in the care given. By looking at the expressions and management of labour pains from the perspective of local women, this thesis touches the discussion on what is the best way for offering care that is of quality. I was able to explore women’s beliefs around the pains of

labour and the possibilities for managing them. Learning about the local reality can help when looking for ways to improve the quality of the maternal care in the area.

There is a shift of focus happening in maternity health care. Many agencies have been looking at the problem of the quality of the care women receive when they go to health centres to deliver their babies. Without diminishing the importance of the quality of the medical health care that's given, those agencies highlight other aspects of the experience women have at the time of delivery. This brought awareness to problems of disrespect, abuse and violence women suffer way too often when using health facilities. To work towards giving care that is of quality and improving maternal health outcomes it is important to consider those issues.

Respectful care

Respectful care, more specifically respectful maternity care, focuses on the interpersonal relationships between care providers and childbearing women. The White Ribbon Alliance (2011), an organization committed with improving maternity health, released a charter that gives a human rights approach to the issue of disrespect and abuse in maternity care; showing a road that can lead to respectful maternity care. They aim to broaden the concept of safe motherhood for beyond an idea of physical safety to encompassing all aspects of the experience women go through when becoming a mother. An experience of disrespect and abuse suffered by a woman when looking for health care could lead to a trauma affecting the woman's health. Besides, it diminishes the trust in the health facilities; which could lead to future avoidance in using health services and a bigger risk of mortality and morbidity when going through pregnancy and delivery.

Motherhood, going through pregnancy and delivering a child are exclusive to women, therefore, it makes sense to make a link between possible maternal disrespect or abuse with gender violence. Respectful care puts the idea of gender violence as a central issue in maternity care. So the expansion of the concept of safe motherhood for one of respectful care would bring in the picture "women's basic human rights, including respect for women's autonomy, dignity, feelings, choices, and preferences, including companionship during maternity care" (White Ribbon Alliance 2011).

A number of studies looked into the problem of poor maternity care and tried to elaborate categories of disrespect, abuse or mistreatment. Some categories that are found in several sources are: physical abuse, lack of consent (informed consent), non-confidential care, non-dignified care or verbal abuse, stigma and discrimination, failure in the communication

between woman and health care provider, abandonment of care and detention in facilities for failure to pay (Bowser and Hill 2010, 3, Bohren et al. 2015, 7).

Based on the categories of disrespect and abuse in maternity services put together in Bowser and Hill's work (Bowser and Hill 2010, 3), and on several human rights documents, the charter of respectful maternity care (White Ribbon Alliance 2011, 2) brings the seven rights of childbearing women, which are:

1. Freedom from harm and ill treatment – against physical abuse;
2. Right to information, informed consent and refusal, and respect for choices and preferences, including companionship during maternity care – against non-consented care;
3. Confidentiality, privacy – against non-confidential care;
4. Dignity, respect – against non-dignified care (including verbal abuse);
5. Equality, freedom from discrimination, equitable care – against discrimination based on specific attributes;
6. Right to timely healthcare and to the highest attainable level of health – against abandonment or denial of care;
7. Liberty, autonomy, self-determination, and freedom from coercion – against detention in facilities.

Management of labour pains and painful procedures during child birth can be linked to rights number 1, 2, 4, 6 and 7. It can fall in the category of physical abuse if a woman is submitted to a painful procedure during delivery without the use of pain relief; as it might be the case of an episiotomy or manual removal of the placenta. It can also be considered physical abuse the intentional denial of pain relief to a woman that cannot handle the labour pains.

Considering a woman should have right to information and respect for her choices and preferences, possible pain management strategies should be informed to women. A woman should then be informed about the nature and characteristics of any pains associated to child birth and about all the available options for its management. Besides, whenever possible a woman should be allowed to choose which strategy she wants for dealing with pain. Giving women knowledge and voice to have more participation when deciding how she is going to

experience labour and all the pain that might be involved would be a way to guarantee a care that will be perceived as being of quality.

Obstetric violence

Obstetric violence is another term for referring to disrespect and abuse in obstetric care. The term is usually applied when there is an effort to label the abuse suffered by women in maternity care as violence (or gender violence) and to criminalise it. It is a more specific term than disrespect and abuse and more simple to be used in a legal interpretation of the problem (Pickles 2015). The term has certainly a bigger emotional weight attached to it and it can be adopted by people or organizations that take a stronger stand against the negative experiences that many women face when giving birth: one example is its use for feminist studies (Shabot 2016). Besides, obstetric violence usually refers (although not exclusively) more specifically to the care received by a woman when she goes to a health facility for the delivery, while disrespect and abuse encompasses more often all the care received in the prenatal and postnatal periods.

The use of the term Obstetric Violence is becoming more common, as the pursuit for a better understanding of what it stands for. At least three countries in Latin America have now a specific legislation against obstetric violence (World Health Organization 2017). In 2010, Venezuela was the pioneer in using the term in its “Organic Law on the Right of Women to a Life Free of Violence”, a law addressing all types of violence against women in Venezuela.

The legislation uses as the definition of obstetric violence the following:

“...the appropriation of the body and reproductive processes of women by health personnel, which is expressed as dehumanized treatment, an abuse of medication, and to convert the natural processes into pathological ones, bringing with it loss of autonomy and the ability to decide freely about their bodies and sexuality, negatively impacting the quality of life of women.” (Pérez D’Gregorio 2010)

Obstetric Violence is linked not only to the care given by health personnel, but also to institutional failures. The importance of defining the term is also about finding a balance between the patient’s expectations, the services offered and the medical necessity. Addressing the issue of Obstetric Violence is working to guarantee women can exercise their rights when going through maternity without negatively interfering with the practice of medicine (Villanueva Egan et al. 2016).

Obstetric Violence is a worldwide problem and it can be characterized as “too little too late” (under medicalization), most commonly for low-income contexts, or “too much, too soon”

(over medicalization), most commonly in high-income contexts (Miller et al. 2016). However, between over and under medicalization there can be other types of abuse: verbal abuse, physical abuse, stigma and discrimination failures in the communication between patient and health attendant, lack of informed consent and confidentiality, among others (Bohren et al. 2015, 7). The Women's Global Network for Reproductive Rights summarized in a pamphlet what constitutes Obstetric Violence, as they put it:

“Obstetric violence is an intersection between: institutional violence and violence against women during pregnancy, childbirth and postpartum. It occurs in both public medical practice and private medical practice. For too many women [as a consequence of obstetric violence] pregnancy is a period associated with suffering, humiliations, ill-health and even death. Obstetric violence can be manifested through: Denial of treatment during childbirth, verbal humiliations, disregard of a woman's needs and pain, invasive practices, physical violence, unnecessary use of medication, forced and coerced medical interventions, detention in facilities for failure to pay, dehumanising or rude treatment. It can also be manifested through discrimination based on race, ethnic or economic background, age, HIV status, gender non-conformity, among others.” (WGNRR 2014)

With the term Obstetric Violence becoming more common, many women feel they can talk about their negative experiences during childbirth. Many voices are being heard, but mostly from women in developed contexts. The use of the term in other contexts can open the possibility for more vulnerable women to raise their voices too.

In the management of pain relief, it is interesting to get women's perspectives to understand if there is any type of violence attached to the matter. By comparing the reality of Uganda to other places around the globe it is possible to find out if those efforts being made to improve women's experience can also help in this context.

Labour Pains

Pain is defined as “an individual sensorial and emotional experience correlated with actual or potential tissue damage” (Jangsten et al. 2005, 149). When a woman is in labour it is usually expected and considered normal that she is going to experience pain. Labour pains are described by most women as very intense, “the most severe pain they have experience”, but they can be seen as important indicators of the progression of labour (Jangsten et al. 2005, 149).

Labour pains are related to an important and emotional experience in a woman's life and is determined by physiological and psychological mechanisms. Studies have pointed that labour pains, although intense, will not last in a woman's memory (Labor and Maguire 2008). That could indicate they are not so important for the experience of delivery. However, although

some researches points to the understanding labour pains don't affect so much women's satisfaction with the childbirth (Labor and Maguire 2008), there is the possibility they can be harmful for the experience if not managed well (Lally et al. 2014). Strong labour pains can be harsh on the mother and affect the baby. If a woman can't handle the labour pains, the stress generated and the variation in the breathing will decrease oxygen intake and blood circulation, transferring less oxygen to the baby in the womb (Labor and Maguire 2008, 15).

Labour pains are also a cultural phenomenon, since it is part of the experience of pregnancy and motherhood. That means the experience of labour pains is also affected by the cultural background where the woman is (Atekyereza and Mubiru 2014). When thinking about the best way to deal with labour pains and how that can end up affecting the health outcomes of pregnant woman it is important to consider the context and the individual. This study intends to contribute in that.

Pain relief can make a difference in the experience of labour and delivery. But it is important to consider the society and culture as well as individual needs and aspirations for the implementation of pain relief initiatives.

Over medicalization vs. Under medicalization

One can say that pregnancy and delivery are natural phenomena women go through since there are women. However, it is undeniable that the development of the practice of medicine and the medical technologies have been helping women to have safer pregnancies and deliveries; minimizing maternal and infant mortality and morbidity. Nonetheless, there are situations when this medical help is not enough, or, in the other hand, it is excessive and becomes a harm. Under and over medicalization are also described as too little, too late (TLTL) and too much, too soon (TMTS) and, although the former is usually associated to low and middle -income countries and the latter to high-income countries, both situations may occur in every country (Miller et al. 2016).

Under medicalization can happen due to a lack of resources in the provider end; being structural, material or human. It can happen due to a lack of resources in the recipient end; lack of knowledge making the woman delay going to a health facility, lack of resources for transportation, lack of autonomy to decide to go to a health facility, among others. It could also happen because of negligence or denial of care; that can be linked back to a lack of resources, but it can also be linked to under trained staff or stigma against some attribute of the mother to be. Culture could as well be influencing the practice of medicine, it is been reported health care

providers can decide on denying treatment as punishment if believed the woman did something considered wrong (CLADEM and CRLP 1998, d'Oliveira, Diniz, and Schraiber 2002).

In Uganda it is most common to find the problem of under medicalization. This happens because of a lack of structure in the health facilities, lack of medical materials and of medical personal. The facilities can lack basic equipment and virtually never have more advanced equipment to deal with complicated cases. Many times, there is lack of water or the buildings suffer from a power cut and, without any emergency generator, leave health care providers working in the dark (Sawaya, Rother, and Thede 2014, Kigozy 2017). The problem of electricity also limits the possibility of using more modern equipment that demands the use of electric energy.

Besides that, there is not enough materials available such as medicines, gloves or even soap for hand washing, and women are many times expected to bring materials themselves when going to a health centre for delivery. When there is the need for an episiotomy, the cut is usually made with a shaving blade that is also many times brought by the mothers themselves.

The Ugandan health system also suffers from shortage of health workers and hospitals are usually crowded without enough personal to attend to everyone. Many health centres have an appointed doctor that is the responsible, but is rarely there, so that nurses and midwives must deal with situations for which they were never trained to handle. Staff has usually a big load of work and that compromise the quality of the service when the health providers are tired and don't feel that their work is valued (Sawaya, Rother, and Thede 2014, Kigozy 2017).

Despite being a low-income country and having under medicalization linked to maternal care problems most of the times, Uganda also faces some situations of over medicalization. Example of this is the routinely use of certain procedures and medicines, such as episiotomies and administration of oxytocin. Over medicalization has a connection with a dehumanization of pregnancy and labour; the transformation of them into pathological processes. It is the use of medical interventions too soon, unnecessary procedures and interventions used routinely, not respecting the individuality of every case.

Discussion around the use of pain relief for labour pains can be easily linked with the issues of over and under medicalization. There are situations where pain relief is non-available and situations when its use is becoming routine. There are studies pointing to the positive sides of having available pain relief for labour pains, like women's feelings of empowerment or control over their own bodies when delivering (Lally et al. 2014). There are other ones criticizing the

routine use of anaesthetics and highlighting the dangers of it. The critics of pain relief say its use has been changing the whole idea around labour pain in high income countries (Walsh 2009, Newman, McKellar, and Pincombe 2016). The critics say that the rise in the use of pain relief can be seen together with the loss of the view of becoming a mother as a rite of passage and the understanding that labour pains are something normal and beneficial to the woman.

Theoretical framework

The role of the researcher

“Sometimes I feel I don’t belong being here in Uganda working with mainly European people... At some moments I feel I would fit somewhere between them and the African people. It is like they understand each other so good and I don’t really. The things that shock them, the things they get excited about, the things they like or dislike. Many of those have been very different between them and me.” (Fieldnote 22.09.2017)

Should a study disclose information about the researcher? Does who the researcher is influence the study’s outcomes? Can research be value-free? What is objectivity in research? These questions are related to some polemic discussions in the academic world. In the quest for the best way of producing knowledge there is sometimes the belief that research can and should be “disinterested, impartial, impersonal, and value-free” (Crasnow 2014, 150). In that understanding good research would be the one based solely in facts, without any interference of values.

There is a lot of critic to that perspective pointing to the impossibility of it (Risjord 2014, 17). The importance of values for the object to be studied is even stronger in social research. In this case we are looking at phenomena that often cannot be isolated from cultural, moral and political values that will give context to the object of study (Crasnow 2014, 150). Critics can go beyond as to point that the researchers position in society might determine even the choice of object to be studied and the methods used to produce knowledge (Mazur 2012, Fegurson 1993).

In the research conducted for this thesis I chose the perspective that believes values matter in the production of knowledge. I looked at how people’s values affected the phenomenon studied. For that reason, I chose to use a qualitative approach that would allow me to look at the complexity of human behaviour. I also believe that my place in society and the values that come with it affect my choices of subject of study and methods. In that case, I believe that I have to be transparent about my social place and my methodology to achieve objectivity.

When using a qualitative design, and being aware that “qualitative research is interpretative research” (Creswell 2014, 187), it is important for me to understand my role as a researcher. I understand that I will bring my outsider perspective into the interpretation of the data. Even if I can consider myself an insider in a very limited way, by being a woman interviewing other women, many other characteristics highlight my outsider feature. I am from another nationality,

socio-economic status, culture; I have a different history and background. I have never experienced a pregnancy or delivered a baby, hence I never used obstetric services myself. All of these may produce biases and values that can be reflected on the research, it is important to be aware of it and have it as clear as possible. For that matter I think it is necessary to write this thesis in a more personal way, using the “I” pronoun and giving details of my experience when conducting this study, so that the reader can understand how and why I might have gotten to my conclusions.

My role as a researcher, student, foreigner; outsider to the culture, language and delivery experiences, has shaped my theoretical choices as well. My theory will thus be one that centres around epistemology and its question on “what is actually possible to know about?”, or the extent of human knowledge. In this way, the discussion around the methods and validity for the generation of knowledge, and the extent of this knowledge, is important. The discussions around the types of knowledge and the insider vs. outsider perspectives are included as well.

The questionings about the extent of the human knowledge are important ones inside epistemology, and among the different views one can be as extreme as believing we can’t really know anything; which is what defends scepticism (Truncellito). Then moving from the extreme end, but yet not so far from scepticism, we find solipsism; which states that one can know nothing outside one’s own mind, in a way that the outside world remains as an unresolvable question (Thornton). A development of solipsism can be the belief in an insider epistemology; which could state in a narrower sense that one can know nothing but oneself and one’s experiences, or a broader sense that one must be an insider in a certain group in order to know anything about others in that group (Fay 1996).

The development of the background theory for this study started with the discussion about insider epistemology and the need of it to be falsified. After getting more inputs from the experiences while researching and writing, and from the data collected, I found standpoint theory to be increasingly relevant for the thesis. Furthermore, the field has a built in “battle” between the natural sciences and the social sciences, with its respective methodologies of producing knowledge. In the end, I propose an agreement between the two views and the idea that the production of knowledge will benefit from one complementing the other.

In this section about theory I intend to take you on a journey of how I developed my theoretical framework. I will go from the discussion around the validity or the possibility of the insider epistemology, through the ideas of standpoint theory of which this thesis can benefit from. I

will touch the discussion of the insider vs. outsider, and finally bring up the discussion on natural sciences vs. social sciences.

One theoretical journey

The theoretical background for this study was developed side by side with the study itself. Of course, there are some ideas about which theories might be useful for the research in the moment the project is made, but in the same way the research itself changes while being developed, the theories must follow that change. Theory here is much more in connection with the methods adopted for the study than with its findings. What is sometimes known as grand theory (Bryman 2012, 6) helped in the choice of the methods used in this research and guided how knowledge was generated. The use of abstract concepts and discussion, as are the ones in the epistemological studies will in the end be important for the understanding of the relevance of this study and the way it can contribute for the body of knowledge on the subjects of maternal health, maternal health services and quality of care.

I can say I started out wide and narrowed the theoretical scope in the development of the study; in the same way I did with the topic of the study. That relates to the choices I made along the way; sometimes presented out of need influenced by external factors, but sometimes originated as the study evolved.

In my project I considered the division between grand theory and middle range theory, a distinction explored by the sociologist Robert K. Merton (Merton 1949). I expected to use grand theory as a perspective chosen to look at reality, or a worldview; in the words of the academic John W. Creswell (Creswell 2014, 8). I wanted to build my concepts and perhaps a theory from the ground, from my data, therefore, I thought a constructivist perspective would be useful. One can't escape from the concept of grounded theory when planning on relying on one's data for the formulation of concepts and/or theory, so that was also included. Grounded theory was thought to help me as "an approach to the generation of theory out of data" or "an approach [to] generate concepts rather than theory" (Bryman 2012, 387).; so, in this sense, grounded theory was seen as guiding the data analyses, more like a methodological tool than a theoretical framework.

As the lenses to look specifically to the phenomenon studied, or as my middle range theory, I expected to use feminism, because at the time I was interested in obstetric violence, which is well characterized as a type of gender violence. It is possible to see a hint to the use of standpoint theory even then at the time of developing the project if one thinks of the

combination between a constructivist worldview and a feminist interpretation of the phenomenon. I am not trying to say standpoint theory is exclusively concerned with feminism nor it is a constructivist theory, but I can see similar reasonings between them two.

When in Uganda, my position as an outsider was highlighted to me over and over, not only while doing my official observations at health centres or having interviews, but also when living my daily life in those two months I spent there. When understanding that my position as an outsider brought attention to certain traits of reality I kept thinking about the discussion around insider epistemology brought by Brian Fay. He highlights many advantages of being an outsider when building knowledge. The development of this idea about the importance of my outsider characteristic and how it will influence the research, and also the fact of relying on the data generated on interviews made in Uganda came with theoretical reasoning more settled at standpoint theory. I will attempt to demonstrate this development of thinking that went from understanding how important it was for me to highlight my outsider position to building a more solid theoretical background with the aid of standpoint theory.

Insider epistemology and Standpoint theory

There are many different theories on the possibilities and methods for generating knowledge. Those happen in the field of epistemology; or the study of knowledge. It is interesting for scientific research to keep this epistemological discussion alive. Debates over the best way to build knowledge, or scientific knowledge, work as refiners of this knowledge itself. Insider epistemology is one of those theories, and the discussion around it developed by Brian Fay in the first chapter of his book *Contemporary Philosophy of Social Science* (Fay 1996) can be helpful. The chapter is called *Do you have to be one to know one?* and Fay justifies the choice of bringing up the *insider epistemology thesis* and then developing a logical pathway that proves the thesis is true only in “very limited ways” and it is not true in “more important ways” by stating that if this thesis came to be true it would “undermine the scientific study of human beings, making the term “social sciences” an oxymoron” (Fay 1996, 10 - 12).

The insider epistemology thesis can be understood as a part of the philosophical position called “solipsism”. This position considers that experiences, feelings, actions, states of mind cannot be understood by anyone else but the one that has them; given that one cannot know anything but oneself (Fay 1996, 9). As it happens with many other flexible terms in philosophy or even in social sciences, the “one” in the solipsism’s perspective can be seen as the one individual or as a group that shares the same characteristics or experiences that constitute the object of study.

If the theory that *one must be an insider to know other insiders* would be considered true, it would be impossible for me to develop a research in Uganda; it could even be that I would not be able to understand the reality of Ugandans even if the research was made by a Ugandan. It would not be possible the sharing of knowledge between different groups. In order to falsify this assumption, or to minimize how it harms the sharing of knowledge it's useful to explore the different types of knowledge and to define what knowledge scientific research is trying to build.

Epistemology is concerned with determining what is knowledge, what it means to know something, what are the types of knowledge and what is the extension of the human knowledge. Therefore, it is concerned with the theories of knowledge and the methods, validity and scope of it. To be more specific, epistemology is concerned with knowledge in the "factive sense", which means based on facts. Still considering knowledge must be based on facts, there can be identified at least three different types of knowledge: procedural knowledge or know-how, acquaintance knowledge or familiarity (maybe know-who or know-what) and propositional knowledge or know-that. Epistemology is, then, more specifically interested in propositional knowledge, and in separating what are justified beliefs from that are just beliefs or opinions (Truncellito).

Defining scientific knowledge is crucial for this discussion. Scientific knowledge is the translation of a phenomenon into intelligible categories; it is to interpret the meaning of a given phenomenon (Fay 1996, 26). The understanding of knowledge in this context is more closely linked to "know that" than to "know how". The latter is also called "tacit knowledge" and the former "explicit knowledge". The term "tacit knowledge" was introduced by the philosopher Michael Polanyi (1966) and describes the knowledge acquired by experiences. It is the knowledge that cannot be easily transmitted from one person to the other. One can understand this as the kind of knowledge only an insider can have. The "know that" or the "explicit knowledge" is the articulated knowledge, it can be more easily transmitted; it is the kind of knowledge an outsider can access and is the one that is usually translated into scientific knowledge (Polanyi 1966).

When admitting that scientific knowledge is "explicit knowledge", or the interpretation of the meaning of a phenomenon, it becomes unnecessary to be an insider. It can be actually easier, in some situations, to know something once one is an outsider. That is because to understand a phenomenon it is sometimes beneficial to have a certain distance from the matter of the study,

in order to visualize the context or the bigger picture. On the other hand, when studying human behaviour, the tacit knowledge can be important, if there is the possibility for making it explicit. To make that happen it is useful to have the insider and outsider perspectives working together.

When insider epistemology states that you need to be an insider in a group to know the other insiders of the same group (Fay 1996, 9), it suggests a close relation between knowledge and being. It affirms that to know others it is necessary to experience things in the same way as they do. Therefore, to build solid knowledge on others, one must be like them in every important aspect (Fay 1996, 26). Which in one hand could be understood as closely related to tacit knowledge. But what if we understand this a little bit differently? What if tacit knowledge and explicit knowledge could be said to work together? An insider can be able to interpret differently a phenomenon because of having a different tacit knowledge (or situational knowledge, for that matter), being able then to generate a different explicit knowledge. Insider epistemology could be said to have something in common with Standpoint theory when understanding that insiders are “epistemically privileged”, in the words of Alison Wylie (2003, 26). Standpoint meets Insider epistemology in believing that insiders “may know different things, or know some things better than those who are comparatively privileged (socially, politically), by virtue of what they typically experience and how they understand their experience.” (Wylie 2003, 26).

However, Standpoint does not state that you need to be an insider to know other insiders, it only defends that the beginning of an inquire will benefit if its placed in the insider and the knowledge he/she has (Smith 1992). Dorothy smith puts it like this: “My notion of standpoint doesn't privilege a knower. It does something rather different. It shifts the ground of knowing, the place where inquiry begins.”(Smith 1992, 91). Even if Smith says that in her understanding Standpoint theory doesn't put the knower as privileged, she brings the idea of the start of the knowledge building being that knower, and that is in agreement with the idea that “they may know different things...”. Standpoint theory is mainly trying to include more perspectives as reliable and valid in the making of knowledge. Perspectives that are usually neglected in many cases for the exact reason of coming from marginalized subjects. The importance of including different perspectives and including the perspectives of the insiders of the phenomenon studied is based on the idea that a person's experiences will influence or shape the knowledge the person has. So, in order to have a more complete reality it is beneficial to include different perspectives or different interpretations of the phenomenon studied. And starting the questionings from insiders will help the development of a richer inquiry.

The classical scientific method and understanding of objectivity comes with the assumption that the researcher must be neutral to the matter of study, a certain distance must be kept between the researcher and the object of study (Crasnow 2014). Standpoint theory challenges that perspective when stating that in some cases research, the production of scientific knowledge and its objectivity might gain if starting from “an interested standpoint” (Wylie 2003, 33). Bringing this logic to the development of this master thesis, the fact that I am an insider for being a woman might have contributed for the choice of the issue studied here; the one of labour pains. Going beyond this master thesis, one researcher who starts inquiry from a political engaged position might be able to identify different types of issues that deserve being studied, issues that would not be given attention otherwise.

One of the points made by Standpoint theory is that research can benefit from having as the inquiry starting point the marginalized exactly because that will probably bring up questions that would not occur to the dominant ones. A concept that helps understanding this phenomenon is that of situated knowledge and the idea that all knowledge is situated; all production of knowledge will have in itself the background of the researcher responsible for it. By exposing this fact, one can understand that knowledge produced by and starting from dominant people will reflect their situational knowledge and end up excluding, even if not intentionally, the situational knowledge of marginalized people. Following that line of thought one can understand also that there is no production of knowledge completely independent of the researcher’s situation (Harding 1993, 57), therefore, in order to achieve better objectivity it is important to take into account where that knowledge is coming from and how it affects the study.

Situated knowledge could be explained as follows: depending on who the researcher is, the social place this researcher comes from, different things will appear to be odd, will call the researcher attention, and different questions will come guiding the research. In the end, a different type of information or knowledge is going to come from each different kind of researcher (Harding 1993). Taking into account the researcher and its background, situating the knowledge produced then, can help not only amplify the general knowledge but also increase objectivity (Wylie 2003). We could maybe say there is not one absolute truth that will belong to everyone in social sciences, but many truths or many versions of it that together will bring real understanding of the social reality.

According to Standpoint theory, the marginalized groups will end up having certain epistemic advantage because they have types of “problems” in their realities that the privileged groups don’t have. That end up enabling them to ask questions that would not appear so easily in privileged groups concerns. The idea is that all knowledge is situated, but the ones who usually build what will be truly considered knowledge are the dominant ones, and they are not able to grasp the whole picture (Harding 1993, 54). So, if we assume all knowledge is situational we can then not only criticize the knowledge that’s being generated by the dominant but also bring different knowledge to fill the gap left by the mainstream knowledge when starting the line of thinking from marginalized locations. In the words of Sandra Harding, “standpoint theory not only acknowledge the social situatedness that is the inescapable lot of all knowledge-seeking projects but also, more importantly, transform it into a systematically available scientific resource.” (Harding 1993, 58)

For the purpose of the research conducted for this thesis, being an outsider helps analysing the matter of labour pains in Uganda putting it against a wider perspective on it. It helps to see the way labour pains are experienced and dealt with as different and then trying to highlight and explain those differences. By being myself an outsider to the Ugandan perspective on the matter, and by bringing in more outsiders when interviewing foreign volunteer midwives, I can make more explicit the oddness of the phenomenon studied constructing a richer analysis of it. Furthermore, interviewing insiders will give voice to those women to talk about their own experience and will bring insights this research could not have otherwise. Considering pregnancy and motherhood usually bear a big emotional and cultural load, it is important to consider insiders voices to build the knowledge also based on the feelings around the phenomenon, those which I could not access without talking to the women that experience those feelings. And here is where Standpoint theory presents itself as shaping the production of knowledge.

What happened then in my theoretical journey was that I started from having Fay’s denial of the insider epistemology in the back of my head while being myself an outsider in many important ways studying a phenomenon in Uganda. That brought to my reasoning the importance of my outsider situation in the development of my project and in building this piece of knowledge. My outsider perspective allowed me to be puzzled by occurrences that might be seen as mundane by Ugandan women; so that I could come up with questionings that would maybe not arise from someone who is very inside that context, enough to stop seeing some aspects of it. At the same time, my experience on the field and inputs coming from my

observations and interactions with insiders were the responsible for my shift of focus; in a way that I can say I allowed my questionings to come from my sources of data. The use of semi-structured interviews and the building of knowledge from the ground brought the importance of the insider perspective for my project, and that was the moment when Standpoint theory gained its importance in my theoretical background. I see Standpoint theory as a middle point between the idea that one must position the furthest as possible from the object of the research, and the idea brought by the insider epistemology that only insiders can know other insiders.

Insider and outsider perspectives

The research made for this master thesis has many layers of interpretation. The main findings or key themes came out of interviews made not only with Ugandan mothers and health care providers, which are the ones that could be said to be in the core of the phenomenon studied. Interviews were also made with volunteer midwives from other countries than Uganda, who have an outsider perspective of that same phenomenon because of being a foreigner, coming from a different culture, many times speaking a different language. Although, at the same time, they are also insiders to that phenomenon to a certain extent. They are women, they might have experienced the pains of labour themselves, they are maternal care providers and they are working inside Ugandan health facilities with the Ugandan mothers. And then there is the researcher, who is the one person that is looking at the phenomenon and analysing it, who is the one making the questions in the interviews, the one shaping the course of the talk and later interpreting all the data generated.

The experiences this study tries to make sense of are the experiences of Ugandan mothers, not only as the ones who feel the pains of labour and try by themselves to cope with them or to manage them, but also taking into account the views of the health personal that are also managing that pain that another woman is feeling. The Ugandan doctors, midwives and health technicians most of the time have experienced the pains of labour in the past and that makes them be an insider in the realm of labour pain experiences. Because of that they might feel they identify with that woman who is in pain in that moment, they can understand they are one of them too because they have been through the same.

Ugandan mothers and mothers who are also health professionals are insiders when the object of study is labour pains. Ugandan health workers who are not mothers are outsiders considering labour pain experiences, but are insiders considering they are from the same country, same society, sometimes same culture. Having experienced labour pains or not, being from the same

country, living in the same society, sharing the same culture or not, being from the same gender, it is important and interesting to consider these characteristics as influences for the understandings of an individual (Harding 1993, Wylie 2003). Considering only Ugandan women, being mothers and/or health care providers, there are already layers of interpretation; the ones that experienced the pain and manage from a lay perspective, the ones that experienced the pain and manage from a health professional perspective and the ones who haven't experienced the pains and manage other women's pains from a health professional perspective.

More layers are added with the interviews with foreign volunteer midwives. Most of them from the United Kingdom, all of them from Europe, all female, all from developed countries, all working in Ugandan health facilities side by side with Ugandan health workers, attending to Ugandan women. And more layers added by the researcher, also a foreign in Uganda, also a woman, from South America, from a developing country, not a health care provider, developing this study in a Norwegian university. I am an insider for being a woman, also to a certain measure for being from a country that has similarities in the health care delivery to the Ugandan system, but most certainly an outsider in every other aspect. In summary, it is a mixture of cultures, realities and perspectives, all of them contributing, in the end, for the generation and interpretation of the data.

The discussion around insiders vs. outsiders to a phenomenon is fruitful for science, but it is even more important for the social sciences. It can be related to the question of objectivity in research and of the possibility of getting distance from the object of study. Dorothy Smith highlights that we are all insiders in the study of social phenomena (Smith 1992), one could add we are all insiders in the study of any phenomenon that happens around us and is considered important enough to justify being studied. That is why I bring the idea of layers of interpretation, they relate to different degrees of *insideness* each individual playing a role in the research project has, and they will all contribute when building some knowledge in that project. Admitting those layers of knowledge will help grasping the complexity of the social reality.

Natural sciences and social sciences

The distinction between natural and social sciences is something relatively new. In earlier stages, social researchers would develop their studies trying to apply the rationales behind the natural sciences. In this scenario, quantitative research was preferred over qualitative research

to explain social phenomena, following the idea that doing so would lead to a more objective knowledge (Harding 2013).

In my research I am looking at a social phenomenon, but I am also looking at a health issue. The construction of health-related knowledge, with what it's sometimes called "health sciences" (Bench 1989), can rely on quantitative methods and qualitative ones, and use both natural and social sciences rationales. Despite that, it is much more common to find "health sciences" related to natural sciences than to social sciences. That brings consequently a big connection of the production of health knowledge to positivism and to quantitative methods (Bryman 2012).

With the extensive use of quantitative methods, research finds itself bind to principles as measurement - or the idea that social phenomena can be operationalized and measured in numbers -, causality – with the use of dependent and independent variables and the logic of cause and consequence, action and reaction -, and generalization – when the researcher looks for a random sample of sufficient magnitude to make possible to generalize what's found for the whole population (Harding 2013). By using those methods to understand health issues connected to social phenomena and human behaviour the knowledge generated ends up being incomplete.

In the beginning of this thesis I presented some of the numbers that are used for explaining where the world is at in the matter of maternal health. I also presented some numbers that are used by the world's big organizations trying to get the maternal health picture to improve. One negative consequence that can be seen of the use of natural sciences rationales for studying social phenomena and implementing social policies is the focus on those numbers. In many cases the effort seems to shift from improving the issue itself, in the case here maternal health, to improving the numbers. Taking as an example the Millennium Development Goals and the Sustainable Development Goals from the United Nations, many of the efforts put in place with the goal of improving maternal health worldwide were on increasing the number of women having access to skilled health care for delivery. If one looks to the numbers, it seems like the efforts have been a great success and therefore maternal health should be improving in very good rates. But that is not necessarily the reality, exactly because the focus was in improving the number of women getting professional health care, many times not taking into consideration the quality of that care.

The operationalization of phenomena can of course be useful, and the statistics will help in the understanding of part of the problem, but qualitative studies are necessary to fill the gap left between abstract numbers and real people with real stories to tell. Qualitative research was developed so the research can take a grasp of the complexities of the human behaviour and the social relations (Harding 2013).

Qualitative research is a more flexible approach to the production of knowledge. It rejects the rigid rules from the natural sciences and positivism. When using qualitative methods the researcher usually starts the study with a broader picture and narrow it down as the study goes, using an inductive approach allowing the generation of theory (Bryman 2012, 36). When using qualitative methods, the researcher is understood to be a part of the research and the disclosure of information indicating the researcher's standpoint and how it influences the research is important to guarantee objectivity (Corbin and Strauss 2015).

Some of the principles that appear in qualitative research and are to some extent in opposition to the principles of quantitative research are: Naturalism, which means to bring the research to the natural environment where the behaviour or phenomenon to be studied happens instead of bringing the subject to the research by making people answer to questionnaires, for example; a holistic approach, taking into account the great picture where the phenomenon to be studied occur, putting into it contextual information instead of isolating variables; and seeing through the eyes of others, using methods such as semi-structured interviews that will allow the perspective of the respondent to show, together with the aspects that person deem important (Harding 2013).

In this study I am choosing qualitative methods because it allows me to have a holistic approach when trying to understand the social sphere of maternal health. I am exploring people's experiences hoping to understand how they build meaning in their reality and maybe discover important variables. Those could be later tested using quantitative methods (Corbin and Strauss 2015). I believe the production of health knowledge will benefit from having natural and social sciences rationales as complementary and not in opposition to each other. The use of quantitative and qualitative methods can bring a more complete picture of the reality when used together. That is specially relevant here when considering the efforts for defining what is a care of quality and the need of putting together clinical quality, perceived quality, quality of the process, responsiveness and quality as a social construct.

Data collection and methods

With this study I was searching for understanding. I wanted to look at different aspects of maternal health that would enrich the existent knowledge. The intention was to bring different perspectives in order to capture the complexity of the matter. Complexity that exists for the exact reason that I am looking at a social phenomenon that encompasses people's behaviour; which might be based on rationality, feelings, habitude, and so on. The methods used for gathering data and analysing it followed that goal. Traveling to Uganda and having face to face interviews with local women, building the rationale around the relationship between the insider and outsider perspectives, bringing in the views of the foreign volunteer midwives and, in the end, pulling key themes out of the data. That process enabled me to build a better understanding of the specific issue of expressions and management of labour pains and of many features of the context around it. At the same time that I brought to this project my own perspective and my own queries, the methods chosen built space for other voices when building this study's findings.

Data gathering (who, how and where)

Working with layers of knowledge (who)

I already mentioned before the different layers of interpretation I am working with in this thesis. I chose to look at my data as layers of interpretation or layers of knowledge because I chose to look at the issue of labour pains as a multifaceted one, but also because I believe looking at it from different angles will help me reach a bigger understanding. The intention is to add to the scope of what's already known to aid in the quest for better maternal health services and maternal health. The data came from three different sources: foreign volunteer midwives, Ugandan mothers and Ugandan health providers. My experiences and my observation influenced the data gathering and the interpretation of the data to an extent and I can consider them as a fourth data source.

The first part of the data gathering was then done with time spent in the health clinics I had access for this study. I interacted actively by doing some volunteer work myself together with the staff. I also spent time in the maternity wards and in delivery rooms observing passively while taking notes. The data gathered on this first moment served for the development of the interview guides used for the next step of the data gathering.

In the second part of data gathering, eleven women were interviewed: five foreign volunteer midwives working in two or more health centres in the Kabarole district, one Ugandan doctor working in the area of neonatology and obstetrics, one Ugandan health technician and mother of nine children, and four Ugandan midwives; all also mothers. The foreign volunteer midwives participant in my interviews were all recruited by the charity Knowledge for Change, which works in connection with the Ugandan public health sector in Fort Portal. The volunteer work developed by those midwives follow the Sustainable Volunteering Project model from the recruitment to the evaluation of the projects (Ackers and Ackers-Johnson 2017).

The foreign volunteer midwives were all from European countries, mostly from the United Kingdom. They were living in Fort Portal, Uganda, between one month and more than one year, with some of them being in the country for the second time. They were working in several different health centres in the area and some of them also worked in the referral general hospital. Their work was developed side by side with the Ugandan health providers attending women for antenatal care, deliveries, postnatal care, HIV monitoring and management, family planning, follow up of the baby's health, immunizations and cervical cancer screening. The data gathered from this group was based on how these women made sense of the reality they found themselves working at by making comparisons to their reality back home and highlighting differences in situations of the daily work routine, but also differences in behaviours of both health care providers and mothers looking for care. The inputs from those interviews were important for this project for allowing different traits of the matter to show, things that would maybe not come to me with the same strength because the reality of the public health care in Brazil is not as different from the Ugandan as it is for the European public health care. This data helped me mostly in the shape of the questionings I came up with when interviewing the local women. Besides, it helped in the explaining of some behaviours when looking at them from more distance.

The Ugandan mothers were the Ugandan women that had between two and nine children and gave birth in Fort Portal. From them I could get the stories of how it is to give birth and to become a mother when being a Ugandan. They explained me how they experienced labour pains, how they expressed it and the way they managed them. They talked about the possibilities they had for managing the pains and what they knew was expected from them when facing labour pains.

The Ugandan health providers could give better insights of the possibilities they have when concerning pain relief, and of what is normal in regard to expressions of labour pains around the health facilities. They could also tell me what they've learned, when working with many different women, about people's understandings around labour pains; not only in the region of Fort Portal, but sometimes making comparisons with other areas in the country.

Sampling

Previously I talked about the limitations this study had and the challenges I faced when conducting research in Uganda. In order to overcome language limitations when interviewing local women, I had to limit my recruitment of participants to women to whom I could communicate in English. Also, to overcome time limitations I had to reduce the number of interviewees; yet having a number of interviews that were enough for common themes to emerge. I selected the sample with the conditions that the women were in position of giving me a satisfactory amount of information on the matter I was looking at and that the sample could comprise the most variation as possible. One solution I found was to have many times the same women giving me the perspective of being a mother and delivering while being Uganda and the perspective of the Ugandan health professional. To add multiple social economic status backgrounds, I had interviewed women in different functions that ask for a different level of education; the interviewees ranged from health technicians, going through midwives, nurses and getting to a doctor. The fact that some of the health care providers were mothers and others were not showed how the experience of labour influenced their perspectives and attitudes. Furthermore, the fact they are immersed in the society being studied made possible they would talk about things that are normal around them, even if they don't believe or follow those things themselves.

Where

The recruitment of participants was made in the two governmental clinics participating in the WECare program from the NGO Knowledge for Change in Fort Portal, where the University of Salford is already doing research. Those two are the Kagote Health Centre III and Bukuuku Health Centre IV, clinics from the public health sector in Uganda. The staff from the charity Knowledge for Change worked as gatekeeper and made possible the contact with the first interviewees. That was then followed by a snowball approach for reaching more respondents in the environment of the Kagote Health Centre III, in the municipality of Fort Portal.

- Fort Portal

“Sometimes it is hard to see the beauty of the green landscape and surroundings. The sadness of the conditions people live in steal my attention. Some houses with 10 to 12 children dressed in dirty and teared clothes. Clothes that are too big or too small. No shoes.” (Fieldnote 30.09.2017)

Fort Portal is one of the major urban centres in Uganda, accounting with a population of 32,627 people in 1991 (BakamaNume 2010, 137). The town is in the western region of the country, in the sub region of Tooro (Tooro Kingdom) and it is part of the district of Kabarole. It is located around 320km from the capital of the country, Kampala.

Fort Portal is the home for the region’s referral hospital, known as Buhinga Hospital, and for the Mountains of the Moon University. These two institutions were the first ones in the region to partner with the British institutions, the University of Salford and the charity Knowledge for Change, with the common goal of improving local health services and health outcomes. The charity Knowledge for Change was of great importance for this study working as gate keeper to the women intervened, for that reason added the section bellow with some information about their work in the area.

- Knowledge for Change

The choice of working in Uganda is also related to the opportunity that was presented by the partnership between the Oslo Metropolitan University and the University of Salford, which has research programs in progress in collaboration with the government Uganda. The group of researchers from the University of Salford is working in partnership with the Non-Governmental Organization Knowledge for Change and the Ugandan University Mountains of the Moon.

Knowledge for Change is a charity that works in Sub Saharan Africa, mostly in Uganda, and has as centre of its activities the “improvement of health care delivery and outcomes”, with special attention to health matters surrounding pregnancy; maternal and infant health (Ackers 2017). The charity works in partnership with the public health care system in Uganda, and puts together the Ugandan health care personal, health professionals from the UK and students of the health and social sciences from the University of Salford and, more recently, from Oslo Metropolitan University. The work developed in Uganda has had its focus in the improvement of infrastructure, but also capacity of both Ugandan and British health professionals and students; with the provision of training and exchange of knowledge.

The NGO Knowledge for Change has a program called “‘WECare’: Supporting Women’s Empowerment and Respectful Maternity Care in Uganda”, they put as the aim of the program the following:

“Disrespectful care not only undermines women’s human rights and disempowers them; it also results in poor levels of engagement with public services and damaging delays in accessing them. Through empowerment of women and collaboration between healthcare staff, stakeholders, families and communities WECare will improve the well-being of mothers and babies.” (Knowledge for Change 2017)

For the year of 2018, the charity plans on continuing its cooperation mainly with two of the health centres in the Fort Portal area, in Kabarole district. K4C intends to concentrate its attention at Kagote Health Centre III and Bukuuku Health Centre IV. The focus will be kept in maternal and newborn health, therefore they will be working together with the local maternity services. The promotion of respectful care is also meant to continue in 2018. That will be done with training and education on the matter; hoping to reach professionals already working in the field and students of the midwifery program of Mountains of the Moon University. The plan is also to develop research on the matter of respectful care in Uganda, studies will be led by in field volunteers of the charity. For the present year the research will give more attention to two topics from respectful care: privacy and pain relief (Ackers 2017).

The first time I have been in Uganda was that for the development of this research, I don’t think it would have been that easy to get in contact with the people I could interview without the help of people that have been working in the country for years. The structure provided by K4C and the aid I got from their staff was crucial for this thesis. One thing I must highlight here is that the Ugandan women I interviewed saw me not only as a foreigner they were talking to, but most likely a foreigner linked to the charity. This fact can influence the data generated on the interviews in some ways. They can maybe feel more comfortable to talk to a foreign person if they know I am part of an organization they know and trust. On the other hand, they might feel tempted to praise the organization or hold information that could be seen as negative about it when talking to me. I tried my best to take this in consideration when going through the data and interpreting it.

How

I am using a qualitative approach because it allows me to have access to subjective experiences and explanations. A quantitative approach would not give space for the type of information I was after to arise. The intention was to bring to the interviews the shape of conversations

between me and the participants. I did that with the use of semi-structured face to face interviews, open-ended questions and then follow up questions. I was hoping to give space for a high level of rapport between me and the participants and a non-hierarchical relationship; what would allow the perspective of the woman being interviewed to appear (Bryman 2012, 492). I prepared an interview guide with the topics I wanted to touch, more themes were added in the development of the data collection.

The focus was on building a rapport with the participant to gain their trust, since I could be considered “different” in the eyes of all the people I talked to. I chose to share information about my own country or my own experience that had no connection to the subject of the interview and that I believed we had in common; one simple example was to talk to the Ugandan participants, before the interviews, about the banana trees we have in Brazil the same way they have in Uganda. By doing so, I expected to get participants more engaged in a conversation with me but avoid influencing the type of information given.

In my many trips to Kagote Health Centre III and Bukuuku Health Centre IV I could get in touch with potential participants to whom I presented the idea of the thesis and who I invited for interviews. With the women interested I agreed a time and a place that we could meet and spend around one hour on the subject.

Since I lived in the same house as many volunteers in Fort Portal, I could get in contact with some of the participant foreign volunteer midwives easily. I counted with the aid of the staff from Knowledge for a Change and with the aid of some of the volunteers from the house to reach other volunteers who lived somewhere else and worked in other health facilities besides the ones I had access to.

When conducting the interviews, there was a preference for informal locations that would help interviewers to get comfortable and diminish any hierarchies or boundaries that can arise in such situations (Bryman 2012, Harding 2013). It was necessary, sometimes, to meet the Ugandan health workers at the clinics where they were on duty. When that was the case, we agreed on meeting later at night, when they had night shifts, in the hours when it is very quiet and there are no patients for many hours. During the night shifts in the smallest health centres there is usually only the midwife on duty and a security guard, so it is easy to have privacy inside one of the offices for conducting an interview.

The interviews followed a flow that reflected the development of the study. I started with questions around the expression of labour pains; which was what called my attention and made

me choose my focus. From that I went to try to understand why women in the area expressed labour pains the way they do and how that can relate to the care they receive in the health centres. In that stage I also tried to understand what the place of labour pains in a woman's life is and in the process of becoming a mother. By the end I brought up the management of labour pains and the use of pain relief. The idea for this last stage was to understand how things are dealt with nowadays and what are their ideas around the topic. With that information I was hoping to understand if the quality of the care received by women there could improve with the aid of pain relief for labour pains.

I made sure to explain the project I was developing before the interview started, I made clear they were not obligated to answer any questions and I got the participants verbal consent. I also informed and ask the consent for recording the interview. To protect the participants identities, I kept personal information out of the data collection, such as names or age.

Data analysis

“Qualitative research is a form of research in which the researcher or a designated coresearcher collect and interprets data, making the researcher as much a part of the research process as the participants and the data they provide.” (Corbin and Strauss 2015, 4)

The data analysis for this study started even before the collection of the data itself. It was at the time when I was preparing myself to develop a research on topics related to maternal health and in connection with respectful care and users' perspectives. When searching for literature and reading on the matter I started already building a direction to the study and constructing a worldview that would latter influence the data collection and further analysis. Since the beginning I understood I was an important part in this study, my standpoint influenced my worldview, and that influenced my methodology and the methods I chose when collecting and analysing the data.

Even if I understand previous information influenced the collection and analysis of data, this research is manly inductive. It started from the identification of an odd phenomenon and moved on to its clarification. From that followed the determination of the area where to look for understanding, but what that understanding would be I expected to learn from the data. Although I approached the data gathering with topics in mind, the hypotheses linked to the phenomenon studied came from the data itself. Besides, if I consider my experiences and observation as data source, the topics I put together or the interviews also came from data.

For analysing the data, grounded theory was used, since the construction of the concepts and discussion was formed from the data gathered with the interviews on the field. Grounded theory is referred to here as “an approach to the generation of theory out of data” or “an approach [to] generate concepts rather than theory” (Bryman 2012, 387). The “concepts” or categories used for making sense of data were not chosen prior to the study but came from the data itself. In this study, data collection and data gathering maintained a cyclical relationship, a characteristic of grounded theory (Corbin and Strauss 2015, 7). After the first stage of the data collection, with observations, I built my interview guides and went on the next stage with the interviews. I kept on analysing the data I had while producing new data with more interviews and having the interviews shaped with time. When analysing it was from the information that came from the interviews that I took out the themes developed in this study.

The strategy for studying the data is the use of thematic analysis. Finding common themes in the different description of the participant’s experiences make it easier to understand the main features of labour pain in Uganda. The data was gathered, coded and then divided in themes to better illustrate the aspects to be discussed. The analysis was around empirical codes generated with the aid of the program Nvivo, those codes were posteriorly refined to better answer this project’s questions.

Silent Labour

This study ended up with two main categories of findings, one concerning expressions of labour pains and the other concerning management of labour pains.

The narratives in the interviews with both foreign volunteer midwives and Ugandan women confirmed my first impressions of women going through labour silently. The data brought also explanations for that phenomenon and displayed the complexity of the matter.

The second group of findings show that pain relief drugs are not used in the area for the management of labour pains and pains brought by procedures necessary in the moment of delivery. In the same way as in the first category, there are different explanations of why this happens.

Besides these two categories of findings, the interviews showed me a reality where the importance of motherhood is extensive in a woman's life. And data also showed that the beliefs about motherhood can end up influencing a woman's expectations, experience and choices for delivering a child.

The object to be analysed here is the labour pains, but since this is something which is always present in the moment of delivery it might be useful to understand better the perceptions women in Uganda have about the process of becoming a mother. I start with the theme motherhood in Uganda to paint a broader picture and then focus in the narrower topic of labour pains afterwards. I chose to do so because I am looking at labour pains as a social phenomenon to understand women's perceptions, experiences and the way they express and manage that pain.

Previous research in Uganda showed how "socio-definitions and perceptions of pregnancy" and "socio-cultural beliefs on pregnancy, which are culturally constructed and rooted in taboos, rituals and practices of their communities" could affect the seeking behaviour of antenatal and postnatal health care (Atekyereza and Mubiru 2014, 1). The same socio-cultural aspects may affect the way women experience and manage the pains of labour, or the way labour pains are managed in health facilities and the importance given to the use of pain relief for them. That is a part of what this research wants to understand better.

In the present chapter I will build the context by talking about motherhood in Uganda and how the interpretations of what it means to be a mother can affect the experience of delivery and maternal health outcomes. I will then present the two categories of findings. One concerning

expression of labour pains; with the title “Screaming silently”. The other concerning management of labour pains; with the title “Painful labour”.

Motherhood in Uganda: building context

“On the way back from the health centre we gave a lift to two of the Ugandan midwives. We were talking, and they were saying that [British Volunteer Midwife] should find herself a boyfriend, they were, in fact, demanding that she had to find herself a boyfriend. Then they asked me if I had a boyfriend and I told them yes. So, they went on asking if we had children and if we wanted children. When I told them I don’t want to have children they made a facial expression that made me feel like an alien. They were asking me why I didn’t want it in an almost accusative tone. And their faces could tell me they could not understand a woman not wanting to have kids.” (Fieldnote 26.09.2017)

“Here if you don’t get children, here if you get married and don’t get children its... I don’t know I can call it... very bad, and someone will always be longing for children. Culturally and even mentally it’s not good at all. And like other countries where man and woman decide not to have and they do not have, but here nobody would wish, either man or a woman, not to have the baby.”

(Ugandan Midwife Four)

The complete woman

Motherhood is still considered an important phase in a woman’s life worldwide. Even in the western high-income countries, not so long ago in history, being a mother and a wife was the major role played by women. Of course, nowadays women participate more and more in all areas of society and motherhood became a choice much more than a destiny determined by your gender. However, bearing a child is still something important and wanted by many women, and it is still something expected to happen in every society even if only for the sake of maintaining the population. The difference would be that in the modern western society a woman is still considered a woman if she chooses not to bear children. Besides, even if only the woman can experience motherhood in it’s whole, all the work involved in having and raising a child is being shared with the partner more and more.

In Uganda, motherhood seems to be crucial for a woman’s life. It is something my experience there showed me that virtually every woman aspires to experience and that is translated in the relatively high fertility rates in the country (World Bank 2016). The interviews showed me that being a woman and being a mother are as connected as to say both can mean the same thing in this context. Concepts as “complete woman”, “real woman” and “true woman” were used to describe those who experienced motherhood.

“OK, you are a woman, but not... how can I say it? Not a complete woman, because there are other things you don't know “you don't know labour pains??” (laugh) “you've never had any pregnancy?!” So... you are a woman, but you've not done that, you haven't gone through that, so you are not a woman... a complete woman.” (Ugandan Midwife Three)

“(...) you have to be a real woman, and you deliver at least one.” (Ugandan Midwife Two)

My observations while in Uganda made me understand that in that country there is much less participation of women in all areas of society and the place women can call their own is that of motherhood. In a context as this, being a mother is not only an important part of the life of a woman who chooses to have a child but is an important part of the life of every woman, “every woman's battle” (Atekyereza and Mubiru 2014, 6).

Motherhood is less of a choice and more of a fate, something you are expected to experience because you were born a female. Therefore, even to become a woman or to be considered a woman in this society one must bear children and must become a mother. That idea was already expressed in other qualitative studies interviewing women in the country. It is a widespread idea that “every true woman must be pregnant and successfully deliver the child normally” (Atekyereza and Mubiru 2014, 6).

Motherhood is also where women have all the power and all the responsibility, and that responsibility is usually not shared with others (Atekyereza and Mubiru 2014, 10). Because of the belief that to be a true and complete woman one should go through pregnancy and a normal delivery successfully and unattended, going to a health facility becomes a taboo. This is expressed in the literature and in the interviews, as in the example below:

“Because mothers also coming to the health centre like here, it's like a taboo, why go to the hospital? You can even deliver from home...” (Ugandan Midwife Three)

Pregnancy in Uganda can be understood then as much more entangled with the social dynamics. A woman becomes pregnant to fulfil a role in that society, to gain independence and be considered mature by others since she can produce children. A woman can become a mother in order to safeguard a marriage too (Atekyereza and Mubiru 2014, 6 -7). That's another idea that was already explored by other studies and came up during my interviews as well. Not that something similar could not occur in a high-income country from the west, but it's much stronger in a society that will more likely accept and even encourage a man to look for other women in case his wife doesn't provide him with children. Two of the interviewees explained to me how that could happen:

“If they are in the Village and they know you don’t have any child, the people will start saying “ah, do you know the other woman who was married the other man? She didn’t get any baby. Now she is staying in that house ten years, but no child.” Even the family members, they start telling that man “have you married a woman or what?” “Even you don’t have any child! Ah, you didn’t marry a woman. You marry another one!” Don’t you see? “You marry another one!”

(Ugandan Technician One)

“UMF: One cannot sit at home waiting for delivery, waiting, waiting... five years, two years, not getting pregnant. And other man decides to go outside and sneak.

Me: So if the woman is not getting pregnant the man tries to find another woman?

UMF: Yes.

Me: And that’s not a bad thing?

UMF: It is bad to the woman, for other people they say “but she has not delivered! So the man had to!” so they are supporting him.”

(Ugandan Midwife Four)

In a highly patriarchal society like this one, the social dynamics can influence women’s understanding of pregnancy and delivery, and whether they choose to search for health care. This type of system might convince women they should go through pregnancy unsupported and take the blame in case something bad happens. Very strong traditions may “for example, deceive women that pregnancy is a test of endurance and subsequently make maternal death just appear sad but normal reality” (Atekyereza and Mubiru 2014, 9 - 10).

The way Ugandan midwives explained it to me was as if to lay women there is sometimes no connection between delivery and health care. That would happen based on the idea that labour is normal process a woman can handle by herself and not a pathology or something one should need aid with. Inside that logic if something went wrong they could attribute the failure to misfortune, as the following passage describes:

“For them, mothers believe, it’s a normal process, you push the baby out... If anything happens maybe it’s just misfortune, you are just unlucky. But things are changing now.”
(Ugandan Midwife Three)

Rite of passage

Many Ugandan midwives explained to me that it is necessary to go through the experiences of pregnancy and delivery to be considered by others and by oneself as a real or a complete woman. That made me imagine the idea that if one would not become a mother she would have

the status of a broken woman, or a woman who is lacking on something. However, a Ugandan doctor put this in different words and made me understand that the experiences of pregnancy and delivery would actually work as some type of feminine rite of passage to achieve maturity. When becoming a mother, then, a girl would become a woman. I will transcribe next the moment when I understood that “real woman” or “complete woman” could mean “mature woman”:

Me: Do you think it's an important thing for women here in Uganda, to become a mother?

UDO: Yeah, it's very important... uhn... to be a woman in cultural aspects you have to bear children, something, so you have to have something to be considered a woman.

Me: So to become a woman you need to go through motherhood...

UDO: Yeah. You can just be a lady, a girl, then when you deliver someone say you can be something.

(Ugandan Doctor One)

There still can be found reference in the modern western society to motherhood as a rite of passage, with delivery being the breaking point and the great challenge women have to face in order to become a mother and part of this special group of people (McCabe 2017). The difference here is that this special group which psychologist Linda Shanti McCabe refers to is the group of mothers; one that could be identified as a subgroup in the category “women”. Meanwhile in the context of this study it could be said that “mothers” and “women” mean the same thing more than being one inside the other. Furthermore, in McCabe’s reality a woman has more freedom to choose if she wants to go through that “rite of passage”, and not choosing to do so will most probably not affect her status as a woman. Whereas in a society where “mother” and “woman” can be said to mean the same a woman will rarely decide on not bearing children, and if she does that, she won’t be considered a woman.

Attitudes towards C-section – the importance of vaginal deliveries

“...every true woman must be pregnant and successfully deliver the child normally.”
(Atekyereza and Mubiru 2014, 6)

Many times, the importance of motherhood for a woman’s life is not only expressed by the idea that one needs to become a mother to be considered a woman, but also by the beliefs around how one should experience the delivery of a child. Because the “normal way” is to deliver a child vaginally, the woman that needs to go through a c-section can be stigmatized or can have her self-esteem harmed for not being able to have a normal birth.

My interviews were made with health care providers, people that understand it is important for a woman and her baby's health to be referred to a caesarean section in case of complications. Most of the times they would tell me about the belief that a real woman should deliver vaginally they would associate that belief to lay women. In despite of that, in a couple of interviews it appeared that this same belief could also influence health care providers experiences. Those interviewees have access to the technical knowledge on pregnancy and delivery and are aware some women will benefit from a caesarean section. Even though it is possible to identify the culture they are coming from when they talk about their own experience with giving birth.

"...the doctor said "don't take a risk, this time you have to take the first Caesarean section". Then it was a good idea for the doctor, for me a refused the thinking I can't deliver the baby. If can deliver others, if others can come and deliver, why me? Caesarean section..." (Ugandan Midwife Four)

"Because in our culture, if a woman delivers by Caesarean section you are not a woman, unless you deliver vaginally, that's when you are called a woman. And to deliver vaginally you have to go through that experience of labour pain." (Ugandan Midwife One)

The importance of having a vaginal delivery also appear as influencing the bond between mother and baby. That would happen because after a vaginal delivery the baby is most times immediately given to the mother and that might not be the case after a Caesarean section. In that case, when going through a vaginal delivery the mother and the new-born would have their first contact earlier. A Ugandan doctor explained to me how it can be different for women that need to go through a caesarean section:

"...you handle them [the baby to the mother] and you go to maybe deliver the placenta, they are so happy "finally", yeah, so they create the bond earlier because they will receive their baby from that time on delivery, so they have an earlier time of bonding compare to these ones who are Caesar. Because after Caesar, they will first take the baby, probably waiting for you to recover." (Ugandan Doctor One)

This idea has an echo in the practices in high income countries and there is a lot of research on the topic. There is an effort to give mother and new-born an opportunity for a first contact as soon as possible after the delivery to help create a bigger emotional connection. This "technique" is called skin-to-skin contact and research shows it's importance for the emotional and physical health of baby and mother (Phillips 2013). Although, that being the case, the issue of skin-to-skin contact can easily be handled with for both vaginal deliveries and Caesarean sections, and that's being implemented already in many places by putting that contact as a

priority and handling the baby to the mother as soon as possible in both vaginal delivery and C-section (Pouraboli et al. 2018).

Even though many of these beliefs around motherhood and delivery appeared in the interviews, many of the Ugandan health care providers also brought up the idea that things are changing as more information reaches women. This happens in relation to a health seeking behaviour when pregnant, searching for skilled attendants when it gets to the time of delivery and the possibility of the need for a C-section.

Awareness and information appear as important for abandoning harmful behaviours or adopting better ones. I will talk more about this as it will appear in the data presented ahead. It is of the opinion of many Ugandan health providers that women in the country are becoming more aware of the existence and the need of assistance in labour, especially in case of complications.

“They used to take it as a misfortune or something, but nowadays at least people know that others can push and others can go for section... They are aware now. If you can’t push you go for a section.” (Ugandan Midwife Three)

“Screaming silently”

“Women are very strong around; they don’t show they are in severe pain. Because sometimes you see someone screaming silently, but when she is full. They don’t make noise.” (Ugandan Midwife One)

The thing that first called my attention and made me move forward on exploring the phenomenon of labour pains for this study, was the way women I observed at the health centres expressed themselves while being in labour or at the time of delivery. As described in the beginning of the thesis, I was puzzled by how silent women were around the maternity ward. I also found it to be very curious to notice what for me seemed to be women dividing their effort between pushing and keeping their composure when delivering the baby. Besides the realization that several times the women that are accompanying the future mother cover her mouth when assisting her to push the baby out.

I then built that first idea that women in Uganda express the pains of labour silently, or don’t really express the pains. Besides, I had the impression that expressing the pains loudly was not accepted socially. From that point I decided to interview women about the matter to confirm or debunk that first idea I had. I interviewed foreign volunteer midwives that were in Uganda

working with maternity care in the health centres of the region of Fort Portal and I interviewed Ugandan health workers from the same region.

By the end of the data collection I had my first impressions supported by the foreign volunteer midwives' perspective and understanding; probably reflecting a similarity in our cultural background. Several foreign volunteer midwives pointed at a big difference in how women express themselves in the region studied and in their countries of origin, or in the United Kingdom, where all of them had worked.

Something that kept being repeated in every interview with foreign volunteer midwives was how different women express themselves in Uganda. The interviewees explained that Ugandan women are very quiet; for some, the interpretation was that they don't really express what they are feeling. Below I present some of the passages where these ideas were expressed:

“So, women [in Uganda] are a lot more quiet than at home, I noticed that...” (Foreign Volunteer Midwife Five)

“I think [Ugandan women express pain when in labour] very different that what we are used to.” (Foreign Volunteer Midwife One)

“And about to how they express it, women are so much more expressive in England (...) Whereas here I don't know if it is a cultural thing or whether they've been told that they can't (...) Because they are quite always mute, always robotic in regards to like the labour and the birth (...) and I do miss that from being an English midwife. I miss having women express themselves a bit more.” (Foreign Volunteer Midwife Three)

“The Ugandan women I have observed labour almost silently and often I would look at them and not even know they are in labour.” (Foreign Volunteer Midwife Two)

Most of the foreign volunteer midwives explained to me they believed the reason for this difference is cultural. Examples are in the passages that follow:

“Because I think their culture doesn't allow them to express the pain.” (Foreign Volunteer Midwife One)

“In the UK it's very normal to be very vocal and vocalize your pain. And here, my feeling is that that's not acceptable.” (Foreign Volunteer Midwife Two)

Cultural background appeared many times in the data as an explanation for women in Fort Portal to try to be silent when in labour. Some other reasons appear together with culture to explain the need women have not to show they are in pain. This one and others will be discussed in more depth in the next section of this chapter.

The foreign volunteer midwives brought up one thing they consider as an issue related to the lack of expression perceived by them. Most of them declared they have difficulties when trying to understand if a woman is in labour, in which stage of labour, or in how much pain a woman is in. This could end up affecting the quality of care. If the midwife has barriers when trying to access the state of the woman they are caring for, they might not be able to offer the care that's necessary for the given situation. When one considers that Uganda receive the aid of many volunteers in the health area, this issue gains amplitude. Different practices and what could even be called a "cultural shock" should always be addressed to insure the foreign aid will be of no harm, and that it will be of best quality.

"(...) if I wasn't looking at them, if I wasn't a midwife and I wasn't tracking the contraction then I wouldn't know something was going on." (Foreign Volunteer Midwife Three)

"(...) it's a really different experience to the UK because, as midwives we read women's signals to tell how far in labour they are, for example. And in the UK I feel very confident doing that, I can see that a woman is in early labour, active labour or pushing; and here I have been thrown off all the time because I can't tell how much pain a woman is in." (Foreign Volunteer Midwife Two)

From the interviews with the Ugandans I got a confirmation of my first impressions to a certain extent, at the same time they widened my understanding of how one can express being in pain. I got from the interviews with Ugandan women that they usually try to contain the pain instead of showing it.

"But I've seen mothers walking into the labour suit with no care taker, they just sit there and then they call us "I am in labour" and before you know it they are pushing before someone has come, and they are not screaming." (Ugandan Doctor One)

Different from the foreign volunteer midwives, who see women labouring silently as something strange and might even miss women expressing themselves louder, Ugandan midwives see women being quiet when labouring as how things should be. Besides, Ugandan midwives told me they can understand if a woman is in labour and what stage of labour a woman is at, even if they don't express the pain loudly.

You see this one is trying to contain the pain, but she is feeling it (...) Here, in Uganda, we usually don't show pain too much, but you can tell, we can tell... (Ugandan Midwife Four)

The idea that women in the area studied might express their labour pains in a different way than what I would expect appeared in a couple of interviews. It was brought up even in interviews with foreign volunteer midwives, as shown in the following excerpts:

“... I feel like they are just expressing themselves naturally you know like, some of them will be moving around, they will be arching their backs, adjusting their bodies to deal with the pain, there is not a great lot of laying on the bed and there is a lot of really quietly but still physically expressing the signs of being in labour...” (Foreign Volunteer Midwife Five)

“the only thing I have notice that a lot of them do, they tap a lot, tap their foreheads, their leg... Themselves. Not hitting, just kind of tapping during a contraction, or they chanter or mumble to themselves about something.” (Foreign Volunteer Midwife Three)

I made specific questions to Ugandan health personal on how they see women expressing the labour pains and how they can tell if a woman is having a contraction or how far in labour she is. In the extract bellow one of the midwives explains that body language and facial expressions are more common than the vocalization of that pain and those are the signs they can use to identify the stage of the labour that woman is at.

“... they turn their back, they are maybe talking to you and you have the pain [in their] face expression... [they don't make] a lot of noise, but the expression, you see... bearing down, you see... you can just see them and say “oh, that's a contraction (...) it's more of a body language (...) maybe you will be talking and the woman stops and, you see the face expression, you see everything and you know that's a contraction.” (Ugandan Midwife Three)

“...most women, the way they control their pain, is moving around and keep walking, others will prefer to lay over the side, others will take tea. Only that taking tea increases the contractions, so it is more pain, so that's not a way of relieving pain... small walking and laying on the side.” (Ugandan Doctor One)

Yeah, that's how I have seen some things differing, for these years I have been in this field. And there are some who are really painful, you see that she is getting it, but she is just squeezing herself like an African. Because she gets “uhm..” but you see it's really hot (like hard)... she keeps smiling, just waiting for the time of the baby (Ugandan Midwife Two)

One thing that I believe is important to notice is the way the Ugandan health providers talked about women not being loud when in labour. Many of the times they would use the pronoun “them” when saying that women believe they should be silent in labour. That brought the idea of a difference between health providers and lay women. That difference was made bigger when I asked directly how those health providers expressed pain in their labour, or how they expected they would express it in the future. Almost all of them told me they screamed and were loud or they believed they would “be a screamer” when in labour. Some of them recognised themselves as being part of a culture where you are not supposed to be loud but labelled themselves as different. This part of the data poses a challenge in this study and exposes one of its limitations. Because all the interviews were made with health providers it is

not possible to build the discussion “us” versus “them” between health providers and lay women. It is not possible then to get to a conclusion if the women interviewed are different from other women inside that given culture or if the beliefs around being silent in labour stay mainly in the interpretation of the “ideal labour” with practice being different. The only source of data I can rely on regarding lay women is my observations in the health clinics, in which I saw how silent women were when in labour and at the time of delivery.

“Because, that’s a normal pain they believe! But me I was there!” (Ugandan Midwife Three)

“I think, myself, I will be screaming a lot. In my culture you don’t really find people screaming like that, people are calm, people are cool, but I think I will be a screamer.” (Ugandan Doctor One)

“Yeah, here you are not supposed to make noise, but me I was just screaming like... Because people tend to cover the feeling, what they are feeling inside so they might not think they are not strong, maybe your mother in law is around and she gonna say “ah... that one is was(?)”. So they tend to hold the pain as much as possible. Me I could not hold the pain; it would come I would “ahhhhhh” (laughs). I was really different, from...” (Ugandan Midwife Three)

Something that may point to a real difference between health providers that have more study and lay women is the way the health technician interviewed explained how she expressed pain in her labour. Because she was the exception in using the pronoun “them” and differentiating her from “other women” that go to the health centre. Occupying the position of technician, this participant was the one with the lowest level of education and, therefore, the one with more proximity to lay women. In this case the pronoun “them” was used in relation to the women who would be loud when in labour, the ones who were doing it wrong. On the other hand, when referring to herself and her daughters she would emphasize the importance of being quiet. The justification used was that there would make no difference to be loud, the pain would still be there and all one would achieve by crying was to disturb the midwives.

No... as for me I didn’t do anything. I just feel that pain I feel, keep quiet. But some of the people, some of them, are making noise, but as for me... I even tell my daughters “if you get pregnant, when I am around, and I hear you making a noise I can beat you. It’s for what? It’s not good for when you are getting the labour. For what? Even if you can talk or cry that pain is not going away.” (Ugandan Health Technician One)

Besides building a picture of how women in Uganda express their pain, I wanted participants to explain to me what they thought made women act the way they do. From both groups interviewed I got many inputs that can help explain why women don’t express the labour pains

loudly. I divided the data in possible answers to the question “Why women in the region of Fort Portal, in Uganda, labour silently?”. I ended up with the categories that follow.

“I also think they are stronger than we can be...”

Women in the area studied being stronger was one explanation for the non-expression of pain. Both foreign volunteer midwives and Ugandan women brought this idea in the interviews. The quotation chosen for this section’s title was taken from an interview with a foreign volunteer midwife and, in quotes used previously here in this chapter, Ugandan midwives said that “*women are very strong around*” and they don’t make noise but “*squeeze themselves like an African*”.

The way strength was brought as an explanation for the silence during labour was usually connected with the idea women had to be strong because that’s how women are supposed to be in their culture. That made me understand that strength would be acquired by women in that society more than being innate. A woman has to be strong for being African, or for belonging to a given tribe, and that’s why one would cover the pain. Strength in this case can be understood as related to the culture and the social roles given to man and women and not something physical.

“You have to be brave! You have to be brave, you have not to show people that you are scared. So you must be strong, you cover.” (Ugandan Midwife Three)

Some interviews show more clearly strength as something acquired and learned and not something innate. They don’t underline that women ARE strong, but they say women need to SHOW strength. It is more related with what women are expected to be than with what they are. Women would try to fit into a roll that was given to them. In this explanation women must show they are brave and strong, and they can’t show their fear or their pain.

“You must be a strong woman, even if you are dying inside (laugh)” (Ugandan Midwife Three)

The figure of the mother in law appeared many times linked to the need women have to show they are strong. Delivering a baby turns into a moment for a woman to prove herself in the eyes of her mother in law.

“if you walk with your mother in law, I think you are gonna have to control yourself, you don’t want to show you are weak.” (Ugandan Doctor One)

“Because people tend to cover the feeling, what they are feeling inside so they might not think they are not strong, maybe your mother in law is around (...) So they tend to hold the pain as much as possible.” (Ugandan Midwife Three)

“... at a point you are gonna think “I will just calm down” especially if it’s your mother in law, you don’t want her to see you screaming so much.” (Ugandan Doctor One)

Some Ugandan midwives were more specific about which cultures had stronger women. They said women from some of the tribes in Uganda are known as screamers when in labour and some labour silently because they are strong. So even in the area studied there could be some women who would not follow the idea that one can’t be loud when in labour, depending on from which tribe they would come from. Although it was more common to hear from the Ugandan midwives that they had contact with louder women when they worked in other parts of the country, around the capital of Kampala. In this case it could be inferred two things. One being that around Kampala it would be more usual for women to express their labour pains loudly because they are part of other tribes with other cultures. The other that those women could maybe express their pain louder for living in an urbanized environment, different from a more rural area of Fort Portal.

“And you think it’s Ugandan women that are stronger?”

Not Ugandan women, because in Ugandaland, in Kampala, those people they can scream.” (Ugandan Midwife One)

“... I’ve been dealing with different tribes (...) Like my registration I did it in Mulago (Kampala) ... they can shout and shout and you think the woman is about to die... what I have not seen here around. (...) here, the culture differs I think. (...) They get pain, but they don’t shout how I saw those people there.” (Ugandan Midwife Two)

One Ugandan doctor that had experience working in the north of the country said: *“In the North and in Kavali, they are more strong, they don’t really scream a lot.” (Ugandan Doctor One).* That could also mean women there follow cultures from specific tribes or that they live in a less urbanized environment.

Shame

It appeared also the explanation that women are ashamed of expressing the pain, afraid of what other people will think of them and talk about them; that they are weak or a coward. That is not detached from the idea women must be strong or show strength. It could be said that I am

adding a new angle for the same matter. If a woman can't show she is strong she will be ashamed. A woman will try to show strength afraid of what others around her will think of her.

“When you make noise here, everybody will turn and look at you, and you will be ashamed. (...) Here actually when you are shouting you get ashamed, and people will talk about you “do you remember the other lady? Do you remember?” so you also fear that.” (Ugandan Midwife Four)

I said previously the mother in law appeared as an important person in this situation. Women would try to give a good impression in the moment of delivery and prove themselves. Besides the pressure of pleasing the mother in law, family members could be there remembering the woman to not bring shame to the family. Beyond being a moment when a woman must bring honour upon herself in front of society and her mother in law, delivery is also a moment when a woman must bring honour to her family. This shows how the experience of labour and of labour pains are something very entangled socially for these women. It is something beyond the private sphere of that woman and her baby. It extends to the whole family and it depends on the approval of the whole community.

“For example, you may have your mother, your husband that will be outside like around, maybe your sister also, they will say “please, don't shame us” it is like shame... so they say “be strong, be strong for us, because we are there for you” (Ugandan Midwife Three)

In the same scenario women would be coerced by others to act the way they do when in labour. That coercion could appear as a psychological threat or even a physical one. In the interview with a Ugandan health technician, who had eight deliveries, she was explaining how she expressed the pains of labour. She said she kept quiet because even if you cry the pain will not go away, but at the same time she said it is not good to make noises and she explained how she passes that idea to her daughters. That would be an example of a physical threat to make women behave when in labour.

“I even tell my daughters “if you get pregnant, when I am around and I hear you making a noise I can beat you.” (Ugandan Health Technician One)

On the other side, a Ugandan midwife explained people can talk about you if you make noise when in labour. That is what I called a psychological threat.

“Yeah! Here, they would say you “you are what, a coward, something like that?” Because, that’s a normal pain they believe!” (Ugandan Midwife Three)

It is a similar way of thinking of that previous explanation that women need to show they are strong. The society, or more specifically, important people around the woman (family or friends) would be coercing women to act in a certain way, independent on how they are feeling.

They are saving energy

“Well I thought about it a bit and my initial thought... ham... feeling was that it was seen as you have to be strong as a Ugandan woman and labour is something normal that women have to go through and you just have to put up with it. But some Ugandan midwife said to me “oh, no, it’s not that, they are just saving their energy”, which changed my perception a bit.” (Foreign Volunteer Midwife Two)

Here there is a purpose for being as quiet as possible when in labour, a more rational justification. Women would use their energy concentrated on pushing the baby, and for that they would be quiet during labour to conserve that energy that will be of better use later. That could be seen as a technique of labouring. I see a parallel with the technique of hypnobirthing, which is gaining some popularity in places like the United Kingdom and the United States. Hypnobirthing uses hypnosis to help the woman have a better delivery experience. When using hypnobirthing the woman “chooses to “tune-out” or to reappraise certain stimuli in order to focus more completely on the object of attention [delivering the baby]” (Beebe 2014, 50).

In this case, being quiet when in labour would be a choice for women, instead of something imposed to them. This is a more private explanation, it would be a strategy chosen by the woman to cope with the pains of labour. The same way some women in high income countries that have access to pain relief drugs but opt for a drug free labour. Some that will choose not to use pain relief for their labour will probably choose a technique to cope with the pains instead of getting rid of them. That would also be the case here, when women choose to focus on pushing and ignoring the pains.

“So I thought it was something that was imposed on women this of silence and internal coping, but actually maybe it’s something that comes from women feeling that this is their coping strategy, that if they are silent they’ve got more to save up and then they feel they are more in control of their labour.” (Foreign Volunteer Midwife Two)

The understanding of women’s behaviours in the moment of labour being rational ones could be extended to the relations between the pregnant woman and her attendants. The phenomenon I observed of the attendant covering the pregnant woman’s mouth when assisting her to push is one example. A Ugandan doctor explains to me why an attendant of the future mother would

tell her to keep her mouth closed, or even cover her mouth with their hand when it's time to push.

“Normally you are not supposed to like breathe, ok, you can breathe, but you can take in some air and try and bear down and push, so they tell her maybe to close her mouth, because other will leave their mouth opened and they will be breathing, so they are not really helping the pushing (...) Because normally you just say maybe close your mouth, or take in some air and close and concentrate on that pushing (...) Because if you don't do that, in the long run, you are going to end up being exhausted and have not really done a good job, the baby starts getting into distress, yet it could easily come out any time.” (Ugandan Doctor One)

Don't disturb the midwife!

“Some of the people coming and see you who is making a noise. A noise for what? And then will be disturbing the midwife, who is there helping you.” (Ugandan Health Technician One)

In this case women would also be coerced to act a certain way. The choice of being silent when in labour would be based on a fear of being mistreated. It can also be linked with cultural background and the beliefs around what is an acceptable behaviour for a woman in labour. In order to guarantee she will receive a good treatment in a health facility, a woman has to behave accordingly. From another angle, it could also indicate a strong hierarchy between lay women and health care providers.

Other studies focused on the matter of mistreatment uncovered a reality in Uganda and other countries where women were mistreated if they were not quiet (Jangsten et al. 2005). Jangsten's study found that in those contexts being quiet is understood as “good behaviour”, while shouting or crying is understood as “scandalous behaviour”. In the same study the findings were that midwives would directly say to women not to disturb them and louder women would be badly treated (Jangsten et al. 2005, 25). This study pointed to the same problems in part of the data. A foreign volunteer midwife touched that issue when describing to me her experiences working at health facilities in Fort Portal.

“One person said to me that the old women tell them not to make, not to express pain too much because they are gonna get told off by the midwives (...) They laugh at them if they do make pain, like if they do moan or anything, so you can see why they would be discouraged to show any pain.(...) In my opinion, why would I express pain, if all I am gonna get is being mocked at, or shouted at... you can see why they don't do it, so...” (Foreign Volunteer Midwife Three)

Fear of mistreatment is then not exclusively observed in Uganda, there are studies from other countries that show this same phenomenon. Women avoid expressing their pain and making

loud noises, even if they are suffering, afraid of being shouted at by the health care providers. The passage below is a study from Latin America describing the same situation.

“There was a senior female obstetrician, a little ill tempered, of whom I was afraid, and because of that I avoided screaming because of the pain as much as possible. I chose to suffer in silence in order to avoid being shouted at. It is worse if we scream when it hurt.”(CLADEM and CRLP 1998, 57)

This could signalize a bigger problem than the fact that women don't express the labour pains; if they do so because they are afraid of mistreatment. It signalizes a lack of communication between women and health care provider and it could potentially influence negatively the health care received. As described in a study from 2002 about violence against women in obstetrics services in many countries: “Relations in maternity units were often so tense that women were afraid to call for help, yell, or express their pain for fear of reprisals.”(d'Oliveira, Diniz, and Schraiber 2002, 1682)

A Ugandan midwife says there are many midwives who will try to stop women from making noise. She points out two variables related to them doing so, one is the attitude of the midwife and the other is lack of compassion based on not understanding the pain the woman is going through. She explains that even herself used to shout at mothers in labour in the past, before she experienced labour herself, but now that she understands the pain women are dealing with she leaves them be loud and make noises.

“UMT: Because even me when I was still schooling and I had not yet delivered any child, I could see the women crying and I say “what's wrong with you? What?!” But the time I pushed out one like this I said “my god, I will never shout at these woman, because I know what they go through.” At least I got some... I witnessed what that pain is.”

ME: But do you think there are midwives that try to stop them from screaming?

UMT: Very many midwives, who don't understand, and some have children, but she can't know... It depends also on the attitude of the midwife.

(Ugandan Midwife Two)

This shows that the treatment women receive in the health centres might vary a lot depending on individual characteristics of the health workers, that could point at a lack of a strong structure that would homogenize the care that is given as to always provide a high standard of care.

“Because midwives will tell you to stop shouting, keep quiet, wait for that thing for the baby to come, and you want to express what you are feeling inside, please stop. Not all midwives, but others are so good and others are rude (...) It happens, that’s what threatens mothers to come to the hospital.” (Ugandan Midwife Three)

“It’s a normal process”

In some situations the interviewees turned the table and made my notion of how a woman should behave when in labour as the odd one. The idea is that why would you cry or scream if that will not help with the pain and if the pain is not a bad thing, just something normal one has to go through.

“We don’t think it’s bad, they think it’s normal, someone gets pain. Most girls they come with their mothers, So the mothers tell them what they went through (...) But it’s, it’s a normal process, the pain is there and when you console the woman she doesn’t shout.” (Ugandan Midwife Two)

Maybe women just act as they see other women act too. It’s something normal inside a given culture, the way a woman expresses the pains is an adaptation to the cultural reality she finds herself in. The same way I explained before I have my notion of what’s a normal behaviour for a woman in labour from TV shows, movies and people around me, the same might be true for women in my study. That was the interpretation of some of the foreign volunteer midwives I spoke with and was the explanation given by some of the Ugandan midwives.

“... is it because it’s seen as a natural process, that everybody goes through. So, culturally, it is just accepted that that’s what’s gonna happen, that’s how you have a baby and that’s what happens until this baby arrives really...” (Foreign Volunteer Midwife Five)

“...it’s something to do maybe with the way they speak to each other about birth or the expectations they have about birth. And women watch each other labour here, so they are seen each other labour silently, and then they think that’s how you do it. And in the UK we are used to TV programs and screaming and shouting. So, I don’t really know, but it’s something I’ve thought about a lot since I’ve got here, because it’s so different, cause presumably the level of pain is the same.” (Foreign Volunteer Midwife Two)

The explanation here is then the culture. A woman has certain behaviours because she belongs to a certain culture. She learned in that culture how to behave, how to go through pregnancy and to cope with the pains of labour. It seems like an easy explanation, one does something one way because everybody else does it like that, and it’s been working until now.

“It depends, if you are find the culture where they are screaming, you also scream, if you find it that they are quiet, you also keep quiet.” (Ugandan Midwife One)

“It depends upon the culture and some individuals. Because, here women don’t make noise, they are very strong, but another culture near here, they make a lot of noise, so it depends where.” (Ugandan Midwife Three)

Uganda is a very multicultural country. There are many different tribes and ethnicities in its territory. Labouring silently would then be a localized phenomenon inside the country. That would be explained by the various tribes and different cultures stating how one should behave in each situation.

“UMT: In Kampala women they are called Baganda, they scream a lot, even in Kasese, they scream a lot, here NO.

ME: Ok, so it’s something from this area?

UMT: Yeah. The culture.” (Ugandan Midwife Three)

Painful Labour

“... In our country, Uganda, it is most of the women have to go through that pain. There is no need to give them pain killer (...) So, for us, we see it’s normal if someone goes through the pain, and you deliver your baby.” (Ugandan Midwife One)

In high-income countries in the west, labour pains can be a part of the experience of delivering a child or not; with the possibility available for women of choosing to have pain killers against the pains of labour (Lally et al. 2014). As the findings for this study will show, that reality is not the same for the low-income countries, which Uganda is part of. For women in those countries pain killers are not in the routine of delivery as it can be in developed countries. Pain killers are virtually never used against the pains of labour and, many times, they are not even used for minor painful procedures as episiotomies. In the reality of these women, pain is an integral part of becoming a mother. It is not strange to think that something that is so present for a given situation might gain reasons that will try to explain the existence of the phenomenon. It is also not strange to think that pain being always there becomes at some point as part of the culture of that population, gaining broader meanings and explanations.

Once again, I believe it helps here to have an idea about the context, to have down a bigger picture that will put the findings of this research in perspective. Public hospitals and health centres in Uganda usually lack basic structure and are underequipped with little material and personnel. The services available can’t meet the demand and it is normal to see hospitals that are crowded with patients who must wait for too long until they get to see a health provider.

This is also true for maternity services and one of the consequences of this is that many responsibilities have fallen on the shoulders of the midwives. Previous studies have highlighted this problem:

“In Uganda, the breadth of the midwifery role has been extended beyond care that can be provided with quality, with health centre midwives caring for 50–60 women per day including providing all immunisations, family planning, HIV counselling, as well as, antenatal care and supporting women during childbirth” (Filby, McConville, and Portela 2016, 10)

A situation as the one presented here could leave handling the comfort of the mother or labour pains aside; for being something non-essential. Which is understandable if there is not enough personnel and time to take care of everything. There are other things to be prioritized and there are no resources left to deal with something that is not an immediate threat to the woman or the baby’s life.

There are at least two factors affecting the way labour pains are dealt with in the area studied. One could be said to be the culture, or how people believe the matter should be taken care of. That can be linked to the beliefs explored in the previous sections around the topic of expressions of pain in labour. The way women express their pains is highly linked to their beliefs around those pains and it influences how they will deal with them. The other factor is the resources people have available to manage that pain; those being material, medicines, knowledge, time, and staff. Besides, labour pains are “normal pains” that will usually signalize something is working as it should instead of indicating a problem. That fact will play a role in a scenario where there are more important things to give priority to than to relieve women from that pain.

In most developed countries pain relief drugs are widely available for being used to help women cope or be freed from the pains they experience in the labour process. I am considering here two types of pains comprise in the concept of “labour pains”. The “natural” pains caused by labouring itself, that could be due to uterus contractions or the dilation of the vaginal canal. But also pains caused by any minor medical procedures that come to be necessary in the moment of delivery; such as episiotomy, or the use of instruments to aid the delivery, like the forceps. In that context, it is not uncommon that a woman will be presented with her options of pain relief when she attends prenatal consultations. When going for prenatal checks the mother to be might get information about what drugs or other coping mechanisms are available

and she will then choose which strategy she would like to adopt for her delivery experience (Lally et al. 2014).

In Uganda this is often not the case. Interviews with foreign volunteer midwives and with Ugandan mothers and health care providers showed a different picture; one in which virtually no woman gets pain relief for the “natural” labour pains and too many don’t get any type of pain relief if there is the need for a minor surgical procedure. The use of pain killer drugs occurs when there is the need for a bigger surgical intervention; when a woman must go through a caesarean section to deliver and in the post-operative. According to the data, anaesthesia can also be used for more complicated procedures, known for being very painful, as manual removal of placenta.

Ugandan midwives I interviewed have contact with foreign volunteer midwives and British charities that work in Uganda. They gave me a comparative description of the use of pain relief for labour pains. They are aware of the availability of pain relief in the United Kingdom and talk about a contrast between there and the reality in Uganda, as in the passage that follows:

“Here we don’t manage anything here, but in the UK mothers are being cared for, mothers have pain relief and they don’t go through the pain we go through. For us we are like animals hun, because we are in the forest cows with the babies. Nothing totally...” (Ugandan Midwife Three)

The practice of having episiotomies without the use of anaesthetics was something I saw while doing observations in the health centres and something that came up in the interviews. The reality is that the procedure of making a small incision to facilitate the delivery of the baby is usually made in health centres that many times don’t have anaesthetics available. But even that being the case, the idea that appeared in the study is that more than unavailability, the use of pain relief is not part of the procedure when performing an episiotomy.

“UMT: They had an episiotomy, for the first one, it was sutured live.”

ME: No pain relief for the episiotomy?

“UMT: No. Not pain relief at all.” (Ugandan Midwife Three)

In the explanations given to me by Ugandan midwives about when and why women would get pain relief drugs I could understand how the lack of resources can influence the way of reasoning. The procedures could maybe originate from the necessity of using limited resources the best way. The repetition of given procedures could normalize what was being done and people would stop thinking about the issue.

The logic I saw in this study was the focus on what can cause visible and immediate health issues. Things that could influence long term, as the satisfaction of the woman of any psychological distress stay in second plan. The reason a woman would be relieved from pain, as it happens in post-operative care, could be to avoid an infection for example. Women in labour or those who just delivered their babies can get access to paracetamol in some cases, but not stronger drugs.

“Yeah, most cases we normally give pain killer is to post-operative care. And those who have already delivered you can give paracetamol for that after birth pain. Then even the post operatives in the hospitals, they are given strong pain killers, class A drugs. Because that pain is too much. I have seen when someone has done a Caesarean section she gets that pain, you can end up getting sepsis, because it makes her ambulate in time. Because of the pain she can ambulate her hips in the bed, hence bringing in micro bacteria that develops so fast, so that woman should be relieved from pain... it’s better.” (Ugandan Midwife Two)

ME: I was just gonna come on to that. So in your experience, you’ve been in Kagote and Bukuuku, anywhere else? Kataraka... And in those three settings you think there is nothing at all to offer?

FVMT: Paracetamol, in all of these settings. There is pethidine, which is sort of an opioid and we use it in the UK, but here I’ve only seen it for manual removal, which is not labour, it’s like something that comes after, a painful procedure to... remove the placenta ...yeah. So, I’ve not seen pethidine used for pain relief in labour, and I think women just know that they are not gonna get anything.

(Foreign Volunteer Midwife Two)

Having access to pain relief when necessary, being because for that specific woman the contraction pains are unbearable or because any medical procedures known for being painful are needed is understood as part of good quality respectful care. The denial of pain relief, on the other hand can fall in the categories of physical abuse (Pickles 2015, 9), abandonment or denial of care (White Ribbon Alliance 2011, 2), or be characterized as obstetric violence (d’Oliveira, Diniz, and Schraiber 2002).

The attitude of not taking into account the pain a woman is going through when in labour can be interpreted as neglect “Sometimes, even though care is provided within the bounds of good practice, neglect is perceived because women are not given the information, support, and compassion needed for them to feel that they are being properly cared for.”(d’Oliveira, Diniz, and Schraiber 2002, 1682)

During the development of this research, after getting the picture that pain relief drugs are rarely used to help women go through labour, I moved on to try to understand the reasons behind that.

“The culture thing”

The reasons for not using pain relief drugs for labour pains are most of the times linked to the reason for not expressing labour pains. The same beliefs influence women and health care providers’ behaviours for the expressions and management of the labour pains. Even if one imagines there would be pain relief drugs available, women would maybe not want to use them. That could be due to a fear of being ashamed for not being strong as other women who went through labour without the use of anything. The use of something to help women go through labour could be seen as taboo, the same way some women would avoid going to health facilities for delivery. Or the simple reason that women believe it is just a “normal process” and it doesn’t need any aid.

“How I told you previously, about the culture thing, why would you go for an epidural if like many women in your culture bearded that pain and they gave birth normally, so as soon as you are done delivering you are gonna be like “ah, they gave her something”.”
(Ugandan Doctor One)

“My experience was... the pain are too much. You see, you start slowly, slowly, slowly... as time goes on, the pain increases, and then... how to say, in Uganda, in our culture they don’t give pain killers. So you don’t get any pain relief. Because they believe that labour is a normal process, you go through it and you deliver your baby.” (Ugandan Midwife Three)

“And it sounded a little bit as if it was like a taboo?”

Yeah! That was what, it’s just what I felt, me and my friend discussed that afterwards and you know, we were like “Christ what a brave woman, she didn’t even want to have the paracetamol.”

(Foreign Volunteer Midwife Five)

“There is also awareness”

Information and education about pain relief drugs and other coping mechanisms are important for the demand side to have an opinion about the use of pain relief drugs.

*“(...) most people are not aware about the epidural, or any other pain killer, they think it’s just a natural pain, they are not educated during antenatal that can also happen.”
(Ugandan Doctor One)*

One Ugandan midwife who had an exchange working and studying in the UK highlighted the difference in the information women have access to in Uganda and in the United Kingdom. That shows that information can give empowerment to women making them be more able to decide over how they want to experience one of the most important moments of their lives. So, more than believing it is normal to feel the pains and having that believe guiding women not to opt for pain relief, there is a lack of knowledge about the existence of such a thing. One cannot form an opinion about something one is not aware of. The focus here would be on the demand side, it is understood that professional health workers have had the education and are aware of the existence of pain relief drugs. What could be happening here is that the lack of knowledge from the mothers to be would prevent any type of pressure coming from the demand side for the availability of pain killer drugs.

“I think most of them, I don’t know, I am not sure, but I think most of them. Because they are aware. There is also awareness, because our mothers here may not be aware of something that other things that exist that can help... But there, at least I saw all the women I interacted with, they know what’s an epidural, they know there is gas and air, so, also awareness, they are always on the internet, reading things... they even read ahead...” (Ugandan Midwife Three)

“They don’t have that here”

Lack of availability could be a reason for not using pain relief drugs for labour pains. So maybe the “culture” developed to be the way it is, or maybe there is no education for mothers on the matter, because the drugs will not be there anyways. More studies on the matter would be necessary to establish a causality relationship between the variables unveiled in this thesis. I hope to contribute by showing the complexity of the matter; pointing to many of the components that might build a justification for why things work a certain way.

The women I interviewed are midwives working in health centres and dealing with deliveries that don’t need to be handled by a doctor or by major surgical procedures. The availability discussed here is the one for that scenario. It was mentioned already in the text that cases that are more complicated and need surgery have the use of strong pain relief drugs as procedure. Women that need to go through a caesarean section usually receive analgesics such as the epidural before the procedure and can get pain relief in the post-operative. According to the

women interviewed who also had experience from bigger hospitals, in that context they have the drugs available.

In the health centres where I conducted this study the only types of pain relief drugs available seem to be paracetamol and sometimes ibuprofen. This study didn't access how often labouring women receive those types of drugs which are usually available, nor the satisfaction with its effectivity. The data shows foreign volunteer midwives and Ugandan midwives believe the drugs available are usually not strong enough for pains occurring during labour. Besides the conclusion was there are no other options available for them to work with.

“They don't have that here. Back home we have gas and air, pethidine, diamorphine... and then you have the epidural, and... But here, they just don't have any options. All that I can give them if I know they are in a lot of pain is paracetamol.” (Foreign Volunteer Midwife Three)

“Well, I don't know why [we don't give pain relief for labour pains], but I think that is the... the deal that is done in Uganda. I don't know the reason why it could have. Be maybe funding, maybe money for buying them, because the supplies are not there.” (Ugandan Midwife Four)

“You don't have anything, for example, here in Kagote you don't have?”

Paracetamol. I don't think paracetamol can help you with that pain. You need something so strong which we don't have.” (Ugandan Midwife Three)

“We have only ibuprofen and paracetamol, those are the pain killers we have here. We don't have tramadol; we don't have anything more.”

(Ugandan Midwife Two)

Labour pains as necessary

Pain is something every mother is going to experience when giving birth. That is especially true for the context of Uganda, where the use of pain relief drugs for labour pains is not part of the routine in maternity care. Levels of pain might be different from woman to woman, usually mothers that have faster deliveries with less labouring times will report feeling less pain than mothers that labour for many hours before being able to deliver. Pain being the norm led women to see it as being normal and led people to try and understand reasons for it to be happening. The interviews made for this study brought different types of explanations that put feeling the pains of labour as something important not only for the whole process of becoming a mother, but also affecting family ties.

It was possible to see a connection with the “need” or obligation to feel pain during labour linked to the obligation of delivering vaginally. So, in that understanding you must feel those pains because they are a part of a normal delivery. If the focus was on the vaginal delivery it would be possible for a woman to go through this “rite of passage” and become a “complete woman” without the need of feeling the pains. But sometimes the focus is on delivering without any type of aid, and the use of pain relief would go against it. Finally, the focus can be given to feeling the pains; so, the pains have a reason to be and are necessary in the process. This research made me understand that, in some situations, in the perception of the women from the region studied the pains of labour have a reason to be and a woman should not prevent them to come or get relief from them.

The context studied has a big participation of foreign health providers used to a work environment where they can offer pain relief. My interviews were made with foreign midwives and local health providers. There was some frustration expressed by foreign midwives about the impossibility to offer some relief to women that were in pain. That raises a question: if maybe the demand for pain relief drugs is linked to a need that health providers must feel they are helpful more than a need that women must be relieved from pain. The following passage express that idea:

“Our access to pain relief in the UK is vats, we have it for everything and I am used to getting pain relief as an adult nurse where just bloody everyone just gets morphine for something, so I am used to just giving pain relief out. With a lot more access to a lot more different types of pain relief for different types of pain, and you are still accessing pain on a scale of one to ten, which is what we use in England. And when you ask someone might say ten while texting the boyfriend... so I am used to that culture where.... I am now in an environment where there is not much pain relief available and I am gonna struggle to see women in pain and I can't help...” (K4C Volunteer Five)

There were two main reasons for the pains of labour being important that came out of my data, I present them bellow:

- The pain comes with a reward, a baby

Something that kept being said by the Ugandan women interviewed was the importance of experiencing labour pains to create a bigger bond with the baby. The idea is that the woman will see the baby as a “reward for the pain” and remembering all the suffering she had to go through to get the baby out she will never abandon her/him.

“No, it was normal birth, I pushed my babies. But the pain, my God... pain relief... we believe it’s a normal process which doesn’t need pain killers, you go through it, so the attachment with your baby will be more strong. As in culture, it’s like: if you feel the pains, those pains will bring you closer to your baby, you will love your baby more because of the pain you went through.”

(Ugandan Midwife Three)

“They say you have to experience that pain so that you feel it, then you respect that baby.”

(Ugandan Midwife One)

“Yeah, because I’ve seen mothers saying “I carried my baby for this long and I had so much pain and then you want to take my baby away from me? You know how much pain I was in bearing this child?” so it’s more like it is a reward for the pain. So you see as a gift, you reward is there. It’s as if you won a gift, you don’t want to let go of it, it’s something special. So a baby would be like a special reward. After the pain. That’s what I normally get from the mothers, what they would say.”

(Ugandan Doctor One)

The importance of creating a bond with the baby appeared before when talking about the praise for vaginal deliveries and the possible problems of a C-section. Now it appears again, this time linked to a different nuance of the whole process of becoming a mother; the labour pains. Maybe also because a vaginal delivery is accompanied by the labour pains much more than c-sections that the pains end up gaining prestige. By having vaginal deliveries as the optimal situation for becoming a mother and a woman, and having pains virtually always present, it is expected that those will gain a deeper meaning. In this situation the variable which strengthens the bond between mother and new-born shifts from having a faster contact between the mother and the baby to experiencing the pains a vaginal delivery is accompanied by. That also puts vaginal deliveries as more desirable than c-sections, because anaesthetics are used when performing the latter. More importantly, that will affect the choices around how to manage labour pains independently of the need of a c-section; and that’s one of this study’s focus.

If it is believed that a woman should go through the pains in order to be a better mother and love that baby better, an intervention that would relieve them from that pain would be undesirable. In another context, that same view is defended by male midwife Denis Walsh. It is curious to notice how the reasonings of a British midwife can be the same as the reasoning of Ugandan lay women (Walsh 2009).

Denis Walsh uses the expression rite of passage referring to delivering a baby when criticizing what he says to be a routinely use of epidurals against labour pain. He believes that the loss of

the idea of delivering a child as a rite of passage is linked to the phenomenon. He also states that feeling the pains of labour are an important part of the experience of becoming a mother. He says, for example, that labour pains will prepare the woman for the responsibility of being a mother and he brings the idea that a natural birth without the use of pain relief creates a bigger bond between the mother and the baby. Because of that he believes women should be taught to cope with the pain much more than given a pain relief (Campbell 2009, Walsh 2009).

- “Let me respect my mom”

Another explanation of the importance of experiencing the labour pains was the belief that if a young woman goes through them she will learn to respect the older women, because now she knows what they went through.

“Because sometimes, these young girls, when they come to deliver, they feel that pain, when they go back they respect their mothers...”

(Ugandan Midwife One)

“...if they feel that pain they get scared “let me respect my mom, because she feel pain when was getting me delivered, even I saw it myself...”

(Ugandan Technician One)

The experience of labour pains is shown to have an importance for the society in this case. It becomes important to search for understanding on the implications relieving women from pain could have for the society in case.

Pain relief as dangerous

Even if there were stronger drugs available for relieving labour pains, that would not necessarily guarantee they would be used. There are other things to be taken into account, as the knowledge on how they work and how to use them.

I asked to the Ugandan midwives if they would give the pain killer drugs to women if they had them available. Some answers showed me insecurity on how to use them. Some of them also were aware of the complications that might come associated with the use of the drugs and said they don't believe Ugandan facilities are equipped properly to ensure its safe use.

“When you give some pain relief you can get an internal rupture, a silent one, and you do not see it, and then woman tears until she gets worse, that’s when you realize “Oh, am I getting a rupture in the uterus and I don’t see it?”, because of that pain relief you gave, whenever the pain comes you will not feel it... But if you don’t give the pain relief and she gets severe pain, which is not normal, which is beyond normal, you will realize it very easily. And you cannot get an internal tear without noticing it, even if it’s silent or... If you realize that “oh, even if she is getting these contractions it is too much”, yeah.” (Ugandan Midwife Two)

“... I would weigh the side effects, because other pain killers have side effects on the babies, so if I had it I would weigh the advantage, because the setting here is different from the setting in the UK, because you can give the pain killer, it gives foetal distress it struggles the baby and end up losing the baby. And a mother could push the baby, yet the pain would be there she would push an alive baby. So I would weigh. (...) Yeah, they have more equipment, the setting is so nice, the doctors are being accessed. Now, here, if you give a mother pain killer, you call a doctor, you don’t see a doctor, you rush to the hospital, you have no transport... you see? So I would weigh. I would weigh the advantages and disadvantages to give the pain killer.” (Ugandan Midwife Three)

This highlights how the development of pain management tactics has to use a global perspective. There are many aspects to be looked at for a safe and effective implementation of any pain relief strategies. It is important to access the demand side, to understand the acceptance of what will be offered. Besides, it is important to access the provision side and make sure the structure is in place, the resources are in place and there is enough quality training for health care providers to implement the pain relief strategies.

Conclusion

This study tells one story of the reality of Ugandan women when becoming mothers. This story highlights themes in connection with the issue of labour pains. These themes should be considered when there is the development of a study or a policy concerning maternal health, respectful care and quality of care.

The main topic of this thesis came up when I decided to narrow down the theme to be researched. I did so because I didn't believe I had the resources to pursue something so broad. In the end, investigating the way women express and manage their labour pains in Fort Portal pointed at so many directions that I believe I only narrowed the study topic down to broaden it up again later.

Two ideas kept being repeated along the development of this study: complexity and balance. Complexity that will be found when someone chooses to analyse something related to human behaviour. Balance between extremes that are sides of the dichotomies that appear when social reality is subjected to simplification. Those dichotomies exist in the academic and the medical world. The ones from the academic world are: natural vs. social sciences and insiders vs. outsiders' perspective. The ones from the medical world are: health providers vs. health users and under vs. over medicalization.

The development and conclusion of this study is based on the belief that those concepts should not be opposing to one another, but complementary. Many times, one side is prioritized in front of the other, when in fact the construction of knowledge and policy implementation would benefit from both sides working together. Apart from the duo under vs. over medicalization, which have both a negative impact in health services delivery and health outcomes. Inside of that discussion I believe the best way would be to go for a balance; which in the end would be something different from under and over medicalization, could maybe be called optimal medicalization.

This study showed how complex labour pains can be, and how entangled its experience and management is with the sociocultural context. I could identify five things influencing how women express pain during labour and five influencing how labour pains are managed in the area studied. Strength, shame, rationality (saving energy), fear of mistreatment and culture are the things influencing how women express their pain when in labour. Culture, awareness, availability, danger and pain as necessary are the things affecting the way labour pains are

managed. Further studies are necessary to determine how important are each of those aspects in relation to women's behaviour.

As highlighted many times in the text, labour pains are an integral part of the experience of delivery. That experience has a lot of social importance and can be interpreted as a rite of passage for women from childhood to maturity, when they become a woman completely. The place where the woman comes from will then influence her understandings around labour and labour pains and the whole delivery experience.

In the end the study shows that women in Uganda are quiet when in labour and delivering if compared to women in western countries. They tend to try to contain the pain, which can be a management strategy in itself. Some of the data pointed to the understanding that being loud when in labour is not widely accepted socially. The expressions of pain for those women end up appearing in a face expression, a body movement or a quiet chanting. Which again can be understood as intertwined with their tactics to deal with that pain.

In the management of labour pains in the area study there is not the use of strong pain relief drugs, except in case of a major surgical intervention, as in the need of a caesarean section. The data gathered here suggests some possible reasons for that. Cultural beliefs could be playing a role, lack of knowledge from the user side, lack of knowledge from the provider side or lack of availability of those drugs.

In relation to the cultural beliefs that could influence the non-use of anaesthetics for labour pains, two stood out. Both give importance to the experience of labour pains and, consequently, go against the idea of taking them away. One says the pains are important to create a bond between mother and baby. The other says they are important to young women to experience the pain, so they respect their mothers.

Although the study showed the existence of some beliefs that could affect the way women express or manage labour pains, many of the local health providers also brought the idea that things are changing as people become more aware and more educated. Awareness, education and information have a lot of importance in the matters of respectful care and quality of care.

I believe a new balance must be reached here, this time concerning cultural relativism. When applying a concept that was developed in a certain reality to another one, a certain level of cultural relativism can be healthy. Respectful care is something very strong in western high-income countries and it's a concept found mainly in the reality of the United Kingdom and the

United States. Obstetric violence is found more often in the reality of the Americas and it was originated in Latin America. Many times, these concepts have the goal to be constructed in a way that they can be applied globally but using the logic of people-centredness there is a need to adapt the concepts and practices to the sociocultural background of the patients.

We know there is a reluctance to access health services and we know that can be linked to quality of care. What we need to understand is what is the best way of defining what is care of quality. When looking at pain relief many questions arise that can point to aspects that are important when defining this quality care. The categories found here as explanations for people's behaviour can help shape health services that will fit the reality and attend people's needs and expectations. Understanding all the reasons behind the way women express and manage their labour pains is important to make maternal health services that will respect their perspectives and will be offered in a way they can accept.

Delivering a child, although being a natural process, is known to present many dangers to women's health, together with the new-born. For that reason, there are many efforts in place to bring skilled health care to attend women when it's time for them to have their babies. This study was based on the idea that there are two sides that should be considered; the one of the provision of services and the one of the demands coming from the user. The experience a woman has when utilizing health services for delivery will influence her future choices and the choices of women she has contact with. Therefore, it is important to promote the meeting between provision and user sides when shaping health services. And to make that possible it is important to understand the reality of the people to whom the service will be offered.

We've seen that there was a change in the way major international organizations deal with the issue of delivering health services that are of quality. Besides having the structure, technology, drugs, good number of health care staff and evidenced based practice, services must be people-centred. This study follows that change, believing that clinical quality must meet users' perceptions of quality. For that, services must be adapted to the reality of where they will be implemented. For people to be benefited from any health care and health outcomes to improve, people must first accept that care.

By choosing a qualitative study I wanted to use the concept of people centredness to the production of knowledge. When doing that I wanted to produce some new knowledge that could be added to the existing one to broaden the understanding around maternal health needs.

With the use of natural sciences methods together with social sciences ones I believe it is possible to find more effective solutions for the improvement of maternal health.

If thinking on the implementation of pain relief drug use in the area studied, I think this study has some to contribute. First, it raises questions on if it is necessary and beneficial for women there to have the option of using pain relief. The understanding about the benefits of pain relief drugs for labour pains must be broadened. My findings raise the doubt if women would be empowered or offended by being given the choice to be spared from labour pains. Second, it brings up the discussion about how possible it would be to have the use of strong pain relief drugs in that context. Drugs used in high income countries can have side effects and it is necessary a minimum structure and access to enough personnel to supervise the woman and deal with any complications that could arise.

The study also touches the issue of standardization and individualization of care. Having women aware of the existence of pain relief drugs and helping them make the best decision on how to manage labour is beneficial to respecting the individuality of every woman. Having a care that is individualized insures a maternal health care that is more humanized. On the other hand, care should be standardized in the sense that every woman will get the same respect and the best quality care independent on who she is or from who she receives that care. According to the local participants that is not the case in Uganda, where you can receive good or bad treatment depending on which midwife gives you care.

Several categories were then enumerated in this thesis that are useful for anyone who decides to investigate maternal health services in Fort Portal, Uganda. And some issues were also underlined, lack of resources, lack of standardized care, lack of information for women and strong beliefs around pregnancy and labour that can be harmful for the woman and baby's health. Those issues can be related to the quality of health care women have access to and can help explain why maternal health is not increasing as much as expected, with women utilizing skilled health care.

More than bringing answers and saying what type of policies should be adopted, I expect this study can contribute with new questions. I believe it highlights how complex social phenomena is and shows social studies should not be simplified. In order to find the best solutions to social matters it is necessary to go deeper and look for multiple perspectives that will help broaden the understanding of social reality. That is the biggest contribution I am hoping to make, adding a small piece of the big puzzle of maternal health.

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Appendix

Interview Guide for Foreign Volunteer Midwives

Introduction

Thank the respondent for participating in the study. Explain the purpose of this interview. Read the consent form and ask for permission to record the interview. Remind that we can stop whenever the respondent thinks it is necessary; there are no obligations to answer the questions; and the information will be kept confidential.

Topics and possible questions

Contextual questions (background):

How long have you been in Uganda?

In which health facilities do you work?

Do you have children?

Specific questions:

EXPRESSION OF LABOUR PAIN

Based on your experience in the country, how would you say women express their pain when in labour?

- Is it different from your home country? How?
- Why do you think it is like that?
- Have you seen differences in behaviour in one or another health facility you worked at?
- Do you think that affects your work (understanding of woman's needs or where in labour the woman is at and the provision of care)?
- Also possible follow up question regarding the reaction of others and the influence of the behaviour of the local midwives on how women express their pain.

MANAGEMENT OF LABOUR PAIN - AVAILABILITY OF PAIN RELIEF

What is your experience with pain relief here?

Interview Guide for Ugandans

Introduction

Thank the respondent for participating in the study. Explain the purpose of this interview. Read the consent form and ask for permission to record the interview. Remind that we can stop whenever the respondent thinks it is necessary; there are no obligations to answer the questions; and the information will be kept confidential.

Topics and possible questions

Contextual questions (background):

Do you have children? How many?

Location of the delivery

In which places do you work or have worked? (to all health personal)

Specific questions:

THE EXPERIENCE OF LABOUR PAINS

How was it when you delivered your first baby?

THE EXPRESSION OF LABOUR PAINS

How do women express labour pains in Uganda? How was it for you?

How can they understand if a woman is in pain and in what stage of labour they are at?

Why are women quiet when in labour?

Is it a bad thing to be loud when in labour?

MANAGEMENT OF LABOUR PAINS

How did you deal with your pains when in labour?

What kind of support did you get from the health providers to manage the labour pains?

AVAILABILITY OF PAIN RELIEF DRUGS (TO HEALTH PERSONAL)

Also try to understand from the health personal how they see the use of pain relief drugs and when they use it or when they don't.

Verbal Consent Script (interviews) – English version

I am a student at Oslo Metropolitan University, in Norway. I am studying a Master's Degree in International Social Welfare and Health Policy. I am developing my Master thesis with the topic of labour pain. I am interested in understanding how women express and manage their pain when in labour in Uganda.

If you agree to participate in this study, I will ask you questions about your experiences of delivery, your experiences as a health provider in maternity facilities, and your perspectives as a Ugandan woman or your perspectives as a foreigner working in Uganda. This usually lasts between 60 and 90 minutes. Some of these may be personal or sensitive questions. You are free to choose not to answer any question. You are also free to end the conversation at any time. If you decide to stop the conversation, you do not have to give me a reason why. I would like to record our conversation with your agreement.

Anything you tell me will be private. I will not use your name or any details that might identify you when I write and publish my work. I will not tell anyone that we have had a conversation, and I will not reveal any personal details. My notes and recordings will be stored securely and then destroyed after the study is completed.

Do you have any questions about me, my project, or this conversation before we begin?

You can contact me at marijansen@gmail.com, or on Whatsapp using the number +4792339736.

Annex



Randi Wærdahl
Postboks 4 St. Olavs plass
0130 OSLO

Vår dato: 16.08.2017

Vår ref: 55098 / 3 / L B

Deres dato:

Deres ref:

Tilbakemelding på melding om behandling av personopplysninger

Vi viser til melding om behandling av personopplysninger, mottatt 11.07.2017.
Meldingen gjelder prosjektet:

| | |
|-----------------------------|--|
| <i>55098</i> | <i>A road to respectful care during childbirth: developing the concept of obstetric violence in Uganda</i> |
| <i>Behandlingsansvarlig</i> | <i>Høgskolen i Oslo og Akershus, ved institusjonens øverste leder</i> |
| <i>Daglig ansvarlig</i> | <i>Randi Wærdahl</i> |
| <i>Student</i> | <i>Mariana Jansen Vieira</i> |

Personvernombudet har vurdert prosjektet, og finner at behandlingen av personopplysninger vil være regulert av § 7-27 i personopplysningsforskriften. Personvernombudet tilrår at prosjektet gjennomføres.

Personvernombudets tilråding forutsetter at prosjektet gjennomføres i tråd med opplysningene gitt i meldeskjemaet, korrespondanse med ombudet, ombudets kommentarer samt personopplysningsloven og helseregisterloven med forskrifter. Behandlingen av personopplysninger kan settes i gang.

Det gjøres oppmerksom på at det skal gis ny melding dersom behandlingen endres i forhold til de opplysninger som ligger til grunn for personvernombudets vurdering.

Endringsmeldinger gis via et eget [skjema](#). Det skal også gis melding etter tre år dersom prosjektet fortsatt pågår. Meldinger skal skje skriftlig til ombudet.

Personvernombudet har lagt ut opplysninger om prosjektet i en [offentlig database](#).

Personvernombudet vil ved prosjektets avslutning, 20.11.2018, rette en henvendelse angående status for behandlingen av personopplysninger.

Dersom noe er uklart ta gjerne kontakt over telefon.

Vennlig hilsen

Katrine Utaaker Segadal
Kene C hristine M. Brandt

Kontaktperson: Lene Christine M. Brandt tlf: 55 58 89 26 / lene.brandt@nsd.no

Vedlegg: Prosjektvurdering

Kopi: Mariana Jansen Vieira, marijansen@gmail.com



Personvernombudet for forskning

Prosjektvurdering - Kommentar

Prosjektnr: 55098

The purpose of the project is to analyse traumatic childbirth experiences of women in a specific municipality in Uganda.

The sample will receive written and oral information about the project, and give their consent to participate. The letter of information is well formulated.

There will be registered sensitive information relating to health.

The Data Protection Official presupposes that the researcher follows internal routines of Høgskolen i Oslo og Akershus regarding data security. If personal data is to be stored on a private computer, the information should be adequately encrypted.

Estimated end date of the project is 20.11.2018. According to the notification form all collected data will be made anonymous by this date.

Making the data anonymous entails processing it in such a way that no individuals can be recognised. This is done by:

- deleting all direct personal data (such as names/lists of reference numbers)
- deleting/rewriting indirectly identifiable data (i.e. an identifying combination of background variables, such as residence/work place, age and gender)
- deleting digital audio files

Please note that also the "Co-researcher" must delete all personal information connected to the project.

The Data Protection Official for Research reminds that the researcher must be aware of possible reactions from informants who have been victims of violence/trauma, and implement measures

to address this. As this could be considered a vulnerable group, we further refer to the Research Ethical guidelines for social sciences, humanities, law and theology (NESH), in particular chapter B. paragraph 14 (confidentiality) and Section C. paragraph 22 (consideration for vulnerable groups).