Jordanian women's experiences and constructions of labour and birth in different settings, over time and across generations: A qualitative study

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Abstract

Background: Overwhelmingly, women in Middle Eastern countries experience birth as dehumanising and disrespectful.

Aim: To examine Jordanian women's experiences and constructions of labour and birth in different settings (home, public and private hospitals in Jordan, and Australian public hospitals), over time and across generations.

Method: A qualitative interpretive design was used. Data were collected by face-to-face semi-structured interviews with 27 Jordanian women. Of these women, 20 were living in Jordan (12 had given birth in the last five years and eight had birthed over 15 years ago) while seven were living in Australia (with birthing experience in both Jordan and Australia). Interview data were transcribed verbatim and analysed thematically.

Results: Women's birth experiences differed across settings and generations and were represented in the four themes: 'Home birth: a place of comfort'; 'Public Hospital: it's what you do'; 'Private Hospital: buying control' and 'Australian maternity care: a mixed experience'. In each theme, the concepts: *Pain, Privacy, the Personal* and to a lesser extent, *Purity (cleanliness),* were present but experienced in different ways depending on the setting (home, public or private hospital) and the country.

Conclusions: The findings demonstrate how meanings attributed to labour and birth, particularly the experience of pain, are produced and reproduced in different settings, providing insights not only into the medical and institutional management of birth, but also the social context influencing decision-making around birth in Jordan and other Middle Eastern countries. In the public hospital environment in Jordan, women were treated in a dehumanised way with no privacy, no support for people and no access to the pain relief they wanted. This was in stark contrast to women birthing at home only one generation before. Change is urgently needed to offer humanised birth in the Jordanian maternity system,

Introduction

Overwhelmingly, women in Jordan and other Middle Eastern countries experience birth as dehumanising and disrespectful [1-4]. Studies report that there is little rapport between women and health professionals, that women lack information about the facilities they will birth in or the procedures that will be used, and women do not always give their consent for procedures [2, 3, 5, 6]. Typically, women labour in bed, alone with no access to a support person [2, 5] or privacy [3, 7], and receive limited support from health professionals [6]. This phenomenon of mistreatment by health professionals is not isolated to the Arab world [8-10] and has garnered the attention of the World Health Organization (WHO) and Safer Motherhood [11]. Studies in countries such as the United States, United Kingdom and Australia are reporting that mistreatment during labour and birth is driving some women to seek alternatives and for some, this is to birth outside of the mainstream maternity system with no health professional present [12-14]. For some women, hospital represents a riskier place to give birth than birthing at home [15]. The

increasing dehumanisation of birth in Jordan and other Arab countries appears to have coincided with the move from birth at home to birth in public hospital facilities and the increasing medicalisation of birth. Not that long ago, birthing at home was considered normal for Middle Eastern women [7, 16, 17].

Authors suggest that significant change in the maternity systems is needed to improve the care and the experience of women in Jordan and the Middle East [2, 3]. But change will not be easy [1, 18]. As a first step, we argue it is important to understand the meanings that Jordanian women give to birth and to understand their birthing experience, including how they view the birth environment, how they construct experiences of pain in labour and birth and what influences these experiences. It is also important to examine what women themselves expect from maternity care and how they may want the system of care to change. To aid this understanding, it is important to explore women's perceptions and experiences of how birth in Jordan has changed over time, including the impact of change in place of birth. Therefore, the aim of this study is to examine Jordanian women's experiences and constructions of labour and birth in different settings (home, public and private hospitals in Jordan, and Australian public hospitals), over time and across generations.

Background

Birth in Jordan

The birth rate in Jordan in 2019 was 21.5 per 1000 population, a 1.24 % decline from 2018 [19]. Almost all women (96%) receive maternity care in hospitals provided by midwives – this includes antenatal care in hospital clinics and community health centres [20]. Three out of four births are attended by a doctor and 82% of mothers receive post-natal care by a doctor, midwife or nurse [21]. There are also increasing numbers of Jordanian women who seek care in private hospitals as a way to ensure privacy and care by specialist obstetricians who they have continuity of care with [22, 23].

This represents a dramatic shift in place of birth in Jordan across one generation with many women becoming grandmothers today having given birth to children at home in the late 1980s. It is only since the later 1970s that childbirth has occurred in hospital in the Middle East and this was influenced by Western medicine and technology [24]. Prior to this childbirth in Jordan was assisted by highly respected and experienced community women known as Dayas [17, 25]. In 1970s, the Jordanian Ministry of Health acted to reduce maternal and infant mortality by introducing a policy promoting hospital births by decreasing hospital cost to the women who birthed in public hospital and not allowing trained midwives to perform home births [17, 25]. At the same time, health care policies in Jordan discouraged home birth and traditional Dayas were only allowed to continue their work at home as a temporary process until they become too old to practice their profession [17]. Thereby experienced traditional midwives eventually died out.

The influence of western countries on birthing in the Middle East

The move to hospitalised birth took place in high income western countries at the end of the 19th and early 20th century, purportedly for the safety of mother and infant [26]. Health professionals and women increasingly came to view hospitals as the safest place to give birth, believing they would ensure positive outcomes, particularly with the increasing use of technology and birth interventions [27, 28]. This medicalisation has created a disconnect between the pregnant woman and her body. By medicalising childbirth, both women and midwives have been described as passive agents in the birthing process [27, 29]. This pattern appears to now be repeated in low and middle income countries including in the Middle East [29]. The increasing dehumanisation of birth in Jordan appears to have coincided with the increasing medicalisation of birth and the influence of western medicine in the Middle East [1, 6].

In Jordan, as in other parts of the world, midwives were originally educated in an apprenticeship style, working with traditional midwives or birth attendants [30]. This was particularly important in a country such as Jordan where women have a preference for a female birth attendant. Increasingly in the Middle East, midwives were trained in hospitals under the supervision of doctors and nurses. As The Jordanian Ministry of Health is responsible for the education and training of healthcare professionals (doctors and midwives) through nursing and midwifery colleges and public and private universities [30]. In 2002, a university-based program for midwives in Jordan was introduced to improve the quality of healthcare provided to pregnant and birthing women by midwives [31]. Jordanian midwives are faced with many challenges in terms of their education and practice, particularly the incongruence between evidence-based practices taught at university and clinical practice [31].

Previous research by the authors [1] revealed that doctors in Jordan dominate maternity care practices in the hospital and direct policy related to maternity care. Midwives are directed to follow the obstetrician's orders to manage normal births, and in some cases they act as assistants to the obstetricians in managing births [1]. In this highly medical context, it was also evident that health professionals – doctors and midwives alike – appeared to view women in a disparaging way, believing that they lacked knowledge regarding the birth process [1]. Health professionals in Jordan blamed women for the way they treated them during labour and birth and described them as uninformed and uncooperative [1]. This impacts on women and as reported in the introduction studies of birth in Jordan and other Middle Eastern countries consistently show how distressed women are at the dehumanised care they experience [2, 3, 5],

Change is needed

The WHO [11] explicitly states that to improve the quality of care there is an urgent need for more evidence and action on ensuring that maternity care is respectful, maintains women's dignity, and offers emotional support [11]. This is reiterated in the WHO position statement on disrespectful care [32]. Safe Motherhood for All calls for maternity care that is comprehensive, participatory, rights based, and uses evidence-based best practice. It is unfortunate that many laboring women across the world experience childbirth as abusive, disrespectful and dehumanised [8, 12, 15].

This WHO position statement on disrespectful care is not just directed however, at low and middle income countries. Increasingly there is evidence in high income countries (HIC), that women are being traumatised by their experience within maternity care systems where intervention in birth is high and medicalisation is impinging on choice and humanised care [12, 15, 33]. We also know from many studies in high income countries that the place of birth and the support women receive from their care providers profoundly impacts on women's birth experience [34-36].

The aim of this study is to examine Jordanian women's experiences and constructions of labour and birth in different settings (home, public and private hospitals in Jordan, and Australian public hospitals), over time and across generations. Women's stories can be a very powerful way of informing health professionals and services about the impact of the care they receive and how this can be used to promote practice change. In this study we draw on the theory of "Birth Territory", developed by Fahy and Parratt [35]. Birth Territory explicates the relationship between the birth environment or place of birth and issues of power and control, and the way the woman experiences labour physiologically and emotionally. It may also inform service redesign.

Methods

Study design and theoretical underpinning

This was a qualitative interpretive study [37] and was informed by a feminist approach and the theory of Birth Territory articulated by Fahy and Parrott [35, 38]. Qualitative interpretive description was selected as the methodological approach to guide the design of the study and analysis of the data [39]. Interpretive description was developed by Thorne, Reimer, Kirkham and Mac-Donald Emes in 1997 [40] and is commonly used in health research to develop understanding of and the meanings that shape how individuals experience a health events such as an illness or in this case, birth [41]. The interpretive descriptive methodological approach aligns philosophically with naturalistic inquiry as it recognises that the human experience is constructed by and dependent on the context in which a phenomenon is experienced, but also that there is the potential for shared realities [39]. The researcher understands that individual reality is a complex, subjective experience impacted on by the context in which it is experienced, and that they, the researcher, may influence the recollection of events being studied due to their interaction with participants [39, 41]. It is therefore an appropriate and broad approach to apply across cultures.

Birth Territory

Fahy and Parratt [35] drew on Foucault's work to theorise the birth room environment, describing the theory of 'Birth Territory'. Birth territory comprises two major concepts - terrain and jurisdiction. Terrain denotes the physical features and geographical area of the birth space and comprises two sub-concepts, Sanctum and the "Surveillance Room". The 'Sanctum' is defined as a homely environment designed to optimise the privacy, ease and comfort of the women; while the 'surveillance room' denotes a clinical environment that optimises, eases and provides comfort for staff [35, p. 6]. The concept of 'Jurisdiction'

refers to the power women have to do as they want within the birth environment. 'Power' is an energy which enables one to be able to do or obtain what one wants. The authors also identified 'disciplinary power' as a process that governs women's behaviour and directs women to follow health professionals' orders and be under their authority and control. Jurisdiction is comprised of four sub-concepts 'integrative power', 'disintegrative power', 'midwifery guardianship' and 'midwifery domination'. Integrative power refers to the power of all participants (women, midwives and any others person) in the birth environment. It is a kind of power that focuses on the woman's enhanced mind-body integration, so that she can respond spontaneously to her bodily sensations during labour and birth. Women's capacity to respond to her body is noticeably limited when they are not afforded privacy.

Fahy and Parratt [35] also described 'midwifery guardianship' as a form of 'integrative power' that involves midwives guarding the woman and her Birth Territory by controlling who accesses the birth space. This enables the woman to experience undisturbed labour and birth and promotes her sense of safety throughout, respecting her beliefs and attitudes during labour and birth. In Fahy and Parratt's work, 'disintegrative power' was described as an ego-centred power that interferes with other forms of power within the birth environment. This power could be used by the woman, midwife or any other person in the birth space. Regardless of who uses it, 'Disintegrative power' limits women's opportunity to feel, trust and respond spontaneously to her bodily sensations.

Fahy and Parratt's work is also informed by feminist concepts of patriarchy and domination. In this study of Jordanian women, feminist theory and methods privilege women's perspectives and experiences and attempt to explain the impact of patriarchy and patriarchal systems on women's experience [42]. At the basis of all forms of feminism is the perspective that women and their lives are valued and there is a focus on exposing women's oppression and a concern for transforming their lives [42, 43]. The aim of feminist based research is ultimately to transform the lives of women through understanding and articulating women's experiences, and challenging the dominant structures and social order [42, 44, 45]. Within feminist research it is recognised that women's voices have been silenced within male-dominated research paradigms and the intention in feminist research is to reveal women's ways of knowing and to give both women and their experiences a voice [42].

Study participants and recruitment

The study was undertaken in Irbid, Jordan and in Sydney, Australia. To capture a diversity of Jordanian women's voices, we sought the experiences of three groups of women. Recent mothers (RM), that is women who had become mothers in the past five years and experienced mothers (EM), that is women who had given birth at least 15 years previously. In addition, to enhance understanding of the meaning of childbirth experiences for Jordanian women we also sought women who had given birth to at least one child in Jordan and in Australia. There was no restriction on long ago women had birthed in Australia. These women are referred to as Australian Jordanian mothers (AJM). This diversity facilitated exploration of the changes in perceptions of birth and birthing practices over generations and in different settings and countries.

Inclusion criteria for the study were women who had a normal or instrumental birth. Primiparous and multiparous women were both included in this study. Exclusion criteria included women who had only ever given birth by caesarean section.

Ethical approval for the study was obtained from the University Human Research Ethics Committee (HREC) (Approval number H12048) in February 2017. Formal written approval was also obtained from the Jordanian Ministry of Health. Participants were recruited between March-May and September-October 2017 and December-February 2018.

Women were recruited through two major primary health care centres (Howara primary health care centre and Al Sareeh primary health care centre) in Irbid in Jordan. An information flyer about the study was placed on walls in both primary health care centres. The participant information sheet was distributed by administrative staff in the health care centres. This information was offered to both younger (RM) and older women (EM) who were mothers. The researcher (SH) was available to speak with interested women about the study in the waiting room of the health care centres and provided potential participants the translated information sheet. The participants were reminded that participation was voluntary and those that provided written consent took part in the study. Some women, particularly the EM, were also recruited in the Jordanian community through word of mouth and women's groups. In Sydney, information about the study was distributed through the Jordanian Women's Association. Snow ball sampling also occurred, with participants telling others about the study. Women who were interested in participating were asked to contact the lead researcher either by email or phone to discuss the study. All women provided written consent prior to the start of data collection.

Data collection

Data were collected by face-to-face semi-structured interviews with the women. Open-ended questions and prompts (see Table 1) were used to allow the participants to talk freely about their childbirth experience. Participants were asked to describe their birth experience(s) and explain their perceptions or the meanings they give to labour and birth. Their experience of pain associated with labour and birth was discussed and how they managed the pain during labour and birth including who was present or supported them. The interviews were arranged for a time that suited the women and were conducted in a mutually convenient place. The interviews lasted for 45 to 60 minutes and were digitally recorded. All the interviews were conducted in Arabic in an appropriate and respectful way by the first author. When interviews were conducted in a woman's home or in a community setting, the first author took food and drink to share with the participants which is an inherently Middle Eastern sign of respect and connection.

Data analysis

Interpretive description attempts to highlight the meanings and understanding of the research, using inductive analytic approaches, critical examination and reflection, to highlight the characteristics and patterns in the research which may inform clinical applications of the results [39, 41]. In undertaking this analysis, we followed the steps of thematic analysis outlined by Braun, Clark and Terry [46].

All the interviews were transcribed verbatim in Arabic by SH and then translated by an experienced translator into English. Following this, back translation was conducted by SH for validation. During this process, notes were made about the key issues that were arising. All researchers read the transcripts in full to start to make sense of the data. Then the transcripts were entered by SH into the program Quirkos. This involved a process of sorting, coding, labelling and developing preliminary interpretations or meanings of the data [46]. Reading and rereading the transcripts and also listening to the recorded interviews was an important step, as it allowed SH and the other researchers to become engaged and absorb the data. Following this, emerging themes were identified. Broader themes were often labelled with terms or words used by participants. Following the development of broader themes, further coding of the data in each theme occurred by identifying linkages and relationships between the themes.

Reflexivity

The first author is a Jordanian trained midwife and mother with a strong interest in improving women's childbirth experiences in Middle Eastern countries. SH has experienced birth in different health settings in both Jordan and Australia. In most interviews the first author also shared her own birth experiences as appropriate with the participants. Using a feminist approach, it is important to share the experience of the researcher with the participants to encourage them to talk freely about their own experiences, but SH remained conscious to not dominate the conversation with her story or not take away from the story being told by the participant. As a member of the community, SH is embedded in the culture and shares the dominant language of the participant group. This resulted in creating a high level of familiarity with 'the field' and the participants involved and this narrowed the gap between the researcher and the participants. During data collection, SH had regular meetings via zoom with her co-researchers and supervision team to discuss the data collection and any challenges encountered in the field. These reflections were recorded in field notes. The co-researchers are not from the same cultural background and acted as a sounding board for SH, checking interpretations and explanations of the data and findings.

Results

Twenty-seven Jordanian women were interviewed. This included 12 RM and eight EM living in Jordan, who were now grandmothers or would be grandmothers soon. A further seven Jordanian women living in Australia who had given birth to at least one child in Jordan and one child in Australia were also interviewed. The RM and the EM were not related in this study

Recent mothers were aged between 19 and 37 years, with a mean age of 31 years. Experienced mothers were aged between 50 and 59 years, with a mean age of 55 years. All the EM who lived in Jordan had given birth to at least one baby at home. In contrast, none of the EM who had given birth in Australia had given birth at home in Jordan. None of the RM had experienced a home birth as this is now a rare event for Jordanian women. All of the EMs had also experienced birth in public hospital with subsequent children except one EM and the comparisons they made during their interviews have informed this

analysis. In addition, four out of 11 EM had experienced birth in private hospitals. In contrast, 14 out of 16 RM had experienced birth in a public hospital and nine out of 16 RM had given birth in private hospital in Jordan.

All of the EM and most of the RM were multiparous, just two of the RM were primiparous. The EMs had between two and ten children and the RMs had between one and five children. Three out of 27 women had one child, four out of 27 women had two children and four out of the 27 women had more than five children. Seven Jordanian women in this study had given birth in both Australia and Jordan. For some their first birth was in Jordan, followed by a birth in Australia, and for others their first birth occurred in Australia with a subsequent birth in Jordan. (see Table 2 for characteristics of the participants).

The initial analysis revealed four major themes that reflected place of birth: 'Home birth: a place of comfort'; 'Public Hospital: it's what you do'; 'Private Hospital: buying control' and 'Australian maternity care: a mixed experience'. There were also four common concepts across the women's narratives - pain, privacy, the personal and to a lesser extent, purity. These four concepts were present in women's narratives over time, through generations and across cultures and in the different birth places – at home, in public hospitals and private hospitals in Jordan and in public hospitals in Australia. These were the narratives that EM passed to younger women in their families and each narrative emphasizes women's sense of being in control or her desire for control over her labour and birth. Each of the themes is discussed separately, however the experience of Jordanian women birthing in Australia is integrated across the first three themes related to birth in Jordan. This is illustrated in the Figure.

Home birth. A place of comfort and control

Only the EM in this study had birthed at home and they talked about home being a place of comfort, where they had the midwife and family around them, providing support. The women who gave birth at home viewed pain during labour as normal, something all women experience and they saw the way they tolerated it as representative of being a 'good' mother. Privacy and Purity or cleanliness were also seen as important and were identified as being consistently offered in the home environment.

Birth and labour pain are every day, normal events

For these EM, the dominant discourse around pain during labour was that it was a normal everyday event. It was seen as a part of life, occurring at home, where a woman recovers quickly and gets on with things. The following statements reflect this view: *"I think pregnancy and having a baby is an everyday activity"* (EM1)*; "It was the norm to go through that pain"* (EM 8) and "*It is something women do, I am not the only woman that gives birth we all do. Everyone is the same"* (EM3).

It was clear the women who gave birth at home expected a speedy recovery: *"The next day after giving birth I was up and running, cooking and vacuuming"* (EM 5). For these mothers, home was an accepted place for birth, something all women did:

"I would prefer (to birth) *at home more than hospital because there is no need to go to the hospital, it is something all women do"* (EM 4).

"At the time I started having labour pain, my family in law were occupied as they were going to visit a girl and to offer a marriage proposal for my brother in law. I told them I was in pain and to postpone it. So they called the midwife for me and they left me alone in the home with the midwife and went to the girl's house (for the proposal)*. It (birth) was something normal all women do"* (EM 1).

Most of the EM interviewed did not feel or remember the pain of labour and birth:

"I am the type I do not feel a lot of pain. I was surprised at that time because I had a mild pain not really pain and within half an hour I gave birth" (EM 1).

"So I told my parents that I had a stomach pain, so they took me to the doctor to see why I was tired, so the doctor examined me and said I would give birth in the next 15-30 minutes" (EM 2).

Pain is something that a 'good' mother copes with

Some of the EM believed it was important to handle the pain of childbirth to be a good mother. The phrase, *"I need to feel it"* was used by several EMs in their interviews (EM 3, EM 7; A-JEM 3) and EM 8 added, *"It is labour pain so no one can help you in relieving that pain and I think to be a good mum you have to feel the pain of birth"*. An EM who gave birth to her last child in a private hospital where pain medication seemed to be an assumed part of the service appeared to regret having pain relief as she linked labour pain with being a good mother:

"In the private hospital they gave me some painkillers in the end but I did not really need it and I think I can handle the pain and I should feel the pain to be a good mum" (EM 3).

This same woman reflected on her birth at home stating, *"There is no need for pain relief because I can handle it"* (EM 3). The EMs also talked about alternative, non-medicated approaches to pain relief, *"I had a hot shower and had some home hot herbs to increase my contractions and finish it quickly"* (EM 3) and *"The midwife helped me by doing perineal massage with olive oil, it helped me a lot"* (EM 7). Some of these strategies they used were spiritual in nature, *"This scared me but I prayed and made a lot of 'Prayers"* (EM 5) and *"The midwife put Quran for me that made me relax"* (EM 4).

I had privacy at home and it is clean

Birth at home was also preferred by the EMs because women's privacy was protected and they did not have to share a room, as was often the case in the public, and sometimes the private hospitals. At home the midwife was viewed as guarding women's privacy, *"She did not let anyone see me and asked them* (family members) *to stay within the same room but in a place where they could not see my body, to sit beside my head"* (EM 7). Some midwives preferred family members to stay in another room only allowing them permission for brief visits with the woman.

"The midwife at home gives me more privacy and care, I had been at home with myself and my family members stayed in a room beside my room" (EM 3).

The EMs also preferred giving birth in their own home as it was their domain and they knew it was clean, *"It is my house, it is cleaner"* (EM 7) and *"The home is cleaner* (than a public hospital)*, you are more comfortable in your own house and its environment"* (EM 1).

She stayed with me the whole time

While privacy was protected at home, women were not left alone. They either had support from the midwife or family, for example, participants described, *"She* (midwife) *stayed with me the whole time until I gave birth"* (EM 8); *"Yes I had my mum and my mother in law"* (EM 6) and, *"At home you were with family, sometimes in the room and sometimes just outside going about their business, so you felt comfortable"* (EM 1).

None of the participants included their husbands when talking about others' role at the home birth, as husbands were not allowed to attend the labour and birth at that time.

"My whole family is around me, my husband and the other kids but they stayed in the other room. I just feel better and more comfortable" (EM 8).

They described the kindness and compassion of the person who was with them, *"She* (the midwife) *was really good and very kind woman"* (EM 4). One EM contrasted their experience with birth in a public hospital:

"She used to be patient with me, not like in the (public) *hospital; they would leave you alone in the room. Staying with one person the whole time during birth is better"* (EM 2).

The women also talked about the practical support they received at home, *"Yes, they make 'prayer' for me, they supported me"* (EM 5) and EM 2 stated, *"Yes I think it is important they support her, help her, look after her and help her eating, drinking and going to the toilet".* Another EM stated this support was important because it could prevent postnatal depression, *"It is very important because there is no time for you to get depressed, they help you, they make you food and they stay around you most of the time"* (EM 1).

Mother to daughter: passing on birth stories?

Given their experience of birthing at home, the EM were asked what would they say about birth to their daughter / daughter in law. All of EMs except one EM tried not to frighten their daughter / daughter in law by telling them that the labour pain is a normal pain that they are going to go through. They have tried to reassure them by these words. As one EM told her daughter in law, *"It is like a daily event in life, nothing to worry about and you will not have a lot of pain when you give birth"* (EM 1); while another said: *"It is an easy process, not that much pain"* (EM 7). Only one EM told her daughter the truth about the labour pain,

"You are going to go through a difficult and painful process and you will stay with contractions and lots of pain for at least two days" (EM 5). And when we asked her about this, she replied that it is better for her daughter to know what she is going to go through and to expect a degree of pain so she will tolerate it.

Birth in public hospitals – It is what you do

Most of the RM and some of the EM interviewed had given birth in a public hospital in Jordan. The statement, *"It is what you do, you go to hospital for birth,"* represented the meaning that RM gave to birthing in a public hospital. The RM did not think that a woman had to suffer when giving birth, *"I did not want to experience the pain that's why I went to the hospital to give birth"* (RM 9). But this was not their experience and in contrast to birth at home, women birthing in the public sector spoke vividly and with distress about their experience of pain during labour and birth. For RM the "*pain was unbearable*", while EM birthing in either Jordan or Australia continued to see birth as normal and labour as something that good mothers embrace or at least must tolerate. In the context of a public hospital in Jordan, women's needs for privacy, personal care and support and for purity or cleanliness were not met. In the public sector, women had no option to request what they wanted.

Pain as unbearable

Statements from the RM reflect their distress at the pain they experienced during labour and birth, *"It was unbearable pain, I cannot handle it"* (RM 11); *"It was a nightmare and I really do not want to get pregnant anymore"* (RM 2). For RM, particularly first time mothers, the negative experiences of labour pain continued if they had an episiotomy during birth. As some RM said:

"It was very hard. Especially with my first baby because I had an episiotomy, it was very painful and hard to move around" (RM 7).

Recent mothers were particularly aggrieved that they had to experience this pain, declaring that *"pain was not normal"* (RM 11) and "*there is no need for it when you can take it away"* (RM 6) and RM 9 stated, "Y*ou should not have to suffer to be a mother*" (RM 9).

In contrast to these RM, the EM who had also had at least one baby in a Jordanian public hospital, continued to view labour pain as normal, something women do and tended to respond negatively to pain relief, *"I would not have asked for painkillers as I see no need for it"* (EM 5) and,

"It is something women do, I am not the only woman that gives birth, we all do. Everyone is the same. So why not be strong and handle the pain" (EM 8).

This same perspective was offered by the EM who had given birth in Australia. Even though mothers giving birth in Australia had more options for medicated pain management, they maintained their view that pain was a normal part of labour and birth: *"I need to feel it"* (A-JEM 3) and,

"I want to feel that feeling when the baby's head comes out of my body. At that time I felt that I was doing something extraordinary" (A-JEM 7).

The RM were distressed that they were denied pain relief in the public hospital. Even if they asked the midwives for pain relief in labour, the women stated they were not listened to, *"I asked for painkillers, they refused and told me 'it is good for you'"* (RM 6); and RM 11 stated *"At least give the woman painkillers to help with the pain; they do not give it at all even if it is your first baby"*.

Recent mother 2 described the response from midwives to her request for pain relief: *"go to a private hospital if you need painkillers".*

This experience contrasted with RM who had given birth in Australia, some of whom had the opportunity to discuss with midwives the available options for pain relief in labour: *"The midwife at antenatal clinic explained to me the options I have for pain relief in labour and I decided to choose the gas"* (A-JRM 5). This participant went on to say, "*There were a lot of options for medicated pain relief but I preferred to use Pethidine injection as it helped me a lot to ease my labour pain.*". However, the EMs who had birthed in Australia indicated they put up with the pain because they had no idea about pain relief in childbirth,

"No, I do not know but you know those days we did not know much about painkillers, no idea of this" (A-JEM 6).

However, the offer and use of medication was not necessarily a positive experience for the women accepting medicated pain relief in Australia, *"I just do not like things that make me dizzy and that's what these painkillers do"* (A-JRM 1). Other women stated: *"They gave me the gas. I do not like it as my mouth dried from it, and I felt it did not take the pain away."* (A-JEM 7).

Some women birthing in Australia were also critical of midwives, noting that at times the midwives refused to give them pain relief in childbirth or sometimes midwives "tricked" the mothers by convincing them to use the gas as a pain relief.

"My sister told the midwife to give me the gas, she said she does not need it; my sister told her just give it to her. She gave me the gas mask and we later noticed that she did not turn the gas on" (A-JRM 1).

They thought midwives sometimes withheld medicated pain relief, *"I am telling her I am in pain with no screaming but she refused. So I pretty much gave birth on my own with no painkillers at all"* (A-JRM 4). In contrast A-JRM 2 believed that midwives used medication because they were busy, *"I felt the midwives gave the gas to me just so I keep busy with it and they can help others".*

Privacy is non-existent

In the public hospital in Jordan there was no privacy. Experienced and recent mothers described the settings where they birthed in Jordan public hospitals, *"There are like six women in the same room, so no privacy"* (RM 6); and *"It was very easy for others to see me during labour and birth and that was very*

distressing for me" (RM 10). Some women did not voice concerns about privacy as it was what they expected. For example, one EM who had birthed in a public hospital considered sharing the same room with other women during birth as normal, but she insisted that the curtains should be drawn between the beds but that there is no need for each woman to have her own room, *"No it does not have to be that everyone has their own room, at least to have curtains closed all the time"* (EM 4). The description 'covered with a simple sheet' represented a level of privacy that was acceptable to some women *"However, they were very respectful and always covered me with the sheets"* (RM 7), while not for others: *"There was a sheet only covering the lower part of my body, but this is quite embarrassing, no privacy"* (RM 3). This lack of privacy was intensified by the invasive approach of some health professionals during labour and birth. For example, women talked of being examined vaginally many times and by many different people: "*It is embarrassing and makes you very uncomfortable"* (RM 4) and another stated:

"Yes, every time there was someone different examining me. That's the problem. It was annoying and frustrating and it hurts a lot" (RM 9).

The EMs who birthed in public hospitals 20 years ago in Jordan talked about being able to demand more privacy where there were no medical students attending the birth.

"Only the midwife and the doctor were present in the labour room in that time and this was a kind of privacy for me" (EM 1).

In contrast, the women who had birthed in a public hospital in Australia talked about the privacy they were afforded: *"I had a really big room, very clean and a bathroom for myself"* (A-JRM 5). All of them appreciated having their own room during labour and birth in Australia. As A-JRM 2 stated, *"Yes I was on my own room, on my own complete privacy"*. They also appreciated the care that health staff took care of their privacy during birth.

"Not one of my family is allowed to be in the labour room when the doctor is present for an internal checkup" (A-JRM 5).

The Australian Jordanian women also noted that they only had one midwife or health professional in their room at one time offering them more privacy in contrast to Jordanian public hospitals:

"You have your own room and you have one midwife and she introduced herself to me, but when the time of my birth was near, the midwife changed and I was attended by another because the previous midwife finished her shift." (A-JRM 4).

She left me alone

The experienced and recent mothers who birthed in public Jordanian hospitals reported that they were not allowed to have a support person with them during labour, *"They do not allow anyone to come in with me in the labour room"* (RM 7). Women also felt abandoned by health professionals: *"In the public*

hospitals they leave you until you give birth" (EM 6). Their request for support in public Jordanian hospitals was often met with the same response as when they asked for pain relief*,"When I told them to let my mum to come in with me in labour they said 'go to private hospital if you want to let anyone to come in with you in labour'"* (RM 9).

Most women wanted to have either their husband and or their mother with them.

"Probably my mum and my husband. That would be nice because they will help me and are there for me and support me" (RM 6).

Again the women who birthed in a public hospital in Jordan and also in Australia, contrasted the two experiences in terms of support:

"The hardest thing was when I went to the hospital (in Jordan) *and I was going to go in by myself with no one with me. I was very scared"* (A-JEM 7).

"At least stay with me (the midwife) *or let my husband be with me. They did not allow anyone to come in with me at all, they had no sympathy"* (A-JRM 4).

Some of the EM and the RM living in Australia and who had birthed in a public hospital in Jordan explained why they thought that the midwives and services in Jordan did not allow anyone to come in with them during labour and birth.

"They do not know how to treat the patient and the family. Maybe do not want families to interfere in their business; that's why they do not let people come in with their families" (A-JEM 3).

Not so clean

Some of the mothers, both recent and experienced, described hospitals as being unclean, *"The cleanliness in the hospitals, there was cockroach on the floor moved between beds in the hospital"* (RM 11) and EM 8 stated, *"The bathroom was very dirty, it was so unclean, blood and dirt everywhere in the bathroom"* and EM 3 described, *"She put me on a sheet full of blood and dirt and I told her to change it but she said 'we have no time you are going to deliver very soon, it is urgent,".* However, some of them considered cleanliness as sanitizing things in the hospital.

"One thing hospitals do not do is sanitise the cupboards, the beds that previous patients had been on. They should sanitize the beds, cupboards and things around you" (RM 6).

Only one experienced mother chose to give birth in the hospital rather than at home because she thought it was cleaner, *"It was always clean but really it is the visitors and the women that dirtied the hospital, not that the hospital itself is dirty or unclean"* (EM 1).

All of the women who gave birth in Australia appreciated the cleanliness of the hospitals in Australia. As some of them stated that, *"Everything around is clean and tidy, so you do not need to worry"* (A-JRM 4),

and, *"I can smell the cleaning products all around the hospital, so I can tell that this place is very clean and sanitized"* (A-JRM 1).

Private hospitals - Buying control

In the past 30 years there has been a dramatic increase in the number of births that occur in private hospitals in Jordan. Many participants of this study had given birth to at least one baby in a private hospital. This included nine RM and four EM.

Women choosing a private hospital were seeking control over their birth experience. The prime reason that women gave for choosing to birth in a private hospital was for pain relief. Private hospitals were also described as cleaner, offering some privacy through the ability to purchase privacy through a private room, and have family with you.

"You do not have to suffer as a mum"

The meaning of birth in the private hospital is captured in this statement *"You do not need to suffer as a mum"*. Recent mothers able to pay for a private hospital chose this option for a range of reasons:

"I want to go to private hospital because I want better care and treatment from the health staff. People that treat you properly. To have your family with you for support" (RM 7).

"In the private hospitals they give me a needle that helps you rest and relax" (RM 8).

But primarily they *"like(d) the idea of pain free birth"* and they preferred to pay to buy their comfort, privacy and care in the private hospital.

"I preferred to pay money as long as I was in a comfortable place. So if I needed something they would give me" (RM 8).

"It depends what insurance you had. The more you paid the more you guaranteed a bed on your own and other thing" (RM 12).

In the Jordanian private hospitals, there are two options of pain relief in labour - epidural or 'Dormicum and Valium' which sedates women during labour and birth, much like twilight sleep used in the past. Some RM liked the idea that they could be virtually asleep during the birth. Recent mother 8 stated, *"The injection. It calmed you and put you to sleep. That was right when the baby's head was crowning"* and RM 12 also stated *"I like the painkillers they used in private hospitals more than having an epidural and else you can wake up and then had the baby"*. In interviews the women were asked if they felt they had missed out on an opportunity to see their baby immediately at birth however, this did not worry some of the women. RM 1 stated, *"No, It did not bother me at all, I just want to finish"* and another RM 4 said: *"I wanted that needle, my doctor gave it to me and I asked for that needle once I was admitted to the hospital"*.

However, again in contrast, the few EM who birthed in a private hospital did not favour being asleep during birth. As EM 3 stated *"It disturbs the skin to skin bonding. I could not see my baby until three hours of giving birth"* and one EM 4 added:

"No I do not like the idea of being asleep when I gave birth. I did not see my daughter straight away and when I woke up I was confused and very tired to even hold my baby" (EM 4).

Gaining some control

Private hospitals offered privacy with your own room, RM 5 stated *"I had my own room at least, and I was in the same room the whole time, I was not moved to another room like public hospital"* and RM 1 noted *"In the public hospitals everything was opened, people coming in and out, no privacy at all. But in the private hospital there was privacy"*. RM 7 also stated *"They examined me vaginally every half an hour in the public hospitals but in the private hospitals every now and then".*

Although this was not always the case. Two women living in Australia and who had their first children in Australia were surprised at the practices in Jordan even in a private hospital:

"I gave birth, there was no bed for me in the maternity ward, they put me in the corridor for two hours waiting for a bed in a private hospital, with people coming and going and men also" (A-JEM 6).

"There was like five women giving birth with me, with no curtains, no nothing, everyone can see each other" (A-JRM 2).

Women also believed that the private hospital was cleaner, RM 5 stated *"I preferred to pay money as long as I was in a clean and comfortable place"* and EM 4 noted *"Big difference between the two* (private and public hospital), *with cleanliness".*

Some of the RM and EM preferred giving birth in a private hospital not just for the privacy they believed they would receive but so they had the choice of choosing a female doctor.

"If I was to get pregnant again I would go to private hospital because I want a female doctor who would be with me the whole time" (RM 12).

"They just gave me a female doctor as I was wearing the burga, they assigned me a female doctor out of respect" (EM 3).

Most of the Jordanian women who were birthing in Australia also reported that they had the choice of a female or male doctor while giving birth in Australia, "*They do not let any male doctors inside the room without your permission"* (A-JRM 4) and A-JEM 3 stated:

"They ask you if you want a male doctor from your monthly visits during pregnancy. They see you wearing a scarf and they know you would prefer a female. So they respect you and your religion".

Sometimes you have someone with you

When birthing in a private hospital in Jordan, women had hoped they would have someone with them. Most indicated that they were allowed one support person to come in with them, *"Yes, they allowed my mum to come in with me the whole time during labour"* (RM 5) and *"They help and support me. It is good to have someone with you; it eases the pain on you"* (EM 4). While others stated that some private hospitals refused their request to have someone with them, *"No, they did not allow anyone to come in with me in labour"* (RM 8).

In contrast, as noted above, the Australian - Jordanian experienced and recent mothers appreciated that the hospitals in Australia allowed some people to stay with them during labour and birth, *"It was lovely to have your family around you when you are in that much pain"* (A-JRM 4), and, *"I appreciated allowing my husband to stay with me the whole time in the labour room"* (A-JRM 2). Some of the Jordanian RM who had birthed in both Jordan and in Australia preferred to have their mothers or female relatives instead of involving the husband in the birth process; for example, *"So if it was a female relative would be better"* (A-J RM 2); *"I do not mind my mum but my husband was not much help"* (A-J RM 4) and *"I do not recommend the husband to come in as he had a hard time dealing with what he saw."* (A-J RM 5).

Only one of the RMs who had birthed in both Jordan and in Australia stated that she did not really want a support person at all in labour.

"I did not really feel I needed anyone as the midwives were good to me" (A-JRM 1).

In the Jordanian private hospitals, women were unlikely to have the same health professional during labour and birth, especially if the birth is complicated and difficult.

"But in private hospital, there was one or two midwives at most. I had not the same midwife the whole time during the birth" (RM 1).

The Jordanian EM and RM who had birthed in Australia had the same problem of dealing with different health staff during birth.

"I have taken a lot of time in my birth so I have dealt with more than one midwife" (A-JEM 7).

"My childbirth experience was a distressing time dealing with many health staff" (A-JRM 4).

Given their experience of birthing in a private hospital, the EM were asked what would they say about birth in a private hospital to the RM. Some of the EM told the RM that *"There is no need to go to a private hospital and pay a lot of money to only give birth there, it is just a few hours of labour pain and you can tolerate that pain as any labouring woman can do"* (EM 3), while others said: "*It (the private hospital) is just good in offering some privacy during birth but the pain is still the same and it is not good for you to take any pain relief, it is good for you to feel that pain"* (EM 1).

Discussion

The aim of this study was to examine Jordanian women's experiences and constructions of labour and birth in different settings (home, public and private hospitals in Jordan, and Australian public hospitals), over time and across generations. The women who participated had given birth either at home, or in a public or private Jordanian hospital or an Australian hospital between 1979 and 2016. The key concepts that emerged from the analysis were; Pain, Privacy, the Personal and to a lesser extent, Purity (cleanliness). Each concept was evident across the different generations of birthing women and in the different places (home and hospital) and countries they birthed in. Importantly, the experiences reported by participants demonstrate how meanings attributed to labour and birth, particularly the experience of pain, are produced and reproduced providing insights not only into the medical and institutional management of birth, but also the social context influencing decision-making around birth in Jordan and other Middle Eastern countries.

Social construction of birth and birth pain

Perceptions and experiences of labour and labour pain differed between the EM and RM. Experienced mothers believed that women's bodies were designed for labour and birth and that medicated pain relief was not necessary. Feeling the pain of labour was associated with being a good mother. Commentators have described the central position of women as mothers in Muslim cultures [47, 48] where mothers have been described as deserving of respect, generosity, and kindness, afforded to her by her children for her role in birthing and raising them [48, 49]. Alternatively, the RM argued that there is no reason why women should suffer pain in labour, that it was not the mark of a good mother and they were amenable to both technological and medicated approaches to birth. It appears in one generation we are seeing changes that occurred in many Western countries over two or even three generations of women.

These perspectives are arguably influenced by two major social movements. Firstly, the medicalisation of birth since the late 18th century in the Western world [26, 50], which resulted in a move from a social model of birth in the home [51] to birth in an institution with a high level of intervention [26] and secondly, the influence of the second wave of feminism. Until the 17th century, birth in most parts of the world was a social event, exclusively female and the only intervention was the presence of a midwife, hospital birth was uncommon [52]. With the advent of scientific medicine in the Western world, birth moved from the home to the hospital, and from a natural phenomenon to a medical event [53]. The 17th and 18th centuries saw a rise in the power and status of the medical profession which became the source of authoritative knowledge [54, 55], and was reflected in the status of those who hold that knowledge in society. In the 19th and 20th, medical influence gained control over birth through medical technology and the development of new forms of analgesia, anesthesia and caesarean section. As discussed at the start of the paper, the shift from home to hospital and the increased use of technology occurred later in the Middle East than in Western countries but arguably when it occurred it was a rapid change over one generation of women.

A study from Kabul revealed that fear of one's own death or losing the baby were important reasons for women choosing birthing in hospital [56]. This helps to explain the perception of the RM in this study, that birthing in hospitals is the best and expected place for them and their babies. Studies in the Middle East also showed that women respected the competence of health professionals and viewed them as experts who provided effective management of emergencies [2, 5, 7, 57]. This aligns with the participants', both the RM and the EM, who viewed the health professional as the only person who knows the best for them and their babies. These trends are in opposition to the increasing evidence that planned home birth is as safe as planned hospital birth for women with no, or few risk factors, resulting in less interventions and fewer complications [15, 58-60].

Second wave feminism has also influenced how women perceive birth [61]. Second-wave feminism is a period of feminist activity and thought that began in the early 1960s. It quickly spread across the Western world, with an aim to increase equality for women [42, 43, 62]. The feminist activists acted to provide protection and services for women who had been abused by men in their lives [62-64]. They also brought attention and raised the awareness to issues such as safe abortion, birth control and sexually transmitted diseases [65, 66]. Feminist critique of the burden of motherhood is complex [67, 68]. Early second-wave feminists also pointed out that maternity was the natural reason for women's oppression and believed that nothing will change for women as long as natural reproduction remains the rule [68, 69].

It is likely that some RM in this study subscribe to certain Western feminist ideas about birth. The RMs did not see that they should shave to uffer during labour and birth to be a good mother. They expected that they would have access to pharmaceuticals and technology enabling them to birth without pain. They also expected to have the support of their partner or family and that the environment would be private and clean. These women were often bitterly disappointed if there was no pain relief, partner support or clean environment. In this study it was clear that some RM then turned to private hospitals to meet their needs for pain relief, but again some were disappointed with their care. Interestingly, while birth in Australia offered women many of the things they wanted, there were some similarities in the negative aspects of the Jordanian experience. For example, some women birthing in Australia were also critical of midwives, noting that at times the midwives refused to give them pain relief in childbirth or sometimes midwives "tricked" the mothers by convincing them to use the gas as a pain relief. And they thought midwives sometimes withheld medicated pain relief. The Australian Jordanian women also noted that they had different midwives or health professional in their room at one time and it is hard to offer a female health provider as well.

Working with pain versus pain relief

The concept of labour pain was a dominant factor in this study. Leap [70] suggests that women's attitudes to labour pain can be divided into two models; 'working with pain' model and 'pain relief' model. Working with pain model clearly explains the EMs' perception and meaning of labour pain as a normal process and that pain during labour plays an important physiological role in the production of the body's natural pain-relieving opiates and endorphins. Internationally, studies indicate that women having home

birth work differently with pain and use a range of non-medicated approaches to pain in contrast to women in hospital who report higher levels of pain and have less options in terms of non-medicated pain relief [70, 71]. Michel Odent [72] and others [70, 73] write that the natural process of birth is best in a quiet, safe environment where women have privacy and those who support them (both family and midwives) are nearby. In this environment, most likely offered at home, women are able to work effectively with the pain of labour [70]. These views align with the beliefs of the EM in this study and earlier research in the Middle East by Kabakian-Khasholian [57] who described that in the traditional societies, childbirth was viewed as a normal event in a woman's life that usually happens at her own home and was supported by the family members. Other researchers have also reported the non-medicated approaches to pain relief, such as having a hot shower, drinking warm herbs, or having a perineal massage with olive oil is commonly used by Middle Eastern women [17, 74]. Experienced mothers also drew on their spiritual beliefs to support them through labour [16, 17, 74, 75]. For example, one EM described the midwife who read the Quran to her, reflecting the importance of spiritual beliefs in Jordanian women's lives

In contrast, Leap [70] argues that the dominant cultural approach to labour in high income countries is the 'pain relief model' in which using some kind of medicated pain relief in labour is the norm [70, 76]. The 'pain relief model' clearly explains the RMs' perception and meaning of labour pain as an unbearable pain that needs medicated pain relief. The RM were adamant in their interviews that no woman should suffer the pain of labour and that it is kind to relieve that pain using any kind of pain relief. With these expectations, the RM birthing in the public hospitals in Jordan and in some private hospitals, spoke with distress about their experience of pain during labour and birth. This experience is supported by the recent meta-synthesis of Middle Eastern women's experiences of birth [6] who emphasised that women in Middle Eastern countries experience birth as abusive, disrespectful and dehumanised. Women birth without family present, but in crowded spaces and with no privacy with limited options for medicated pain relief, and certainly there were no options for alternative sources of working with pain, like immersion in water or other non-medicated methods. Instead women suffer. Some RM then turned to private hospitals to meet their needs, again they were disappointed. The meaning of labour pain for the EM and RM is subjective and dependent on what is available and this further supports the generational differences in the meaning and experience of labour pain.

Control & Power – Birth territory

In Jordan and other Middle Eastern countries, the move from birth at home to hospital has disrupted factors such as one to one support and privacy known to assist the birth process and to support women to work with pain in labour [16, 17].

As introduced in this paper, the birth environment is a central concept in the theoretical work of midwifery researchers such as Fahy and Parratt [35] and Stenglin and Foureur [77]. Birth Territory as articulated by Fahy and Parratt's [35] identifies the relationship between the environment of the birth room and who has control over what happens in that space and during birth, and the way the woman experiences labour physiologically and emotionally. In this theory, the midwife has a responsibility to 'guard' the birth territory

for women – to ensure the environment is conducive to facilitating normal physiological birth. In this study, it was evident that at home the daya was able to guard the women's birth space, indeed some EM indicated that the daya kept family members outside of the room. In this environment, the women were able to labour and birth as they wanted and they spoke in a positive way about pain. Many studies report the benefit of continuity of care from midwives during labour and birth, describing how midwives support and guide women through pain, enabling them to feel confident and positive about their capabilities and inner strength [76, 78].

In contrast, in both the public and private hospitals in Jordan and even in some instances in Australia, it was evident that women had no control over what happened to them during labour and birth. As Fahy and Parratt [35] would explain, 'disciplinary power' in Jordanian hospitals governed women's behaviour and directed women to follow midwives' and doctors' orders. In these birthing environments, women were not able to respond spontaneously to their bodily sensations during labour and birth. As described by Fahy and Parratt this results in 'disintegrative power' which limits women's opportunity to feel, trust and respond spontaneously to her bodily sensations [35, p. 6].

In this study, some women demonstrated their intention to seize control over their birthing experience by seeking care in a private hospital. In making this choice, the participants were wanting to reclaim control over their birth experience, to control their labour pain, to ensure their privacy, and to assert the right to be accompanied by a trusted family member. Private hospitals were also marketed as having some of the comforts of home, together with some of the advantages of modern birth like medicated pain relief, something that should be, but was not available in public hospitals. In the private hospital women in this study reported being in control of some things such as privacy (own room) and pain where they can ask to be knocked out (a form of twilight sleep) [79]. They were also seen as cleaner and hence the desire for purity was also met more than in the public sector. Personal support needs, such as having a support person, was sometimes met but not always.

Seeking privacy

Research has demonstrated that a birth environment that provides women with privacy supports the hormonal processes of labour and birth [80, 81]. Numerous studies [7, 16, 82, 83] including one in Egypt [7] have reported that women feel more in control and emotionally secure birthing at home because they are able to maintain their privacy. This is consistent with the perception of the EM who had birthed at home and reported that they felt comfortable and secure in their own space at home. As described by the RM, Mohammad et al [3] described that in Jordan, most public hospitals are teaching hospitals and labour wards are usually noisy and crowded with medical, nursing and midwifery students. The situation is similar in Egypt [7] making the atmosphere very tense. Christiaens and Bracke [84] also indicated that participants voiced irritation at having to birth in a room with many other laboring women in public hospitals in Turkey.

Place of birth facilitates or disrupts personal support

The findings of this study revealed that at home women were not left alone. They either had support from the midwife or family. The lack of support from someone familiar and caring was a major concern for the women birthing in Jordanian hospitals. Their request for a support person in public Jordanian hospitals was often met with the same negative response as when they asked for pain relief. When birthing in a private hospital in Jordan, women in this study had hoped they would have someone with them. Most indicated that they were allowed one person to come in with them, while others stated that some private hospitals refused their request to have someone with them. In contrast, the Australian - Jordanian EM and RM appreciated that the hospitals in Australia allowed some people to stay with them during labour and birth.

There is significant evidence showing that support and continuity of care during labour decrease women's need for pain relief and reduce the length of labour [3, 70, 85] including a systematic review providing level 1 evidence of the benefits of continuous support during labour and birth [86]. This is also supported by studies in the Middle East [3, 85, 87]. A study conducted in Lebanon by Kabakian-Khasholian [88], showed that women greatly value the presence of someone who they know and trust during labour. Similarly in the UAE, Mosallam et al [85] observed a decreased length of labour and reduced need for pain relief and labour induction in women who had a supporter during labour and birth. In Jordan, women who had a female labour supporter were less likely to require pain relief and reported a satisfied childbirth experience compared with those who did not have a female supporter [89].

Purity and cleanliness

The EM in this study preferred giving birth in their own home as it was their domain and they knew it was clean. Some of the mothers, both recent and experienced, described public hospitals as being unclean. However, all of the recent and experienced mothers who gave birth in Australia appreciated the cleanliness of the hospitals in Australia. A good physical birth environment influences women's positive assessment of the childbirth services [90, 91]. Cleanliness and maintenance of hygiene were reported as determinants of satisfaction in studies in a number of LMIC [90, 92-95] and this includes good building infrastructure with water supply, beds and cleanliness [92, 93]. In Bangladesh, a study reported that participants who rated the availability of a clean toilet as 'good' were significantly more satisfied with the care than those who rated these facilities as 'poor' [92].

Implications for practice

This study demonstrates the high level of disregard for women and their need for pain relief, privacy and support during birth in Jordan. This disregard is deeply embedded in a maternity system dominated by medicine and associated patriarchal cultural practices and beliefs [2, 6]. It also demonstrates the important role that the place birth occurs has on women's experiences. Making change is not easy but it is important to consider what small changes could occur to start to make a difference to women's birth experience.

Recommendations for a way forward stemming from this study and others include increasing the opportunity for prenatal education classes focused on women's needs and most importantly improving the quality of emotional care provided to laboring women [3, 4, 96, 97]. Oweis and Abushaikha [96] and Kridli et al [97] both suggested that women should be offered childbirth education sessions that are culturally sensitive and present evidence-based information. These education sessions should also be adherent with religious practices and beliefs of the society. This however implies that the onus is on women becoming more educated and agitating for change without any responsibility on health professionals and services to change. El-Nemer et al [7] suggested that staff require education about compassionate care for women and Hatamleh et al [2] stated that midwives need to take a more active role in childbirth education and develop their knowledge and skills in normal birth to be able to support women to make decisions regarding their birth. Ultimately, health professionals must understand the impact of their practices. Using the voice of women, such as those voices presented in this study, may be one way to shift attitudes in undergraduate and continuing education.

Strengths and Limitations of the paper

This study offers an in-depth exploration of the concepts of pain, privacy, the personal (or social support) and purity or cleanliness relating to labour and birth reported by Jordanian women across different generations. It was unique in taking an intergenerational and cross country perspective which demonstrating that the birth environment impacts on women's experiences. The study offered an opportunity to explore the hegemonic nature of women's birthing experience in Jordan. Change is urgently needed and the first author is now leading a participatory action research study bringing women together with health professionals to identify strategies for change.

This study has several limitations that should be noted. First, the study was conducted in Irbid, Jordan where the EMs and RMs either birthed in the same public or private hospital and therefore the findings may not be generalizable to other women in Jordan and the Middle East. While the invitation to participate in the study was open to all, only 27 Jordanian women agreed to be interviewed in this study. This is small number of women from one country may not represent the views of other women. In addition, while we had set the criteria for RMs to have had their last child in the past five years, we found a number of women were very keen to participate who had their last child between 6 to 8 years previously. We agreed to include these women in the study. However, gaining insight from 27 participants provides a platform to understand Jordanian women's experience of labour and birth pain. Another limitation was that the participating women self-selected, so they agreed to be interviewed and women who did not agree may have had different stories to tell. Finally, women may not have necessarily felt comfortable to discuss everything they had experienced. Further research is needed for exploring the impact of all these four concepts on women's birth narratives and stories.

Conclusion

This study describes the experiences of Jordanian women giving birth across countries and through generations. It also explains that the four major concepts of Pain, Privacy, Personal and Purity remained centrally important across the different generations and in the different places and countries they gave birth in. This study demonstrates how the place of birth in Jordan (home, public hospital or private hospital) either ensures or disrupts privacy and having support of family members (personal). In the public hospital environment in Jordan, women (RM) were treated in a dehumanised way with no privacy, no support people and no access to the pain relief they wanted. This was such a stark contrast to women birthing at home only one generation before.

Pain became the dominant and central issue in this study but how women reported their experiences of pain varied across the generations and time periods. Pain experiences appeared to have been most influenced by the degree of privacy and personal support and care women experienced.

Declarations

Ethical Approval

This study was approved by the Western Sydney University Human Research Ethics Committee (HREC) (Approval Number H12048) with approval from the Jordanian Ministry of Health.

Consent for publication:

Not applicable

Availability of Data & Materials

The datasets used and/or analysed during the current study are available from the corresponding author on reasonable request.

Competing Interests

The authors declare that there are no conflicts of interest of any members of this research group to this piece of research.

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Authors Contributions

SH designed the study, collected the data, conducted primary analysis and led the preparation of the manuscript.

VS, HD and OO assisted in designing the study and guided data collection, supported and confirmed the data analysis and contributed to the preparation of the manuscript.

All authors read and approved the final manuscript

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Abbreviations

AJM: Australian Jordanian Mothers.

A-JEM: Australian-Jordanian Experienced Mothers.

A-JRM: Australian-Jordanian Recent Mothers.

EM: Experienced Mothers.

HIC: High Income Countries.

HREC: Human Research Ethics & Committee.

LMIC: Low and Middle Income Countries.

RM: Recent Mothers.

WHO: World Health Organisation.

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Tables

Table 1: Questions and key prompts used in the interviews

1. Can you describe your birth experiences for me? (prompt around where the participant gave birth; who was with her; what the services were like?
2. What does pain during labour and birth mean to you? How would you describe the pain and what did you do to manage with this pain?
3. Do you think that our attitudes to childbirth, including pain, are different to our mothers and why?
4. (For RMs) How did your mother or mother in law influence how and where you birthed? What did they say to you about labour and birth during your pregnancy?
5. (For EMs) How did your own mother or mother in law influence how and where you birthed? What would you or have you said to your daughter or daughter in law in relation to labour and birth?
6. Describe any particular cultural practices that are important to you in relation to birth?

Table 2 Characteristics of Participants

ɔther	Mothers' age	No. of children	Age of the mothers' last child	No. of children born at home	No. of children born in public hospital	No. of children born in private hospital
M 1	53	7	20	2	5	0
M 2	59	4	22	2	2	0
M 3	59	2	18	1	0	1
M 4	51	5	18	2	2	1
M 5	59	5	18	1	4	0
M 6	52	5	17	1	4	0
M 7	53	6	18	1	5	0
M 8	59	10	19	5	4	1
M 1	29	3	1	0	2	1
M 2	25	2	2	0	2	0
M 3	35	4	5	0	4	0
M 4	35	2	7	0	1	1
M 5	33	4	3	0	2	2
M 6	37	5	8	0	5	0
M 7	34	4	8	0	3	1
M 8	33	1	5	0	0	1
M 9	19	1	1	0	1	0
M 10	37	4	3	0	4	0
M 11	33	3	3	0	3	0
M 12	28	1	2	0	0	1
RM	30	3	1	0	2(Australia)	1(Jordan)
RM	32	4	1	0	2(Australia)	2(Jordan)
EM	50	4	17	0	4(3Australia & 1 Jordan)	0
RM	20	2	1	0	2(1 in Australia& 1 in Jordan)	0
RM	30	3	7	0	2(Australia)	1(Jordan)
EM	58	6	23	0	2(Australia)	4(Jordan)
EM	57	5	19	0	5(4 in Australia & 1 in Jordan)	0

Figures

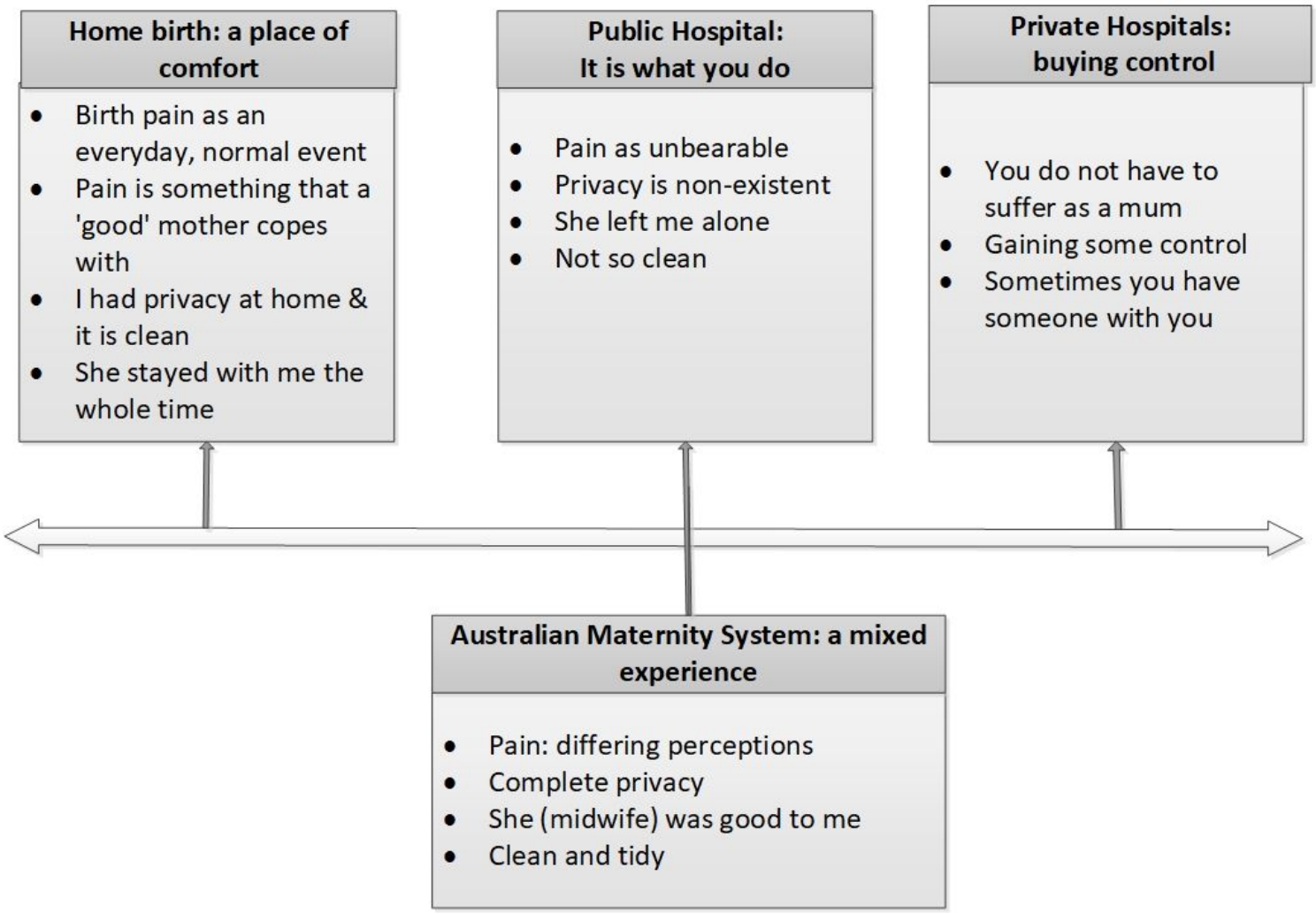

Figure 1

Thematic analysis

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