

**THE CHILDBIRTH EXPERIENCE AMONGST WOMEN FROM  
DIVERSE SPIRITUAL BACKGROUNDS:  
AN EXPLORATORY STUDY AT PUBLIC HOSPITALS  
IN THE UMGUNGUNDLOVU DISTRICT OF  
KWAZULU-NATAL**

**BY  
ANOOSHA RAMANAND**

A dissertation submitted in fulfilment of requirements for the  
Degree of  
Master of Health Sciences: Nursing  
Faculty of Health Sciences  
Durban University of Technology

Supervisor: Professor R. Bhagwan  
Co-supervisor: Mrs. C. N Adams

2016

## **Declaration**

I, Anoosha Ramanand, declare that the research reported in this dissertation is my original work, except where otherwise indicated. All sources used or cited have been explicitly acknowledged by means of complete references. This work has not been submitted previously to the Durban University of Technology or to any other institution for any purpose.

### **Anoosha Ramanand**

Signature\_\_\_\_\_

Date\_\_\_\_\_

### **Approved for final submission**

#### **Supervisor:**

Signature\_\_\_\_\_

Professor R. Bhagwan (PhD)

Assoc. Prof. Community Health Studies

Child and Youth Care Program

Durban University of Technology

Date\_\_\_\_\_

#### **Co-Supervisor:**

Signature\_\_\_\_\_

Mrs C.N Adams (RN; RM; MCur.)

Date\_\_\_\_\_

## **ABSTRACT**

### **Introduction**

Through centuries the birth of a baby has been considered as a deeply felt spiritual experience. Childbirth is not merely a physiological experience; it also embraces social, emotional, psychological, spiritual and religious aspects. In most Western societies the sacred moment of birth dissipates within the context of a pressured hospital environment. Whilst literature and empirical research has proliferated on midwifery very little has been done to explore how women experience childbirth personally and more importantly how spirituality interfaces within the context of the childbirth experience and midwifery care.

There is a growing body of literature on spiritually sensitive care. However, there remained a need to inquire about mother's personal experience and how spirituality interfaces with the childbirth experience in the hospital context.

### **Problem statement**

Whilst empirical research in the field of midwifery, has grown, research pertaining to the spiritual aspects related to women's diverse spiritual needs during childbirth is sparse (Crowther and Hall 2015). Furthermore little attention has been paid to issues relating to how women experienced childbirth in the public sector, and how religion and spirituality influence and impact on childbirth. It is against this background that the current study was conceived.

## **Purpose of the study**

The purpose of this study was to explore and describe the experience of childbirth amongst women from diverse spiritual or religious backgrounds viz. Christianity, Islam, African Traditional Religion and Hinduism, at public hospitals in the uMgungundlovu District of KwaZulu-Natal.

## **Methodology**

A qualitative, explorative, descriptive and contextual study design was used. A total sample of twenty-two postnatal mothers from the following common spiritual backgrounds in South Africa viz. Christianity, Islam, African Traditional Religion and Hinduism were purposively chosen. Data was collected until saturation. Participants were selected from three public hospitals in the uMgungundlovu District of KwaZulu-Natal. Data was collected by means of semi-structured interviews conducted six weeks post-delivery at the six-week health check, but within three months of delivery. Interviews were transcribed manually; the data was analysed through thematic analysis.

## **Findings**

The main themes drawn from the data reflected that childbirth was a deeply personal and meaningful experience. It was seen as a spiritual experience and spirituality was seen as a vital support system in enabling mothers to cope better with pain and other challenges. Emotional and comfort needs were also identified by mothers as being very important to cope with pain and an easier delivery. The presence of midwives and the need for partner and family support were also seen to be important. More importantly the study found that their spirituality and spiritually based activities and rituals were an important aspect of the overall birth experience. The study found a diverse range of spiritual practices and rituals that were salient across all the spiritual

worldviews during childbirth and post-delivery. It also found that mothers often resorted to alternate and traditional therapies to help cope with labour and delivery all of which have salience to midwifery practice that is both respectful and sensitive to the diverse worldviews of mothers.

## **Conclusion**

Collectively the data reflected that childbirth was a holistic experience that cannot be separated also from partner, family and medical support. Whilst traditionally effective midwifery practice may have been so to focus on primarily physical care, the study found that the physical component is interrelated with the psychological, social and cultural aspects as well. Hence effective and ethical midwifery practice is inseparable from these facets but most importantly inseparable from the spiritual worldviews that most mothers follow and ascribe to. Contemporary education needs to recognize the current move towards spiritual care and provide knowledge and skill to deal with patients from diverse spiritual backgrounds. Finally it needs to recognize as this study has found, that childbirth is a multifaceted experience which is spiritual in nature. Viewed in this way both midwives and the management of public hospitals should then make every effort to create spiritually sensitive care during the childbirth experience.

## **Dedication**

This study is dedicated to my husband Ashwan and my daughters Sarisha and Kevitha. A special thank you to my husband for his unconditional support understanding, love and care.

To my daughters Sarisha and Kevitha, a heartfelt thank you for the never-ending words of encouragement and technical support.

## **Acknowledgements**

A special thank you to my supervisor Professor R. Bhagwan, whose constant guidance, motivation, support and encouragement assisted me through this journey.

Thank you to my co-supervisor Mrs. C.N. Adams for your support.

Durban University of Technology for the opportunity to register for the Master of Health Science degree: Nursing.

Department of Health KwaZulu-Natal, for permission to use the facilities at the various institutions and clinics.

District Health KwaZulu-Natal for granting me permission to conduct my research at the clinics.

Operational managers in charge at the hospital wards for making initial contacts.

Sisters at the various clinics for using their facilities.

Mothers who participated in the study.

The librarians from the Durban University of Technology: Berea Campus - Mr Dennis Mpumlwana; Riverside Campus - Mr. Andrew Naicker.

My family, colleagues and friends for being supportive, understanding and tolerant with me during this journey.

Finally I thank God for giving me the knowledge and strength to persevere with this research study.

## **TABLE OF CONTENTS**

<b>CONTENTS</b>	<b>PAGE</b>
DECLARATION	i
ABSTRACT	ii
DEDICATION	v
ACKNOWLEDGEMENTS	vi
TABLE OF CONTENTS	vii
LIST OF FIGURES	xiv
LIST OF TABLES	xiv
LIST OF APPENDICES	xv
ACRONYMS	xvi
<b>CHAPTER 1</b>	<b>1</b>
1.1 INTRODUCTION	1
1.2 BACKGROUND TO THE STUDY	2
1.3 THE SOUTH AFRICAN NATIONAL HEALTH SYSTEM AND MIDWIFERY SERVICES	4
1.4 RELIGION AND SPIRITUALITY IN RELATION TO THE CHILDBIRTH EXPERIENCE	6
1.5 A BRIEF OVERVIEW OF RELIGIONS IN SOUTH AFRICA	9



1.5.1 African Traditional Religion	10
1.5.2 Islam	10
1.5.3 Christianity	11
1.5.4 Hinduism	11
1.6 PERSONAL RELATIONSHIP TO THE TOPIC	12
1.7 PROBLEM STATEMENT	13
1.8 PURPOSE OF THE STUDY	15
1.9 OBJECTIVES OF THE STUDY	17
1.10 RESEARCH QUESTIONS	18
1.11 SIGNIFICANCE OF THE STUDY	18
1.12 KEY CONCEPTS	22
1.12.1 Childbirth	22
1.12.2 Childbirth experience	22
1.12.3 Culture	22
1.12.4 Diverse traditional groups	23
1.12.5 Labour experience	23
1.12.6 Midwife	24
1.12.7 Postnatal	24

1.12.8 Religion	24
1.12.9 Spirituality	25
1.12.10 Tradition	25
1.12.11 Worldview	26
1.13 CONCEPTUAL FRAMEWORK	26
1.14 OVERVIEW OF THE RESEARCH METHODOLOGY	30
1.15 STRUCTURE OF THE DISSERTATION	32
1.16 CONCLUSION	32
<b>CHAPTER 2</b>	<b>33</b>
LITERATURE REVIEW	33
2.1 INTRODUCTION	33
2.2 LABOUR, NATURAL BIRTH AND THE MIDWIVES' DUTY	35
2.3 WOMEN'S CHILDBIRTH EXPERIENCES	39
2.3.1 Childbirth experience as a spiritual event	39
2.3.2 Childbirth experience relating to support	43
2.3.3 The aspect of 'presence' in the experience of childbirth	44
2.3.4 Working in partnership with women	45

2.3.5 A trusting relationship in the childbirth experience	46
2.3.6 Birth experience and being in control	47
2.3.7 Women's experiences of expectations during childbirth	48
2.3.8 Midwives experiences: Engaging with women during childbirth	50
2.3.9 Women's experiences of pain during childbirth	52
2.3.10 Women's birth experiences in hospitals	56
2.4 BELIEF SYSTEMS, ALTERNATIVE MEDICINES AND CHILD BIRTH	60
2.4.1 International setting	60
2.4.2 The local setting	65
2.5 CONCLUSION	72
<b>CHAPTER 3</b>	<b>73</b>
RESEARCH METHODOLOGY	73
3.1 INTRODUCTION	73
3.2 RESEARCH DESIGN	73
3.3 RESEARCHER ROLE AND REFLEXIVITY	75
3.4 STUDY SETTING	77

3.5 STUDY POPULATION	78
3.6 STUDY SAMPLE	78
3.7 SAMPLING PROCESS	79
3.7.1 Inclusion criteria	80
3.7.2 Exclusion criteria	80
3.8 Context of the study and sample	81
3.9 Sampling method	82
3.10 Pilot study	84
3.11 DATA COLLECTION PROCESS	86
3.11.1 The interview guide	86
3.11.2 The interview setting	87
3.11.3 The interview process	88
3.12 DATA CAPTURING AND DATA ANALYSIS	90
3.13 TRUSTWORTHINESS	92
3.13.1 Credibility	93
3.13.2 Confirmability	93

3.13.3 Dependability	94
3.13.4 Transferability	94
3.13.5 Authenticity	94
3.14 ETHICAL CONSIDERATIONS	95
3.14.1 Beneficence	95
3.14.2 Non-malificence	96
3.14.3 Respect for human dignity	97
3.14.4 Justice	97
3.15 LIMITATIONS	97
3.16 CONCLUSION	98
<b>CHAPTER FOUR</b>	<b>99</b>
PRESENTATION OF RESULTS	99
4.1 INTRODUCTION	99
4.2 PRESENTATION OF THEMES	104
4.3 CONCLUSION	139

<b>CHAPTER FIVE</b>	140
DISCUSSION OF THE FINDINGS, RECOMMENDATIONS AND CONCLUSIONS OF THE STUDY	140
5.1 INTRODUCTION	140
5.2 DISCUSSION OF THE FINDINGS	141
5.2.1 THE CHILDBIRTH EXPERIENCE	142
5.2.2 DIFFERENT SPIRITUAL BELIEFS AND PRACTICES	155
5.2.3 CUSTOMS AND CULTURAL PRACTICES	158
5.3 RECOMMENDATIONS	160
5.3.1 Recommendations for nursing practice and education	160
5.3.2 Recommendations for policy makers	162
5.3.3 Recommendations for nursing research	162
5.3.4 Recommendations for further research	163
5.4 LIMITATIONS	163
5.5 CONCLUSIONS OF THE STUDY	164
<b>REFERENCES</b>	166

## **List of Figures**

Figure 1.1: Dimensions of nursing in Native American Culture	27
--	----

## **List of Tables**

Table 4.1: Demographic profile of participants	100
Table 4.2: Derived themes	102

<b>List of Appendices</b>	<b>207</b>
Appendix 1: Letter of permission to KwaZulu-Natal Department of Health	207
Appendix 2: Letter of permission to the District Manager	209
Appendix 3(a): Letter of permission to Chief Executive Officer Hospital (1)	211
Appendix 3(b): Letter of permission to Chief Executive Officer Hospital (2)	213
Appendix 3(c): Letter of permission to Chief Executive Officer Hospital (3)	215
Appendix 4(a): Letter of information and consent to participants (English)	217
Appendix 4(b): Letter of information and consent to participants (Zulu)	221
Appendix 5: Interview guide	226
Appendix 6: Ethical approval	227



## **Acronyms**

CTG:	Cardiotocograph
PHC:	Primary Health Care
SANC:	South African Nursing Council
VIZ:	Namely
WHO:	World Health Organization

# CHAPTER 1

## INTRODUCTON

### 1.1 INTRODUCTION

For centuries the birth of a baby has been regarded as a deeply spiritual experience for couples. In most Western societies, however, the sacred moment of birth tends to dissipate in the milieu of the hospital environment. Whilst most midwives are aware that childbirth is a deeply personal spiritual experience, this is ignored within the highly medicalised approach which tends to focus mainly on the physiological aspects in the hospital environment. Emerging empirical work attests to childbirth being a spiritually-felt meaningful experience (Crowther and Hall 2015: 3). Whilst there is growing literature on the provision of spiritual care in nursing practice (Chandramohan 2013:1), little has been written about contemporary midwifery practice and whether it creates a space for a holistic and spiritually sensitive childbirth experience.

The experience of a first birth, or subsequent births, remains with a woman for a lifetime (Mensah, Mogale and Richter 2014: 29). Childbirth is not just a physiological experience; it also embraces social, emotional, psychological and spiritual aspects as well. This requires then that a mother's needs be considered holistically within the hospital environment.

Globally through the centuries, the childbearing experience has been deemed important and central to both a woman and her family (Berg, Ólafsdóttir and Lundgren 2012: 79; World Health Organization 2005b: 5). Mitchell (2001:1) described childbirth as a celebration of life. Furthermore, the childbirth experience has been described as an exceptional, momentous and incomparable moment that brings overwhelming joy (McGuinness 2006:

328; Goldstein 2012: 144; Lleras 2007: 19). For Bruyere (2012: 39) childbirth is one of the most spiritual experiences, despite an individual's level of religious attachment or religiosity. It has been described as a deeply moving experience which brings a mixture of profound emotions and discovery (Schneider 2013: 46; Lliadou 2012: 385; Wilde-Larsson *et al.* 2011: 1168; Mitchell 2001: 1; Sellers 2012: 142; White 2007: 28; Jukelevics 1990: 11). Simkin (2006: 4) reiterated this, stating that there is no other single event that includes intense sensations and emotions such as joy, pain, fear, worry, self-doubt, unpredictability, exposure, and vulnerability. It is therefore crucial that every attempt is made to provide all women with a fulfilling and holistic birth experience that is sensitive not only to the physiological facets but to the psychological and religious and/or spiritual needs as well.

The International Confederation of Midwives has aimed to improve the standard of care provided to women, babies and families globally through evidence-based practice (Sellers 2012: 14; de Kock and van der Walt 2004: 1-10). In this vein, scholars have argued that midwives need to recognise and be more aware that women have significant and lasting memories of the type of professional care received during labour and birth (Simkin 2002 cited in Callister 2006: 8). Hence the manner in which midwives relate to expectant parents during the birthing process greatly influences the parents' experience for a long time (Hallgren, Kihlgren and Olsson 2005: 606; Simkin 1992 cited in Kainz, Eliasson and von Post 2010: 621; Mercer, Green-Jervis and Brannigan 2012: 717). It is therefore crucial that midwives understand the meaning of childbirth from the mother's biopsychosocial and spiritual perspective and endeavour to be cognisant of these multifaceted needs whilst mothers are in labour.

## **1.2 BACKGROUND TO THE STUDY**

According to Crowther (2014: 8) the experience of birth has varied meanings across different social contexts and cultures. A consideration not only of

physiological aspects but psychological aspects such as the need for support as well as spiritual beliefs ensures that the sacred significance of birth remains part of the experience. Crowther and Hall (2015: 2) indicated that although religious beliefs are viewed as an aspect of spiritually based care, very little attention has been paid to the religious and spiritual beliefs of women in midwifery practice. O'Brien (2010: 242) argued that it is important to recognise the family's religious tradition, so that midwives may be more attentive to the nature and level of spiritual care and support needed by mothers during labour and post-delivery process.

Although childbirth is a much anticipated experience, it is not unnatural for all mothers to exhibit anxiety during this time. Childbirth is a multifaceted experience, which requires that each woman has a sense of security and personal support and sound midwifery care, all of which contributes to the childbirth experience (Dencker *et al.* 2010). The role of the midwife then remains integral not only to providing physiological care but also psychological reassurance, sensitivity to the need for partner support and the respect for spiritual beliefs and practices as well.

Competent and skilled midwives are a crucial part of nursing and midwifery (Chokwe and Wright 2012: 653). In the World Health Organization (WHO): World Health Report (2005b: 5), it was advocated that women must not only receive care that is optimally safe and professionally driven, but they must also have a culturally sensitive birth experience that respects a woman's religious and spiritual beliefs. During pregnancy and childbirth women are concerned primarily, with having a healthy and normal baby. They are also dependent on midwives for intense emotional support during this deeply personal event, and are hopeful of having a pleasant and dignified experience. In order to achieve this, the International Confederation of Midwives (2011: 1) developed clearly defined core competencies and guidelines which are followed by midwives around the globe (Sellers 2012: 15). Some of the core skills and knowledge that are emphasised beyond just

what encompasses physical care are: quality culturally sensitive health education for pre-pregnant women and families; care and counselling during antenatal care; high quality culturally sensitive care during labour; culturally sensitive post-natal care and high quality comprehensive care for the newborn infant up to two months (Sellers 2012: 14).

The midwife plays an extremely significant role in the childbirth experience due to the increased number of women who give birth at hospitals (Mobarakabadi, Najmabadi and Tabatabaie 2015: 1; Askari *et al.* 2014: 46; Downe 2006: 53). This is particularly true within the public hospital context. The following sub-section explores the midwifery service within the South African National Health system.

### **1.3 THE SOUTH AFRICAN NATIONAL HEALTH SYSTEM AND MIDWIFERY SERVICES**

The dismantling of apartheid structures and the new democratic dispensation that followed saw an increasing number of racially and culturally diverse people being seen at all public hospitals and health care centres (Lubbe 2008: 5). Nursing staff were challenged to offer nursing care to people from diverse backgrounds without professional preparedness or experience of these diverse cultural and sociological factors. Lubbe (2008:5) emphasised that in particular there was a desperate need for information dissemination regarding the different religious groups for greater professional preparedness amongst midwives.

In this vein Mpantsha (2003: 27) noted that despite the admission of diverse cultural patients in health care services after 1994, contemporary midwives are still challenged to provide culturally sensitive care to patients from diverse religious and spiritual backgrounds. It is within this context that this study sought to explore and describe the childbirth experience of women at public health hospitals. More importantly women from the four major religious

groups in South Africa, viz. Christian, Islamic, Hindu and African Traditional Religion groups, were recruited to be part of the sample to explore whether their spiritual beliefs and practices were considered during the childbirth experience. Women from these groupings were sampled from public hospital settings in the uMgungundlovu District of KwaZulu-Natal in South Africa. It was envisaged that this inquiry would enrich the knowledge base of midwives related to the provision of nursing care for women from these common religious backgrounds in South Africa. Hence the study sought not only to explore the childbirth experience at public hospitals in terms of physiological care, but extended the inquiry to whether the spiritual aspects for mothers were considered as well.

Currently in South Africa most women give birth in hospitals (du Plessis 2005: 23) and midwives are the key role players in the provision of maternity care (Wilde-Larsson *et al.* 2011: 1168). According to the Department of Health (2015: 14), approximately 60-70% of all women who use government facilities would also require the services of a hospital at some stage during their pregnancy. During the childbirth process, women encounter a midwife as their first point of contact; this person becomes the closest healthcare professional during the childbirth experience (Adeyemo 2013: 14). Midwifery services are also rendered at primary health care clinics.

Primary Health Care (PHC) is the first component of a continuing health process which is made available by the South African National Health System. Primary Health Care is to provide health services closest to where citizens reside or are employed. The next level of care is the Community Health Centres, which offer a 24-hour comprehensive obstetric service run by nurses and midwives. These services include labour and delivery services, followed by hospital care. Should the mother develop complications, the midwife has an important function in terms of referring the mother to be managed at a hospital level. In the event where PHC services do not render labour and delivery services, mothers are advised to deliver their child in a

hospital. Hospitals are divided into three levels of services namely Level 1, which is a district hospital and is integrated into larger hospitals in urban areas; Level 2, which is known as a regional hospital and acts as the base for a health region; and Level 3, which is a tertiary hospital rendering services to high risk mothers (Fraser, Cooper and Nolte 2010: 11). Health services at all levels needs to be of a high quality and standard in order to meet the expectations and needs of women, thereby enabling them to have a satisfying, positive and memorable childbirth experience. This includes a better informed health professional who is also sensitive to the spiritual needs of women from diverse religious or cultural backgrounds.

Tjale and de Villiers (2004: 9) argued that health practitioners need to have knowledge of diverse religions or cultures in order to meet the needs of patients from different backgrounds. Vanderpool (1990: 12 cited in Pera and van Tonder 2011: 181) said that human beings expect that health systems and religious systems serve as the guiding tools for medical treatment and healing. There are specific rituals and ceremonies that underpin different religious worldviews that require consideration in patient care. Hence this study sought to not only focus on the physiological and psychological aspects of care in the public hospital context, but also the spiritual aspects that interface with the childbirth experience. This was explored through the lens of women from the Islamic, Hindu, African Traditional Religion and Christian religious worldviews who were the most common religious groupings in the geographical area being investigated.

#### **1.4 RELIGION AND SPIRITUALITY IN RELATION TO THE CHILDBIRTH EXPERIENCE**

Spirituality within the context of this study is “defined to be inclusive of diverse religious and non-religious expressions” (Canda and Furman 1999: 38). Scholars in the field of spirituality have defined spirituality as ‘the gestalt of the total process of human life and development encompassing biological,

mental, social, and spiritual aspects. It is not reducible to any of these components; rather it is the wholeness of what it is to be human. This is the broadest meaning of the term” (Canda 1988a and Okundaye and Gray 1999 cited in Bhagwan 2002: 1). This definition is adopted as the guiding definition as it embraces then not only the physiological and psychological aspects of care but includes the spiritual as well.

Spirituality in the literature is viewed as being multi-dimensional (Koenig 2012: 2) and both religiosity and spirituality are seen to be interrelated constructs which allows religion and religious experience to be subsumed within definitions and conceptualizations of spirituality. After conducting a content analysis of definitions of religion and spirituality in the nursing literature, Emblen (1992 cited in Zinnbauer and Pargament 2005 : 25) defined religion “as a system of organized beliefs and worship which a person practices, and spirituality as “a personal life principle which animates a transcendent quality of relationship with God.” Williams and Sternthal (2007: S47) described religion as features of belief and behaviour that is related to the sacred and which is grounded in a religious community or tradition. Zinnbauer and Pargament (1997 cited in Zinnbauer and Pargament 2005 : 26) added that religiousness included references to organizational practices or activities, attendance at services and performance of rituals, whilst spirituality referred to feelings or experiences of connectedness with sacred beings and a way of being through relationships with one self, others, nature or life. Hence religiosity and religion are interrelated with spirituality and has been subsumed under the umbrella of definitions of spirituality. Spirituality however does not always include religiousness or experience related specifically to a faith or tradition or religious group and one can have a spiritual experience outside the confines of organized religion (Bhagwan 2002: 68).

Most importantly, however is that both religion and spirituality are seen as important elements of health and well-being (Callister and Khalaf (2010: 16).



Linked to religion is culture and ethnicity which is interconnected with this. Within a single religious tradition e.g. Hinduism or African Traditional Religion, there can be varying patterns of worship, religiosity, and rituals, beliefs and practice which is identified as cultural or ethnic differences (Canda and Furman 1999: 97).

In a more broad sense as defined at the outset of this sub-section, Ferret (2011: 5) wrote that spirituality involves interaction at several levels of awareness and can be experienced by all individuals irrespective of religion, race, creed and culture. In the context of this study, Crowther (2014: 9) and Crowther and Hall (2015: 2) expressed the moment of childbirth as a significant and joyous spiritual and deeply sacred experience. Despite the seemingly tacit nature of the sacred significance of spirituality during childbirth, Lahood (2007: 4) emphasised that spirituality and sacredness in childbirth continue to be unearthed in research. It can therefore be posited that during the childbirth experience mothers connect with something sacred, profound and meaningful.

Lydon-Lam (2012: 19) added that whilst spirituality is about the content of what we believe, it is also significantly linked to the experiences and relationships that we have with those around us. Hence the mother at the interface of the relationship between midwife and her other support systems is crucial. Fuller (2012: 43) argued that the manner in which a woman in labour responds to her birthing experience is moulded and articulated primarily through her spiritual, religious and cultural beliefs. The midwife stands at a pivotal position in relation not only to the mother but also her family, because giving birth is a central life event for families. Downe (2006: 46) expressed that the depth and richness of a mother's childbirth experience is dependent on her religious or spiritual beliefs. It is therefore important that the midwife is more deeply aware of the holistic needs of the mother during labour because spiritual and religious beliefs and accompanying rituals, such

as prayer, serve as helpful coping mechanisms during labour and childbirth (Callister and Khalaf 2010: 16).

In order to become aware of the different religious or spiritual support systems mothers rely on during childbirth, midwives need to have an understanding of the diverse religious or spiritual practices and activities mothers may engage in. Further, the midwife needs to understand how a mother's religious or spiritual beliefs and practices can be used to create enhanced support for her during childbirth and post-delivery. This will give her insight into the mother's needs and the different religious or spiritual support practices and systems that will enable recovery and healing (Molloy 2008: 23). This was supported by eminent scholar Koenig (2012: 12), who found through empirical research that religion and spirituality enabled coping with the stresses of life. Pregnancy and childbirth involves traditional beliefs and practices which the midwife needs to be knowledgeable about, in order to demonstrate respect and sensitivity during this process (de Kock, van der Walt and Jones 2009: 2-1).

### **1.5 A BRIEF OVERVIEW OF RELIGIONS IN SOUTH AFRICA**

South Africa is a diverse country and reflects a multicultural population which is mirrored by diverse religious groups (Bhagwan 2010: 301; Lubbe 2008: 5). Africans constitute 80,2%, Whites 8,4%, Coloured 8,8%, and Indian/Asian 2,5% (South African Statistics SA 2014). Within this population the major religious groups include African Traditional Religion, Christianity, Islam, Hinduism and Judaism (South African Government Information 2011/12; Bhagwan 2010: 301). It is therefore expected that midwives will encounter mothers primarily from these groups and an enhanced understanding of their spiritual needs and beliefs and practices are crucial to clinical competence. In the following sub-sections the features of these major religious groupings are summarized.

### **1.5.1 African Traditional Religion**

Religion is a core facet in the life of African people (van Butselaar 2014: 219). The African religion is the oldest form of religion in South Africa (Lubbe 2008: 5). According to Elion and Strieman (2001: 36) rituals involving prayer, music, drumming and the presence of African Traditional healers such as sangomas, are the cornerstones of this religion. In the African Traditional Religion there are no holy texts, however there is a deep belief in God as the Supreme Being, who channels his energy through the ancestors. The African Traditional Religion sees religion as the foundation of all life (Beyers 2010; Eliot and Strieman 2001: 11) and hence is extremely salient during childbirth. African scholar Mbiti (1971: 5) asserted that there is no division “between the spiritual and the physical”. Birth rituals therefore become extremely significant for the mother, family and community (Lubbe 2008: 19; Downe 2006: 46).

### **1.5.2 Islam**

Muslims follow Islam and submit to the will of ‘Allah’ (God). Islam means ‘peace’. Central to Islam is oneness, that is, God is one and ‘He is the author’. Muslims believe that their religion was completed by Prophet Muhammad who was the last and greatest prophet (Lubbe 2008: 51; Tjale and de Villiers 2004: 95). Elion and Strieman (2001: 106) explained that there are five major aspects that underpin Islam, viz: ‘belief,’ ‘prayer,’ ‘charity,’ ‘fasting’ and ‘pilgrimage’. The mosque is the place of worship for Muslims; it is also used for meetings, educational forums and other functions. In the Islamic religion the rites of passage consist of rituals at birth as well as a series of rituals with regard to naming the newborn.

### **1.5.3 Christianity**

According to Lubbe (2008: 38) Christianity is the world's largest religion. In South Africa more than 80% of the population are Christians and a large number are Black South Africans (South African Government Information 2011/12), who continue to believe in Christianity as well as the rituals and practices of the African Traditional religion. Most Christians follow the teachings of Jesus Christ and believe in one God who has created the world and watches over it. Tjale and de Villiers (2004: 88) asserted that a majority of Christians believe that God acts in three distinct ways while retaining his oneness: as God the Father, who made and cares for the world; as God the Son, who came to the earth as Jesus; and as God the Holy Spirit, who is at work in the world. The sacred place for where Christians worship is the church. Birth celebrations in the Christian religion consist, primarily of a naming ceremony, dedication and infant baptism.

### **1.5.4 Hinduism**

Hinduism originates from India (Coward and Sidhu 2000: 1167; Laroia and Sharma 2006: 94) and is the third largest religion in the world after Christianity and Islam. Although the largest Hindu population resides in India, the number of Hindus have risen in the Western world. Hindus believe in a Supreme Being 'Bramah' (The Creator), Vishnu (The Protector) and Shiva (The Destroyer). Hindus also believe in a vast number of gods and goddesses and each one represents a different aspect of Brahma's power (Lubbe 2008: 45). They embrace numerous beliefs and religious practices of relevance both during and shortly after childbirth. This is because the birth of a baby is seen as a celebration for family and society (Laroia and Sharma 2006: 94).

## 1.6 PERSONAL RELATIONSHIP TO THE TOPIC

Reflexivity is an important aspect of qualitative research (Creswell 2013: 47). Self awareness and introspection of personal values enabled the researcher to discover a true sense of the experience of childbirth from the participant's view in this study. The researcher also endeavoured to set aside her personal bias in order to explore the topic (Polit and Beck 2012: 179).

The researchers' experience as a professional nurse and midwife created the awareness that each mother has different expectations when she is admitted into hospital to give birth. She brings with her, her family history, unique health needs and as well as her spiritual beliefs, values and preferences pertaining to her care (Weatherspoon 2011: 44). The diversity of the South African population demands that midwives provide spiritually sensitive care, by taking into consideration the spiritual beliefs of each woman and whatever religious and or cultural practices are subsumed within their spiritual background. Whilst it may not be possible to know everything about every religious group, Pera and van Tonder (2011: 179) stated that health care workers should be sensitive, flexible and have some knowledge of the different religious groups and ethnic or cultural sub-groups.

Childbirth is an innate experience. The researcher is a mother, although she did not have a natural birth experience. She has also had the experience of childbirth in a public hospital setting. All the participants chosen for this study experienced natural births. The researcher identified the importance of spirituality (as defined in the preceding sub-sections), or religious and or spiritual beliefs and practices as being an important dimension of the overall childbirth experience. This was due to both her personal and professional experience. Hence after identifying an empirical gap in the South African literature with regard to what mothers experiences were at public hospitals, the researcher opted to explore same in a holistic way. Hence the study was designed to explore not only how mothers experienced childbirth at a public

hospital, but also their level of care and support (psychological and emotional aspects) as well as how their religious and or spiritual beliefs interacted with and were considered during the childbirth experience. This holistic inquiry is aligned with the operational definition of spirituality that is presented under sub-section 1.4.

Significant professional experience as a midwife supported the notion that women rely heavily on their personal religiosity and spirituality during childbirth, and also shortly after childbirth for healing and recovery. Hence the impetus for the current study which explored how women experienced childbirth at a public hospital and how their own and family's religious or spiritual beliefs and practices had affected and impacted on the birth experience.

Professional experience also led the researcher to believe that midwives play a crucial role in creating a unique personal space for mothers. Whilst being respectful of the patient's various physiological challenges is important, providing both emotional and psychological support as well as respect for the religious and spiritual dimensions as well is important. Callister (2006: 7) argued that understanding the unique meaning of childbirth for each individual, enhances the quality of a woman's birth experience.

## **1.7 PROBLEM STATEMENT**

Empirical research in the field of midwifery has burgeoned. Very little research however has been done, with regards to whether the holistic needs of mothers are considered at public hospitals and more importantly spirituality within a midwifery context. Whilst scholars both globally and locally in South Africa, have recognised that culturally competent nursing care must be responsive to the particular needs of culturally diverse patients little research has been done to explore mothers' spiritual needs during the childbirth

experience. The latter is crucial because seen holistically spirituality involves not only the physiological and psychological facets but the spiritual as well. Eminent scholars support the view that pregnancy and childbirth are centred on cultural, social and physiological experiences (Maputle and Hiss 2013: 1; M'Soka 2010: 1; Dahlen, Barclay and Homer 2010b; Lemon 2006: 54).

Bhagwan (2010: 301) described South Africa as a religiously diverse society within which there are multiple ethnic and cultural groups. In offering services to mothers it is crucial that midwives understand the spiritual diversity of beliefs, customs, rituals and practices of these groups. Empirical work related to the spiritual and religious aspects of women during childbirth is sparse (Fuller 2012: 43; Crowther and Hall 2015: 2) particularly in the local context. This prompted the need for the present study in South Africa. The researcher was able to locate only one study conducted by Brookes (1991: 4) on the experiences of childbirth in Natal on Indian primiparous women, which involved twelve women from a provincial hospital and three from a private hospital. The sample consisted of women who followed the Hindu, Christian or Islamic traditions. This study found that there are various religious practices that should be recognised and actively encouraged where beneficial during childbirth.

Studies undertaken in the United States (Mixer 2008: 23; Hill, Hunt and Hyrkäs 2011: 72; Jackson 2007: 17), in India (Kaphle, Hancock and Newman 2013: 1179) and in Europe (Papadopoulos and Omeri 2008: 45) documented the need particularly for a transcultural approach to nursing. These scholars expressed that despite the improvements in health brought on by technological innovation, there are still gross inequalities within the health system. These include access, appointments at health care centres and providers, and also issues related to cultural sensitivity. Researchers in the United States and the United Kingdom argued that there is a need to render culturally sensitive and safe holistic care which is compatible with the patient's cultural beliefs and values, particularly in midwifery practice

(Lewallen 2011: 4; Callister and Khalaf 2010: 16; Fisher, Bowman and Thomas 2002: 151; Campinha-Bacote 2003; Doherty 2010: 50; Maxwell 2009: 1; Narayanasamy 2002: 643).

Research into how women experience childbirth in public hospitals is crucial for a better understanding of how they can be assisted and supported in having a more holistic and fulfilling birth experience (Askari *et al.* 2014: 47). In line with this The World Health Organization (WHO) (2005a: 69) declared that there is a consequent need and demand for women to receive care that is close to their birthing cultures. This calls for midwives to become equipped with knowledge about the needs of women from different spiritual backgrounds because there is value in the rituals surrounding birth. This is salient as it is central to family life. Lubbe (2008: 6) stressed that even a basic understanding of the different spiritual beliefs and practices will aid in preventing insensitive situations and the avoidance of being unintentionally offensive. If there is a lack of understanding of spiritual and religious needs it could lead to stereotyping (Jackson 2007: 17). This study therefore aims to enhance further the growing contribution to the knowledge related to spiritually sensitive nursing practice.

## **1.8 PURPOSE OF THE STUDY**

The main aim of this study was to explore and describe how women from diverse spiritual backgrounds experienced childbirth at public hospitals in the uMgungundlovu District of KwaZulu-Natal. The study sought to understand the personal experience in this context, the level of support received from midwives and how spirituality influenced and impacted on the experience. It also sought to understand what spiritually or religiously derived alternate therapies were used by mothers during childbirth. This was done with a sample of women from diverse spiritual backgrounds viz. Christianity, Islam, African Traditional Religion and Hinduism, at public hospitals in the uMgungundlovu District of KwaZulu-Natal.



This study contributes to rich and meaningful information regarding each woman's personal experience of childbirth and what specific knowledge and skills may be required by midwives to strengthen their role in midwifery practice. It is important for midwives to have a deeper understanding of how mothers experience childbirth at these hospitals, their biopsychosocial needs and challenges and how they experience childbirth spiritually and what spiritual issues must be considered as part of a holistic approach to midwifery care.

Midwives are the key providers of maternal care; it is therefore important for them to understand that each woman is socialised into a different background, and the context in which each woman experiences childbirth is unique and individualised. These experiences, whether negative or positive, can equip midwives to provide care to mothers that extends beyond the basic physiological aspects of hospital care (Askari *et al.* 2014: 46). Downe (2006: 53) affirmed that midwives have the power to make a difference for the birthing woman. Although the doctor and the midwife have a shared responsibility, the task of combining the spiritual, religious, physiological and psychological aspects of women's care is the sole responsibility of the midwife (Fraser, Cooper and Nolte 2010: 6).

A recent study by Bruyere (2012: 42) and Kaphle, Hancock and Newman (2013: 1179) confirmed that there is space for bringing spiritual and medical ideas together in the midwifery profession, to form a women-centred model of care. Wilson (2012: 16) concluded that education, cultural awareness and spiritual sensitivity are vital to promoting positive birthing experiences. Wilson (2012: 16) further stated that the first step towards cultural competence is for childbirth educators to demonstrate understanding and respect for spiritual beliefs, behaviours and practices.

Adams and Bianchi (2008: 106) emphasised that a selection of skills and conduct, together with an environment that supports professional nursing, is

crucial to fulfilling a mother's expectations and needs bearing in mind that quality of care is a major health concern in the hospital setting. It must also be acknowledged that the emotions and thoughts of the childbirth experience are remembered for a lifetime, and each mother ought to look back on her childbirth experience with contentment (Simkin 2006: 6). This is often overlooked within the busy and pressured environments of public hospitals. This study was therefore significant as it explored how mothers experienced childbirth in a multi-dimensional way and particularly some of their spiritual beliefs and practices crucial to creating a more holistic and spiritually satisfying experience.

Maimbolwa *et al.* (2003: 263) emphasised that women and families through the years have strongly valued their traditional and spiritual beliefs. They noted that women preferred home births as opposed to hospital births, so as to be able to have a more personally satisfying experience that considers privacy, support and spiritual factors. Writing with regards to public hospitals Rabor, Taghipour and Najmabadi (2015: 156) concluded that respect for a mother's values and religion are vital to the relationship between mothers and midwives. There is evident need, therefore, for spiritually based care in midwifery practice (Chandramohan 2013: 1).

## **1.9 OBJECTIVES OF THE STUDY**

The objectives of the study were as follows:

- To explore and describe the personal experience of childbirth amongst women from diverse spiritual backgrounds in the uMgungundlovu District of KwaZulu-Natal.
- To explore and describe the nature of support provided by the midwives in attendance of women from diverse spiritual backgrounds in the uMgungundlovu District of KwaZulu-Natal.

- To explore how spiritual beliefs and practices influenced and impacted on the birth experience of women from diverse spiritual backgrounds in the uMgungundlovu District of KwaZulu-Natal.
- To ascertain if any alternate therapies/methods were used during the birth experience of women from diverse spiritual backgrounds in the uMgungundlovu District of KwaZulu-Natal.
- To make recommendations to enhance quality, safe and competent midwifery care to women from diverse spiritual backgrounds in the uMgungundlovu District of KwaZulu-Natal.

### **1.10 RESEARCH QUESTIONS**

- How is childbirth experienced personally amongst women from diverse spiritual backgrounds at public hospitals in the uMgungundlovu District of KwaZulu-Natal?
- What was the nature of support provided by midwives in attendance of women from diverse spiritual backgrounds in the uMgungundlovu District of KwaZulu-Natal?
- How did the spiritual beliefs and practices influence and impact on the birth experience of women from diverse spiritual backgrounds in the uMgungundlovu District of KwaZulu-Natal?
- What are the alternate therapy/methods used by mothers from diverse spiritual backgrounds during childbirth?
- What recommendations can be made to enhance quality, safe and competent midwifery care to women from diverse spiritual backgrounds in the uMgungundlovu District of KwaZulu-Natal.

### **1.11 SIGNIFICANCE OF THE STUDY**

Through reflection on personal and professional experience in public hospitals, the researcher was aware that although midwives managed the

physiological and clinical aspects of care, they did not consider the spiritual dimensions in contemporary midwifery care. Lubbe (2008: 5) emphasised that an increasing number of South Africans encounter people of different religious and spiritual beliefs. This is also the case for midwives, who play a vital role in the childbirth experience of patients (Lleras 2007: 19).

There is a huge gap in current literature on spirituality at the juncture of childbearing (Callister and Khalaf 2010: 16; Marks 2006: 607; Lasch 2000: 20). In South Africa very little empirical research exists and studies related to this topic are non-existent in the uMgungundlovu district of KwaZulu-Natal. This formed the impetus to explore women's personal experience of childbirth at public hospitals but more so to inquire about how spirituality interacted and influenced with this experience. Women from the four major religious groups in South Africa in which the study was conducted were involved viz. Hindu, Islam, African Traditional Religion and Christianity.

It was believed that through qualitatively exploring the personal experience of childbirth with women of these diverse spiritual backgrounds, it would provide valuable information regarding their experience of childbirth spiritually and what spiritual factors need to be considered as part of midwifery care. It was also to inquire whether their personal spirituality served as a source of support during this process and whether their spiritual beliefs and practices were respected. This information is crucial to ensuring a spiritually based approach to midwifery care.

A good quality, safe and competent health care service is a strong determining factor of overall satisfying care and healthy birth outcomes (Lewallen 2011: 4; Nyango *et al.* 2010: 135). This requires midwives to be aware of the biopsychosocial and cultural facets of each woman in preparing her physically and psychologically for the birthing experience (Tebid *et al.* 2011: 972).

While Lubbe (2008: 5) wrote that one cannot manage health and illness without the inclusion of religion and culture in the care of patients, Tjale and de Villiers (2004: 117) and Abu-Ras and Laird (2011: 59) affirmed that it is important for health professionals to be sensitive to differences in spiritual backgrounds of individuals. Cultural and religious norms mould one's beliefs and values to create a foundation in making choices. In this context, midwives encounter clients from different backgrounds and are challenged to create culturally safe care (Mitchell 2001: 2). Campinha-Bacote (2003) therefore emphasised that health care providers should consider cultural and religious factors as a priority in health care.

In hospitals there are often set rules and procedures to follow. Midwives strive to complete duties timeously, paying little attention to a mother's cultural, religious, spiritual, psychological, and emotional needs during childbirth, all of which holistically have huge personal significance. Interview data from a study undertaken by Maputle and Hiss (2010: 12) in the Limpopo province of South Africa revealed that women in labour had no choice but to follow the rules of midwives. As a result there was limited shared participation and responsibility-sharing, which reflected that the psychological and spiritual facets were often ignored during childbirth.

Thorstensson *et al.* (2012: 1) explored professional support offered by midwives during labour. They found that the level of support offered by midwives during labour was affected by the ideology taken on by the midwives. Ideologies referred to 'with institution' and 'with woman' perspectives. The 'with institution' ideology focuses mainly on task performance and efficiency, while the 'with woman' ideology focuses on emotional labour. It was concluded that when midwives adopted the 'with woman' ideology a wider range of supportive needs were met.

Other empirical work on women's birth experiences in hospitals revealed stereotyped negative attitudes of midwives, structural constraints, political

and administrative barriers and dehumanisation of the sacred birthing experience. These studies were carried out in the United States (Otis and Brett 2008: 46; Hicks *et al.* 2008: 1234; White 2007: 27; Straus, McEwen and Hussein 2007: 181); in Peru (Gabrysch *et al.* 2009: 724); in Canada (Behruzi *et al.* 2011: 11); in Greece (Sapountzi-Krepia *et al.* 2008: 124); and in rural Tanzania (Shimpuku 2002: 1).

Additionally, it was also found that there was a lack of support for women during childbirth (Straus, McEwen and Hussein 2007: 185; Bruyere 2012: 40; Shimpuku 2002: 117). Numerous international writers have argued that support is a crucial component of sensitive and responsive woman-centred care in the United States (Fair and Morrison 2011: 21), United Kingdom (Hardin and Buckner 2004: 10), Greece (Lliadou 2012: 385) and Nigeria (Morhason-Bello *et al.* 2007: 553; Ramashwar 2008: 202). Support during childbirth has positive psychological outcomes and enhances control and birth satisfaction, creating an optimistic outlook on motherhood (Sauls 2002: 737). It is therefore imperative that midwives be fully informed of the value of such support during childbirth experience.

Midwives are seen as important people in the health care system and by mothers themselves as support givers (Hardin and Buckner 2004: 15). Madsen (2011: 601) and Bazant and Koenig (2009: 84-85) professed the need for midwives to demonstrate care, empathy and support during childbirth, in partnership with the woman and her family. Partner and family support was found to be crucial to professional assistance because of emotional reasons and spiritual values (Shimpuku 2002: 121).

In the United Nations Population Fund Report (2011: 8) it was noted that there was a worldwide shortage of health care workers, which includes midwives. Due to the shortage within the profession, midwives are forced to undertake primarily duties related to the physiological aspects of care. This is a result of the demanding hospital environment where policies and

procedures need to be adhered to in order to fulfil the basic requirements of physiological care. (Maputle and Nolte 2008: 56). There is however a need for a deeper consideration of the psychological, emotional and spiritual aspects of care.

## **1.12 KEY CONCEPTS**

### **1.12.1 Childbirth**

“Childbirth is a process of giving birth to a baby” (Tiran 2008: 41). This process includes both the labour (the process of birth) and delivery (the birth itself). For the purpose of this study childbirth is referred to as the process from the commencement of labour until after the baby is born (Larkin, Begley and Devane 2009: e49).

### **1.12.2 Childbirth experience**

Childbirth is described as a complex experience. It includes having a sense of security and supposed control; labour pain; personal support; midwifery care; previous birth experience; intrapartum analgesia; information given; and involvement in decision-making, all of which contribute to the childbirth experience (Dencker *et al.* 2010). In the context of this study, these aspects will be considered as the event took place in a public hospital. Each mother’s experience of labour and birth and how she perceived and interpreted this personal experience, including her religious and spiritual perspective will be explored.

### **1.12.3 Culture**

Culture is described as a set of guidelines that includes people’s ideas, values or morals, customs or traditions, beliefs and concerns or expected

patterns of behaviour that are influential and steady, and which outlines the lives of human beings (Leininger 1988 cited in Coffman 2004: 100; Helman 2007: 2; Leininger cited in Lobo 2006: 33; Bawadi 2009: 23; de Kock and van der Walt 2004: 2-1). Cohen (2011: 9) argues that religious doctrines or religion aids in shaping the manner in which culture develops. Helman (2007: 4), posited that it is difficult to separate or isolate purely cultural beliefs because culture and religion have an interchangeable relationship through the concept of 'an inherited lens' through which an individual perceives and understands the world. It is proposed then that religion or religious views be used to explain inter-cultural similarities and differences which confirms the intrinsic link between religion and culture. Hence when arguing for culturally competent care it must be noted that religious values, beliefs and practices must be respected within this understanding.

#### **1.12.4 Diverse traditional groups**

According to South African Statistics SA (2014) the population number of South Africa consists of diverse traditional groups. Some examples are the Hindu, Muslim/Islamic, Christian and the African Traditional Religion.

#### **1.12.5 Labour experience**

According to Fraser, Cooper and Nolte (2010: 441) as birth approaches physical changes takes place viz. the cervix becomes soft and able to dilate and contractions of the uterus intensify. As labour progresses, the pain intensifies. Normal labour, which occurs at 37-42 weeks of pregnancy, may be described as the process by which the fetus, placenta and membranes are expelled through the birth canal. It is also described as being a spontaneous process resulting in a healthy mother and infant (World Health Organization 1977 cited in Fraser, Cooper and Nolte 2010: 441). The labour experience entails both physiological and psychological processes which has



a special meaning in every culture, and may be accompanied by certain rituals (Fraser, Cooper and Nolte 2010: 441).

#### **1.12.6 Midwife**

A midwife is a licensed person who is registered with the South African Nursing Council and has completed a recognised education and training programme to nurture, assist and treat the client, who can be a woman, a neonate or a family in the process of promoting a healthy pregnancy, labour and post-partum period (South African Nursing Council 2001).

#### **1.12.7 Postnatal**

This refers to the first four to six weeks after childbirth, and this period is considered the postnatal period or the postpartum period during which time the woman's body returns to its normal state (Sellers 2012: 514; Fraser and Cooper 2003: 626).

#### **1.12.8 Religion**

This construct has been defined under sub-section 1.4 and its interrelationship with spirituality clarified. Religion is expressed as having a value system which is characterised by an organised set of rituals and beliefs that brings meaning in a particular group of people. These beliefs entail religious practices such as prayer; meditation; healing; sacrifice; purification; belief in supernatural powers, beings and divinities, which is believed to protect, bring peace and safety, pleasure and strength to cope (Patterson 2014: 183; van Butselaar 2014: 223; Pera and van Tonder 2011: 179). These resonate with certain definitions of spirituality in contemporary literature (Bhagwan 2002: 68).

In this study the spiritual worldviews of women from the Christian, African Traditional Religion, Islamic and Hindu backgrounds is explored.

### **1.12.9 Spirituality**

Vaughan (1991 cited in Bhagwan 2002: 68) described spirituality as a phenomenon that can be experienced by all humankind. Spirituality is thus not the special property of any group or religion but rather exists within the hearts of all men and women regardless of race, creed and culture, both within and outside of religious institutions. As stated by Lydon-Lam (2012: 18) human beings are social and relational beings who often find great meaning in connection and intimacy with something other than themselves. This alludes to the connectedness crucial in the midwife-mother relationship.

Although spirituality is said to link us to the experiences and relationships we have with those around us, Eckersley (2007: S54) asserted that religion is the most common representation and expression of spirituality. It can therefore be described as a personal search for meaning, connectedness and a purpose in life which brings hope, peace and empowerment through a set of beliefs and norms (Andrews and Boyle 2008: 358; Crowther 2014: 9; Tanyi 2002 cited in Crowther and Hall 2015: 2; Lydon-Lam 2012: 19; Bhagwan 2002: 68).

### **1.12.10 Tradition**

Yadgar (2013: 456) stated that tradition is described as something into which one is born, and through which one attains his or her foundation to life. This is the knowledge and the customs that are passed on from generation to generation, and that which gives meaning to practice and how to conduct oneself as an individual and as a member of society (Yadgar 2013: 456; Baldwin *et al.* 2004: 11). In the context of this study tradition may be used to describe the values, beliefs and practices of women from the Christian,

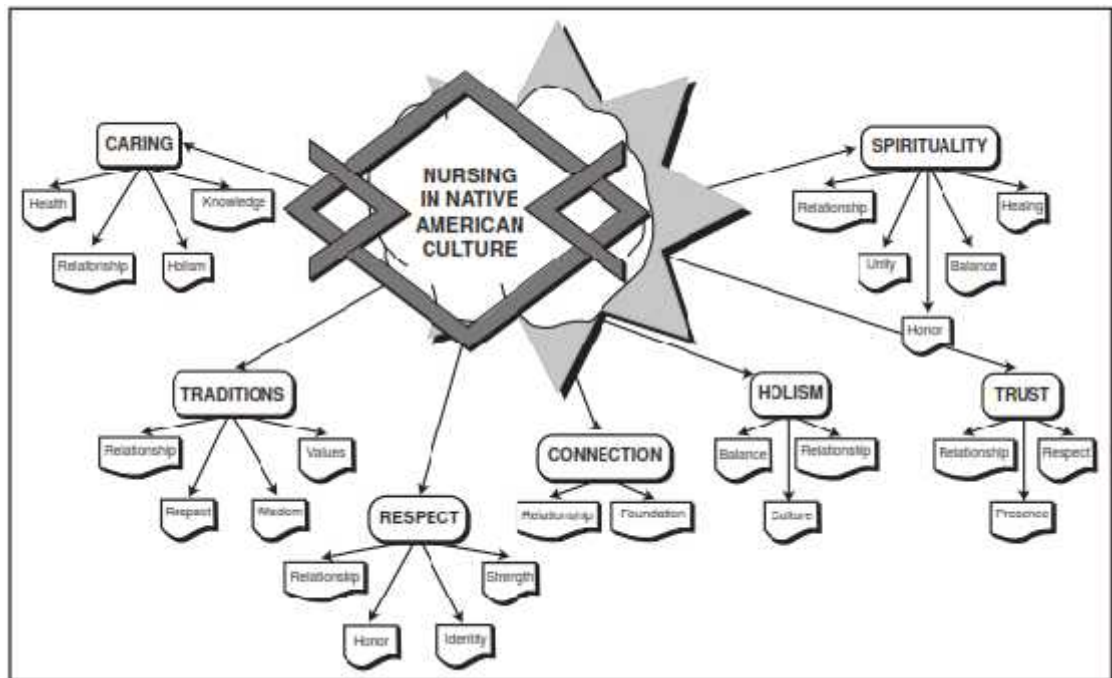
African Traditional Religion, Islamic and Hindu backgrounds. Religion is seen to be subsumed within the definition of spirituality in this study. Furthermore as explained culture is seen as a facet of religion and hence it is considered a part of religious or spiritually sensitive care.

#### **1.12.11 Worldview**

Worldview is defined as a mental image of how individuals see and interpret the world around them, and which consists of beliefs and values that are shared (Andrews and Boyle 2008: 67; Tjale and de Villiers 2004: 13). In this study participants were chosen from the Christian, African Traditional Religion, Islam and Hindu spiritual/religious backgrounds. Worldview refers to how they see and interpret the world around them.

#### **1.13 CONCEPTUAL FRAMEWORK**

Midwives need to be fully informed of the cultural, religious, spiritual and traditional attributes attached by the mother during the childbirth experience, in order for mothers to have a positive and satisfying experience. In Figure 1.1 below, Lowe and Struthers (2001: 280) identify seven dimensions used to assist Native American nurses in understanding the holistic aspects related to caring. As discussed under sub-section 1.4 spirituality is seen holistically as an interrelatedness of all facets of a human being.



**Figure 1.1: Dimensions of nursing in Native American Culture**

(Lowe and Struthers 2001: 280)

According to Lowe and Struthers (2001: 280) a conceptual framework is used to outline and reflect on thoughts, and to provide direction and momentum (Polit and Beck 2008: 145; Burns and Grove 2011: 238). It also makes it possible for the researcher to associate the findings to nursing knowledge, and to gather evidence for practice (Polit and Beck 2008: 145).

The seven dimensions highlighted by Lowe and Struthers (2001: 280) focus on nursing in a Native American culture. This conceptual framework was adapted for the South African context for this study, more specifically because the participants in this study were women from different spiritual backgrounds. These seven unique dimensions are ‘caring, traditions, respect, spirituality, connection, holism, trust and spirituality’, and are relevant to holistic midwifery care and the focus of this study (Lowe and Struthers 2001: 280). They were used to categorise and illustrate the meaning that mothers attach to their experience of childbirth.

Lowe and Struthers (2001: 282) posited that this framework is momentous to the nursing profession, and was therefore adopted as the guiding framework for this study. All seven dimensions contribute to the childbirth experience and were useful in developing the interview guide. They were incorporated into the study which unfolded the biopsychosocial and cultural aspects of the phenomenon of childbirth. The dimensions as described below were used to categorise and portray the holistic aspects of caring which are useful in midwifery care.

### **Caring**

The element of caring involves not only the physical aspects of care, but caring from an emotional, psychological, spiritual, religious and cultural aspect. "Caring goes beyond the physical", and caring consists of characteristics of health, relationships, holism and knowledge (Lowe and Struthers 2001: 281). Therefore caring in midwifery requires that the midwife takes into consideration the emotional, psychological, spiritual, religious and cultural aspects in order for each woman to have a satisfying and positive birth experience.

### **Traditions**

Culture and tradition play a significant role in a woman's experience of childbirth. Lowe and Struthers (2001: 281) stated that association with tradition is important because it assists in the nursing process. Women from the Islamic, Hindu, Christian and the African Traditional religion participated in this study. They follow different values, religious and traditional beliefs and practices, even during childbirth. Having knowledge of these values and beliefs will allow midwives to better understand their cues during labour and childbirth.

## **Respect**

Mothers go into hospital with the notion of having certain expectations, and one of these is to be respected. Respect entails being polite, having a good attitude and also being acknowledged. Respect also means to be accepted despite the cultural and traditional background one comes from. Midwives need to respect mothers, and it is therefore an important dimension in midwifery care.

## **Connectedness**

Creating a relationship between the midwife and the mother is significant in enabling the mother to have a positive and satisfying experience. This type of relationship can be built from trust and support; this could be partner and family support, as well as the midwife's presence during the process of childbirth. This type of support and the presence of the midwife allow a special connection to take place. Lowe and Struthers (2001: 283) described connectedness as securing relationship and responsibility together, which is pertinent in midwifery care.

## **Holism**

Lowe and Struthers (2001: 281) espoused that holism comprises of balance, culture and relationship. Sellers (2012: 721) concurred, by describing holism as an important aspect of understanding and caring by taking into consideration a person's complete physical, mental and social state. Culture includes beliefs, religion, spirituality and healing. Holism and connectedness are interlinked and interrelated to holistic care, which is important in midwifery care.

## **Trust**

Lowe and Struthers (2001: 281) stated that trust consists of characteristics such as relationship, presence and respect. They also highlighted that it is the nurse's responsibility to build a trusting relationship with the patient. This is important in midwifery care because it is the midwife's responsibility to support and be present with mothers during childbirth. This leads to building a trusting relationship with them because midwives work in partnership with women.

## **Spirituality**

Spirituality is essential to human subsistence (Lowe and Struthers 2001: 283). Bhagwan (2002: 192) added that spirituality and religion are important aspects of human existence. Spirituality is an important aspect in rendering holistic care which is deemed as significant during pregnancy and childbirth (Lydon-Lam 2012: 18-19). It is therefore important for midwives to understand this facet because they may encounter mothers from different religious and cultural traditions who may view birth as a spiritual event.

The above-mentioned dimensions of Lowe and Struthers (2001: 281) support the purpose of this study. The conceptual framework of Lowe and Struthers (2001: 280) was relevant as it resonates with the objectives of the study.

### **1.14 OVERVIEW OF THE RESEARCH METHODOLOGY**

The focus of this study was to explore and describe the personal experience of childbirth in Hindu, African Traditional Religion, Islamic and Christian women at public hospitals in the uMgungundlovu District of KwaZulu-Natal. A qualitative approach was found to be most appropriate, as it allows for a systematic exploration of a topic from the chosen set of population for the study (Polit and Beck 2008: 17). The best way in which women could share

their experiences in this study was through a semi-structured interview. The researcher adhered to the principles of ethics whereby final ethical clearance was obtained from The Durban University of Technology: Institutional Research Ethics Committee. Trustworthiness was also maintained and the criteria of credibility, transferability, dependability, confirmability and authenticity were used. The principles of ethics and the criteria of trustworthiness are discussed in detail in chapter 3.

Participants were allowed to talk freely, with ease, and were given latitude to share their childbirth experiences. This technique ensured that the researcher gained information that was required to fulfil the objectives of the study (Polit and Beck 2008: 394).

Human life experiences cannot just be described; the essence of meanings of these experiences can be uncovered by understanding and interpreting them (Polit and Beck 2012: 496). As Sandelowski (2000: 335) asserted, all description entails interpretation in qualitative studies. This methodology allowed the researcher to extract rich, descriptive information and the meanings about childbirth experience from the participant's perspective. The data collected in this study was analysed by use of thematic analysis, which was guided by Braun and Clarke (2006: 18). Themes were explicated about the childbirth experience of Hindu, Islamic, Christian and women from the African Traditional Religion, thereby illuminating the research topic by means of thick description (Henning, van Rensburg and Smit 2004: 142). A detailed account of the research methodology follows in Chapter 3.



## **1.15 STRUCTURE OF THE DISSERTATION**

- Chapter 1: Introduction and background to the study.
- Chapter 2: Literature review.
- Chapter 3: Research methodology.
- Chapter 4: Presentation of the findings.
- Chapter 5: Discussion of the findings, recommendations and conclusions of the study.

## **1.16 CONCLUSION**

The introductory chapter provides an overview and outline of the topic under study. The problem statement and the rationale, the objectives, research questions, the purpose and significance of the study were discussed. The conceptual framework that was used to guide the study and its relevance was described. A brief overview of the methodology and rationale was also presented. Chapter 2 presents in-depth information from a wide range of literature sources that further grounded the topic under study.

## CHAPTER 2

### LITERATURE REVIEW

#### 2.1 INTRODUCTION

A literature review is a written coherent argument which involves finding, reading, understanding and forming conclusions about the existing published research and theory, and presenting it in an organised manner (Machi and McEvoy 2009: 4; Brink, van der Walt and van Rensburg 2012: 70). A review of the literature is undertaken to synthesise what is known and not known about the topic and provides a background for the problem being studied (Burns and Grove 2011: 189; Brink, van der Walt and van Rensburg 2012: 70). As outlined by Polit and Beck (2012: 94) qualitative researchers differ in their opinions about reviewing the literature prior to conducting a new study. Some qualitative researchers advocate that no literature review should be conducted before the inquiry commences (Speziale and Carpenter 2007: 26). They proposed, however, that an initial literature review be undertaken to understand the context of the study and to recognise the gaps within the studies. However de Vos *et al.* (2011: 298) asserted that the view of not doing a literature review to guide one's study has changed, due to large scale developments and diversity in qualitative research.

In shaping the background information for this study, an initial search was done to obtain information on labour, natural birth and the midwife's duty. An extensive literature search was also done after analysing the data to prevent personal biases about the topic, as advocated by Speziale and Carpenter (2007: 26). Speziale and Carpenter (2007: 26) further specified that the purpose of the literature review in a qualitative study is to express how the findings fit into what is already known about the phenomenon.

The main focus of the literature review in this chapter is related to the childbirth experience. In positioning this study within the context of current scholarship, the researcher was able to draw knowledge about the childbirth experiences within a global context. The midwife's role in engaging with mothers during childbirth and literature on birth experience in hospitals are discussed. Attention has also been given to the importance of understanding and respecting one's spiritual and or religious beliefs and practices within the context of holistic nursing and midwifery care. Global and local perspectives on the use of complementary and alternative medicine within belief systems are also presented.

A search was done utilising the following databases: Biomedcentral, dutlib.dut.ac.za, Ebscohost, Elsevier health, Google, Medscape, Proquest, Research archive, Google Scholar and Science Direct. Following the search the journals that were used to retrieve articles relevant to the study and to support the findings of this study is included in the reference list. A combination of the following key words was used during the searches: childbirth, childbirth experience, hospital birth, culture, tradition, religion, spirituality, Hindu religion, Christianity, Islamic religion, African Traditional religion, culture care, South Africa childbirth experience, midwives experiences childbirth, culturally sensitive care midwifery, childbirth labour support, women's expectations childbirth, mother's perceptions childbirth experience and professional ethical role midwife.

Throughout history the midwife's duty is referred to as precious work, which is the midwife's calling in assisting women during childbirth (Hartigan 1990; Hampton and Hampton 2000: 218). Women anticipate labour differently and also behave differently during labour for varied psycho-social, physiological and spiritual reasons. This study explores in particular the religious or spiritual facets; as Sellers (2012: 313) said, "Labour and childbirth have a special meaning for every culture" accompanied by birth rituals.

## 2.2 LABOUR, NATURAL BIRTH AND THE MIDWIVES' DUTY

Childbirth is a complex multi-dimensional and subjective experience for childbearing women (Larkin, Begley and Devane 2009: e49; Dencker *et al.* 2010). This includes the birth outcome, safe birth of the baby and the birth process, which is the physical and cognitive processes of labour and birth experienced by individual women. Mensah, Mogale and Richter (2014: 32) found that labour and delivery was recognised as being a physical and emotional journey. The midwife's role is therefore multifaceted in the care of both the mother and baby. Midwives are entrusted to care for mothers during labour and childbirth.

Normal labour occurs spontaneously when the mother has reached pregnancy between 37 and 42 weeks. Certain hormones such as oestrogen, oxytocin and prostaglandins initiate contractions of the uterus, thereby stimulating the onset of labour. It is a natural process which is completed within approximately eighteen hours, hopefully with both mother and baby in a healthy condition (Sellers 2012: 314; de Kock and van der Walt 2004: 12-4). Natural birth takes place with limited or no intervention. In addition, Parratt (2002: 10) stated that when mothers give birth naturally they feel good about themselves.

According to Sellers (2012: 316) and Fraser and Cooper (2003: 436) there are four stages of labour. These are described as follows:

- Stage one: This stage occurs from the onset of labour when the mother experiences regular and rhythmic contractions accompanied by dilatation of the cervix, lower abdominal pain or backache. The intensity and duration of the contractions become stronger towards the end of the first stage. During this phase the mother may experience irritability, panic sensations, a sense of helplessness, hyperventilation and restlessness and she may feel that she cannot continue any longer. This stage lasts between three and eight hours in the woman

who is in labour for the first time, and for a slightly shorter time in a mother who has experienced labour and birth more than once. The mother may also have the urge to bear down (push) through this transitional stage (de Kock and van der Walt 2004: 12-4).

- Stage two: During the second stage the cervix becomes fully dilated and the mother begins to feel the urge to bear down. This second phase is also known as the expulsive phase (de Kock and van der Walt 2004: 12-4). The midwife also advises the mother as to when to push and when not to push. This stage lasts for approximately two hours for the woman who is in labour for the first time, and approximately 45 minutes for the mother who has experienced labour and birth previously.
- Stage three: The events during this stage begin from the time the baby is born up to the time that the placenta and membranes (products of conception) are expelled. Here the duration varies. If active management is adopted it lasts for approximately five to fifteen minutes; with passive management (spontaneous delivery of the placenta) it can last up to 45 to 60 minutes.
- Stage four: This is the period after the delivery of the placenta up to one hour after the baby is born.

Once the mother recognises that she is in labour she should make contact with the midwife (Sellers 2012: 314). Midwife means 'with woman' (Fraser and Cooper 2003: 3; Fraser, Cooper and Nolte 2010: 3; Edwards 2007: 7; Doherty 2010: 41) and the term 'midwife' is derived from the old English 'with woman' (Kaufman 1993 cited in Lundgren 2002: 42). The midwife is recognised worldwide as being the person who is alongside and supporting women giving birth (Fraser and Cooper 2003: 3; Edwards 2007: 7). Magill-Cuerden (2007b: 326) concurred that it is the midwife who works with the woman and is acquainted with what women desire for their care. The midwife performs a vital function in caring for a pregnant woman, from her first

antenatal visit to the time of delivery of her baby and to caring for her and her baby thereafter (Snyman 2007: 8). Contrary to findings by Ngomane and Mulaudzi (2010: 36), Cohen (2004: 427) wrote that midwives are the experts in childbirth and have a hands-on task at the antenatal, labour and delivery and post-natal period. Russel (2007: 128) added that the midwife's role in the labour ward involves care for both high- and low-risk women. Maxwell (2009: 35) supported this view, stating that older experienced midwives believed that a woman was not qualified to practice as a midwife if she did not have a calling.

Clift-Matthews (2006: 632) described the midwife's role as diverse and challenging, yet rewarding. Childbirth experience is not only a physiological process but an emotional, cognitive and a spiritual event (Callister *et al.* 1999 *cited in* Mitchell 2001: 1). Rooks and Ernst (1999: 19) concurred that midwives value childbirth as an emotionally, socially, culturally, and often spiritually meaningful life experience with the possibility of making women feel and being stronger. They also strengthen bonds between family members and the newborn. In midwifery care, having an awareness and acquaintance with women is important for sensitivity to emotions and the ability to acquire knowledge through an empathic approach (Barnfather 2013: 32). de Kock and van der Walt (2004: 13-2) emphasised that midwives also need to take into consideration factors such as communication, mechanical factors, customs, attitudes and belief when attending to women in labour because these factors have a major influence on their birth experience. Fair and Morrison (2011: 24) added that effective communication between the patient and the health care professional has been made known to enhance satisfaction with health care. Hence religious customs and traditions are important. Kaphle, Hancock and Newman (2013: 1179) argued that it is possible to merge cultural and medical ideas together in the midwifery profession.

Halldorsdottir and Karlsdottir's (2011: 806) study focused on the development of a theory on the empowerment of childbearing women, where the midwife's professionalism was central. The five principal factors that emerged were professional caring; competence and wisdom; empowering interaction and partnership, together with the midwife's personal and professional development. These five factors make up the midwife's professionalism. A midwife's professionalism is thus an important factor in empowering women during the childbearing process. It was also noted that the desire to do good goes along with the hope to create a good life for others. This meant maintaining the dignity of the woman giving birth (Halldorsdottir and Karlsdottir 2011: 811).

In maintaining the dignity of women, one must be aware of and be sensitive to and respectful of another person's culture (Chokwe and Wright 2012: 663) and respect them for whom they are (Magill-Cuerden 2007a: 126). Fraser, Cooper and Nolte (2010: 7) stated that it is imperative that midwives have an understanding of the social, cultural and contextual differences, in order to respond to the individual needs of women and their families. According to Halldorsdottir and Karlsdottir (2011: 806) the quality of midwifery service is the key feature of the woman's experience of childbirth, for which the midwife is responsible and accountable. Although the midwife carries out her duties in accordance with the Nursing Act (Act No. 33 of 2005) and the South African Nursing Council Regulation R2488 of 26 October 1990, it is in her best professional interest to become more familiar with diverse religious and social needs of mothers during the childbirth process.

According to de Kock and van der Walt (2004: 13-2) South Africa consists of women from various religious and cultural backgrounds who may have different beliefs and customs relating to childbirth. It was also concluded that an essential part of labour ward practice by midwives is to provide adequate privacy for mothers during labour, so that women are taken care of with dignity and respect (de Kock and van der Walt 2004: 13-2). Therefore it is

imperative for midwives to have knowledge of childbirth and knowledge of the experiences of women during labour and childbirth.

## **2.3 WOMEN'S CHILDBIRTH EXPERIENCES**

Past research has focused mainly on the outcome of childbirth, and is related to complications during labour and delivery and the reduction of maternal mortality. Kinney *et al.* (2010: 8) reported that many sub-Saharan countries are at the tipping point for achieving the United Nations Millennium Development goal number five, namely improving maternal health. Most African studies have concentrated on the importance of skilled birth attendance, especially for those women of the low income group living in rural areas and giving birth unattended (Crowe *et al.* 2012; Worku, Yalew and Afework 2013: 1). Montagu *et al.* (2011: 1) examined the place of delivery and factors that led to women giving birth at home. It was found that a home birth was more common amongst the poor due to socio-cultural factors and a lack of access to health facilities. Wealthier women chose to give birth in private institutions, while some gave birth at government hospitals.

### **2.3.1 Childbirth experience as a spiritual event**

Studies related to the experience of childbirth considered spirituality as an important facet in rendering holistic care (Ayers-Gould 2000: 17; Lydon-Lam 2012: 18-19). Reed (1992 cited in Lydon-Lam 2012: 18-19) described spirituality as a journey in search of meaning and purpose in one's self, in a manner as to empower and not to devalue the individual. According to Lowe and Struthers (2001: 283) spirituality is fundamental to human survival.

Martsof and Mickley (1998), and Buck (2006 cited in Lydon-Lam 2012: 20) discussed spirituality by use of five primary components viz. 'meaning' whereby individuals are motivated to make sense of events and obtain meaning and ultimate purpose in their lives; 'becoming' that is getting to



know oneself through self reflection on the life journey; 'connecting' where individuals may connect with things of this world, that is family, friends, nature and with the divine, the universe, God. Typical of this are new mothers' unique bonding relationship with their newborn babies (Lydon-Lam 2012: 21). The fourth component was values or beliefs which often include certain religious beliefs and transcendence, which relates to expansion of self boundaries. Lydon-Lam's (2012: 21) study findings revealed that pregnant women regularly reported spirituality as a source of guidance, blessing, strength and confidence. Likewise Adams and Bianchi (2008: 109) indicated that spirituality was found to be a source of inner strength and comfort during labour; this included prayer, meditation, chanting, reading, reciting from scriptures and the use of rituals or sacraments. Chandramohan (2013: 95) conducted a study on "Spirituality and spiritual care amongst professional nurses at public hospitals in KwaZulu-Natal". Findings revealed that private or personal prayer is an important part of a comprehensive approach in enhancing well-being and recovery.

Maxwell (2009: 1) outlined the traditional culture of midwives in the early twentieth century. Among African-American women spirituality in traditional midwifery played a leading role in childbirth, and it was believed that childbirth had a direct connection to God (Maxwell 2009: 35). This is consistent with Callister and Khalaf's (2010: 19) study, where themes from narrative data findings revealed that women relied on God and believed that God can and will influence their birth outcomes for a more positive experience. Downe (2006: 44) concluded that for those with religious beliefs the birth experience may bring them closer to a Higher Being they believe in, and bringing a new life into this world for whom one is accountable. It also brings one closer to God.

Lahood (2007: 3) expressed that a number of modern women could experience non-ordinary states of consciousness during childbirth. While being engaged in anthropological fieldwork in New Zealand, he gathered

stories from mothers, fathers and midwives who had participated in transpersonal events during childbirth. An example of one such story was when a woman who was in labour and at the peak of a very strong contraction, saw a vision of a man dressed in a suit appearing before her. She thought it was her father or grandfather, or an angel or God. When the next contraction came she found herself in the same dark place and called for him, she questioned him and he said that he had come to help her, and with those words the baby was born. The non-ordinary states of consciousness experienced brought about a change in the woman's physical and psychic condition, which was known as an 'extraordinary experience' and thought to have a natural healing element (Lahood 2007: 4). Notably, non-ordinary states of consciousness could also be an essential part of the support offered to women during childbirth (Lahood 2007: 4). This further gives value to respecting the importance of culturally sensitive care and the needs of a mother during her experience of childbirth.

Koren *et al.* (2009: 118) argued that a valuable contributory factor to quality patient care is an environment of professional nursing coupled with the spiritual meaning that nurses find in their work. Ferret (2011: 1) stated that many nurses still feel inadequate, however, when responding to the spiritual needs of their patients. Vance (2001 cited in Ferret 2011: 8) found that factors such as time constraints, lack of education and fears of personal inadequacy were reasons for the lack of rendering spiritual care. Sellers (2012: 721) stated that this aspect of taking a person's complete physical, mental and social being is called holism and is known as a theory of health, which is important in understanding and treating illness. The individual is recognised as a whole person, which implies that every dimension of human life is equally important including the biological, social, psychological and spiritual dimensions (Ferret 2011: 6). In fulfilling this aspect of a satisfying spiritual birth experience for mothers during the birth process, they required adequate holistic support.

The above studies concentrated on spirituality relating to holistic care (Ayers-Gould 2000: 17; Ferret 2011: 1; Koren *et al.* 2009: 118). Studies by Lydon-Lam (2012: 20), Maxwell (2009: 1) and Lahood (2007: 4) showed that spirituality is an important aspect in childbearing women. According to Downe (2006: 41) many studies have investigated the connection between spirituality and religion in health, on pain relief, spiritual needs and family support in palliative care (Hanssen and Pedersen 2013: 523). There has also been a review of research on religion, spirituality and health (Koenig 2012: 1); culture, spirituality and religion (Eckersley 2007: S54); and transcultural spirituality and nursing practice in the context of dying and bereavement (Holloway 2006: 833). A further study explored the association between religious involvement in pregnant women with regard to health risk behaviours such as smoking, drinking, marijuana use and multiple sex partners (Page, Ellison and Lee 2009: 621). A few studies only focused on the role of spirituality around childbirth. Crowther and Hall (2015) focused in their study and other studies, on a discussion about complex contextual experiences of childbirth in relation to a growing interest in spiritual care assessments and guidelines. They concluded that the introduction of spiritual care guidelines into midwifery practice does not address the spiritual meaning or significance of childbirth. It is therefore important that the midwifery curriculum be adapted to the specific needs of the country (United Nations Population Fund 2011: 6).

Fuller (2012: 43) stated that culture and spirituality are inseparable aspects in childbirth, as is religion, because spirituality may be cherished by one's religious beliefs and practices. Significantly in her study it was found that childbirth was seen as a time to grow closer to God, making religion more meaningful. It was also revealed that rituals and beliefs were effective coping mechanisms during the birth experience. The conclusion was that through the sense of presence birth practitioners can find ways to provide holistic care within various birthing traditions, for example by the use of candles and other women repeating mantras (prayer verse). Similarly, Louwagie (2008:

17) revealed that Native American Indian patients value their religious and spiritual healing practices and beliefs. It was also noted that staff at the Woodwinds Hospital in Woodbury are dedicated to promoting health and healing, even during childbirth. Furthermore, guidelines were formulated for the use of sacred herbs, candles, use of oils and sacred objects in the patient's birthing room. These were incorporated as a policy guideline to assist staff to understand the importance of Native American Indians' sacred objects, ceremonies and worldview. Kennedy (2011: 76) added that as one's worldview influences one's childbirth practices, to a large extent this is culturally defined. In fulfilling this aspect of a satisfying spiritual and religious birth experience, mothers require adequate support.

### **2.3.2 Childbirth experience relating to support**

Support is considered as one of the most significant aspects of the global birth experience (Hodnett 2002: s160; Lundgren 2002: 34; Brown 2007; Moore 2009: 2; Kennedy 2011: 77; Etowa 2012a: 27; Goldstein 2012: 138). According to Sauls (2004 cited in Adams and Bianchi 2008: 106) labour support is the "intentional human interaction between the intrapartum nurse and the labouring woman that assists the client to cope in a positive manner during the process of giving birth". This supports the idea of Lowe and Struthers (2001: 283) of the relationship between the nurse and the patient. Goldstein (2012: 138) shared her experience of home birth. It was noted that having her husband, a doula (a trained lay care worker who assists with the care for women in labour) and a midwife as support, were most valuable during the birthing process.

In an international study in Canada it was found that differences existed among black women's views with regard to childbirth, which highlighted the event as a personal and individual experience (Etowa 2012a: 27). Supportive behaviours from family members and health care professionals were the main themes that emerged from qualitative data findings. These

behaviours incorporated both physical and emotional cues and informal sharing of knowledge, which were very important for Canadian black women. Emotional labour support was said to be reassuring and contributed to the feeling of being loved and cared about (Adams and Bianchi 2008: 109). Similarly, in a study in Africa Shimpuku (2002: 121) pointed out that advice and emotional support was perceived as useful for mothers during their experiences of giving birth in hospital.

Other studies established that women who had continuous one-to-one support during childbirth were more likely to have a slightly shorter duration of labour and a spontaneous vaginal delivery, without the use of analgesia or anaesthesia (Brown 2007). Other authors noted that mothers often faced social, emotional, physical health and workplace challenges, with little or no support (Corry and Jolivet 2009: 9). Midwives are important people in being with women as the midwife's presence in the birthing room and engaging with the mother enables creating a secure and safe environment for a fulfilling birth experience (Fuller 2012: 45).

### **2.3.3 The aspect of 'presence' in the experience of childbirth**

The midwife's presence is essential in midwifery. It was found that women highlighted that the presence of the midwife as well as the doctor in the labour and delivery room was important (Iravani *et al.* 2015: 36). Presence is a characteristic of trust (Lowe and Struthers 2001: 281; Lundgren 2002: 34). The authors highlighted that it is the midwife's responsibility to build a trusting relationship with the patient. Presence at the bedside is important in conveying support, as it is a central concept in caring and as a role of being a companion for the woman (Bowers 2002: 742; Lundgren 2002: 34). In her study Lundgren (2002: 34) included three themes, namely: to be an individual, to have a trusting relationship and to be supported and guided on one's own terms (Clift-Matthews 2006: 632).

Burkhardt and Nagai-Jacobson (1994 cited in Lundgren 2002: 41) stated that in order to be present at any particular moment and being with another involves a “knowing that is of the intellect, heart, body and spirit”. Lundgren (2002: 41) wrote that genuine presence could require stillness and silence, or demand activities at other times. If midwives are to convey presence, effective and satisfying care in the birthing room then they need to have an open mind, be honest, non-judgemental, understanding, and listen intently to the mother’s needs and concerns (Adams and Bianchi 2008: 109; Adeyemo 2013: 18). In the study by Thorstensson *et al.* (2012: 8) it was also reported that nurses are too busy completing paperwork, instead of being able to listen to them. Given that hospital labour wards are busy and short staffed, Cardiotocograph (CTG) monitoring is routine. In the United Nations Population Fund Report (2011: 8) report it was stated that there is a worldwide shortage of health care workers, a high increase in the number of patients and a demand for more nursing staff, which suggests that service delivery is being compromised. Mitchell (2001: 8) explained that “nursing is recognized as the partnership that exists between the nurse and the client which will lead midwifery care that is empowering, appropriate and acceptable”. Working in partnership with women is imperative in meeting the needs of the women during childbirth.

#### **2.3.4 Working in partnership with women**

“Working in partnership is the key to empowering others” (Mitchell 2001: 8). Behruzi *et al.* (2011: 2) concluded that empowerment at childbirth is relevant to midwifery care as the support of midwives is the most fundamental factors in a positive childbirth experience. Additionally, women do feel empowered when adequate support is received during childbirth (Hardin and Buckner 2004: 14). This is similar to the International Confederation of Midwives (2011: 4) who stated that a midwife should work in partnership with women, give the necessary support, care and advice during pregnancy, labour and the post-partum period. Working in partnership with women demands having

a trusting relationship, which can be possible with good communication between the midwife and the mother. According to the South African National Department of Health (2015: 49) it is evidently stated that midwives are required to communicate clearly to women, be supportive and be encouraging, to gain co-operation. Dahlen, Barclay and Homer (2010a: 58) explored first time mothers' birth experiences in hospital in Australia. They reported a lack of communication, particularly with regard to midwives, which caused isolation and distress during labour and birth. The woman communicates by verbal communication and through her body as non-verbal cues (Lundgren 2002: 35). The midwife therefore needs to be observant and be present with the women in the labour ward so that she can understand the needs of the women. This will allow the midwife to build a trusting relationship with the woman.

### **2.3.5 A trusting relationship in the childbirth experience**

Professional midwifery demands a special love for people so that patients feel secure in emotionally engaging with midwives. This feeling should come from within a person; it cannot be enforced (Olsson and Adolfsson 2011: 459). In addition, Lundgren (2002: 36) wrote that the relationship between the woman and the midwife has an impact on the birthing woman's experience because it strengthens her self-confidence.

It was noted that midwives with experience were better able to use intuition in practice to offer support, because they possessed inner confidence (Olsson and Adolfsson 2011: 458; Walsh 2006: 662). Intuition involves attentiveness and listening skills which are important characteristics in showing genuine engagement, in order to gain trust and establish a secure relationship between the midwife and the woman. Magill-Cuerden (2006: 374) referred to these characteristics as the hidden characteristics of midwifery; these are characteristics and skills that must filter into midwifery care to ensure holistic care is given to women.

In Merg and Carmoney's (2012: 74) study women and childbirth educators were interviewed about their experiences of homebirth after hospital birth. It was noted that trusting relationships were built between the homebirth midwives and the women together with assurance that whatever was done, was intended for the best interest of the women and their babies. Merg and Carmoney (2012: 74) also highlighted that the midwife and the woman share a special relationship; the woman feels being supported which in turn builds her confidence towards feeling in control of herself.

### **2.3.6 Birth experience and being in control**

Being in control is important for a positive birthing experience in women (Lundgren 2002: 42). This idea was confirmed by Hildingsson, Johansson, Karlström, and Fenwick (2013: 161), who found that a woman's perceived level of control and her ability to work her way through the pain of labour without using any pain relief medication significantly predicted a positive birth experience. According to Behruzi *et al.* (2011: 2) it was found that women need to be adequately prepared for labour and delivery at antenatal classes. Similarly Nawal and Goli (2013: 6) also found that birth preparedness enabled a positive birth experience. Chokwe and Wright (2013: 5) established that at state and private hospitals in South Africa there was poor communication between patients and midwives, and the latter failed to explain procedures to the patients. The support of midwives will assist mothers to be in control of their bodies and minds so that they will be better able to make choices. This is consistent with Adams and Bianchi (2008: 109) who stated that if women are to become confident they need labour support, such as instructional or informational support, which also allows the woman to be part of the decision-making process which women expect. Noseworthy, Phibbs and Benn (2013: e47) found that partner and family play a significant role in decision making during childbirth. These authors concluded that factors such as individual practices, local hospital cultures, medicalised birth and staff shortages outline the way in which care decisions are made. The



main fear of a woman is to lose control, particularly if she has experienced past distress and hurt (McGrath 2012: 76; Fraser and Cooper 2003: 659). Confidence comes from trusting one's self and one's feelings, as well as having faith in one's self (McGrath 2012: 75). Fraser, Cooper and Nolte (2010: 441) added that a woman in labour should be persuaded to trust her own instincts and listen to her body, and to get the necessary support by communicating her feelings. Furthermore, Cook (2010: 54) found that women felt empowered when they followed their instincts because it also led to a rewarding experience.

### **2.3.7 Women's experiences of expectations during childbirth**

When women enter hospitals they expect to be accepted, that is, to receive courtesy and consideration for their different views. This was emphasised as displaying respect (Iravani *et al.* 2015: 36; Magill-Cuerden 2007a: 126). McGrath (2012: 75) stated that one's beliefs and one's expectation of experiences could have an impact on both conscious and unconscious roles. She discussed fear during pregnancy and birth, and said that fear is a normal and necessary feeling that women experience. In McGrath's (2012: 75) study it was revealed that fear is normal, considering that pregnancy and birth involve great change and a mixture of emotions in a woman's life.

Results from Beck and Watson's (2010: 241) study validated that women's experiences of subsequent childbirth, after previous traumatic childbirth, could either heal or re-traumatise them thus leaving a "lasting imprint on their lives". In addition Simkin (2002 cited in Callister 2006: 8) emphasised that women have long-term memories of professional care received during labour and delivery. This stems from the fact that women experience anxiety and pain and are vulnerable during this time. It was construed that women who had homebirths after previous hospital births viewed childbirth as a natural and satisfying experience with fulfilment of their expectations (Christiaens and Bracke 2007 cited in Merg and Carmoney 2012: 74). From an obstetrical

nurse's perspective of first-hand experience of childbirth, it was verified that mothers required education and information with regard to expectations before, during and after delivery (Lleras 2007: 20).

Lundgren (2002: 42) affirmed that the midwife's presence provides companionship; shares the responsibility of childbirth; to have openness; to listen to; and to be sensitive to the wishes and needs of the woman. This meant striving to become a companion. Non-verbal cues from the woman increased as the labour process progressed, which is important as this is a way of communication through her body (Lundgren 2002: 35). McGuinness (2006: 328) concurred that when women follow their instincts at birth they expect their midwives to read their reactions and give them support.

In sharing this responsibility of childbirth the midwife's focus has to be towards the woman's needs and desires (Lundgren 2002: 35), as women have different expectations and understandings of care during childbirth (Hrešanová 2014: 981). This is salient in midwifery care, as Corry and Jolivet (2009: 8) stated that 'woman centered care' should focus on timeliness and efficiency, the values and culture, and choices and preferences in promoting the best possible health outcomes. Being tied to their beds for monitoring does not allow woman to have free choice of delivery position. According to Allison (2005: 6) the squatting position for delivery was noted as the choice of birthing position in women throughout the world. It is normal practice in certain traditional cultures, and is said to ease the delivery process. Sellers (2012: 335) added that part of the responsibility of the midwife is to assist mothers to develop a birth plan, which includes the position for delivery as one of the issues. An example of this was highlighted in a study in Zambia by Maimbolwa *et al.* (2003: 263), where mothers preferred to deliver at home because of their cultural childbirth practices and beliefs. It was noted that some of these practices viz. ambulating during labour, free choice of labour position and women support during labour, still exist in contemporary midwifery care. Sessions (2013: 50) added that when women use natural

birth practices, such as ambulating freely during labour and birth, they are better able to be in control during birth. This leads to positive birth experiences. Lowe and Struthers (2001: 281) concurred that respect, values and wisdom are characteristics that describe the concept of tradition. The next section draws attention to midwives' experiences of engaging with women during childbirth.

### **2.3.8 Midwives experiences: engaging with women during childbirth**

Florendo (2011: 66-68) reflected that student nurses' experience of handling childbirth for the first time was exciting, uplifting and rewarding, however they felt anxious on witnessing the pain women experienced. They wrote about how their mothers felt during this experience. According to Olsson and Adolfsson (2011: 455) and Walsh (2006: 662) an experienced midwife is better equipped with confidence and is better able to use her instincts in practice. Novice midwives need guided knowledge in assisting women during childbirth.

Davis and Walker (2010: 604) concluded that midwives always tried to create a birthing space which was tranquil and private, so that women could feel safe and have an enjoyable and successful birth experience in all birth settings. It was found, however, that the obstetric hospital posed certain challenges in creating, maintaining and protecting this space, which was seen as difficult work. Notwithstanding the fact that midwives work with women throughout their pregnancies trying to create the experience of childbirth as a natural physiological process, midwives experience challenges of being hurried in busy obstetric hospitals (Davis and Walker 2010: 608). Nevertheless, midwives continued to utilise alternative constructive approaches such as grooming the women for obstetric consultation, towards preparing them to maintain control over their experiences whilst giving birth in the hospital (Davis and Walker 2010: 608).

Merg and Carmoney (2012: 71) collected qualitative data from women about home birth after hospital birth, and described models of midwifery care. The first model was the medical model, which required that any risks associated with childbirth should be medically managed. The other model was the midwifery model, whose standpoint was that “childbirth is a normal physiological process which works best when there is the least amount of interference” (International Confederation of Midwives 2012 cited in Merg and Carmoney 2012: 70). Results revealed that homebirth appealed to all participants, because they felt that the homebirth midwives did everything in their power to give women the best possible birth experience with less interference and more holistic care and attention.

Keating and Fleming (2009: 519) conducted a study on midwives’ experiences of facilitating normal birth in an obstetric-led unit. It was found that midwives experienced an uneasy working relationship in the hospital labour ward setting, and were more confined to the medical system of birth than focusing on the individual needs of the women. There was fragmentation of care because midwives were constantly moved from one task to another during the course of a woman’s labour and birth. Stress and frustration amongst midwives were highlighted (Keating and Fleming 2009: 523). Giving birth in hospitals is visualised as stressful and poses a challenge to midwives, in trying to create a space for birth to take place in as normal a process as possible. This highlights the difficulties between the midwives’ needs and hospital provision of adequate resources.

Maputle and Hiss (2010: 12) stated that midwifery care during childbirth was strictly routine in order to keep up with the policies and procedures that were purposively placed in the maternity ward of a hospital. Although the focus was midwife-centred care, rather than woman-centred care, the physiological process and changes that take place during childbirth was taken into consideration. This was guided by the biomedical model which concentrated mainly on detection of abnormalities which midwives were accustomed to

(Pearson, Vaughn and Fitzgerald 1998 cited in Maputle and Hiss 2010: 6). The woman in labour had no choice, however, but to follow the rules of the midwife. As a result there was limited shared participation; hence, the psychological aspects of how women experienced childbirth from their worldview was ignored (Maputle and Hiss 2010: 12). This means that holistic midwifery care was not rendered, which may lead to the woman's dissatisfaction with her experience.

According to Maxwell (2009: 35), older experienced midwives believed that a woman was not qualified to practice as a midwife if she did not have a calling and feel the sense of being motivated by spiritual forces beyond herself. As a result, new recruits went through emotions of panic and lack of enthusiasm, because they felt being a midwife carried a lot of responsibility. Maxwell (2009: 43) noted that experienced midwives were aware of the pain, suffering, problems and complications encountered during childbirth. These are but the physiological aspects of caring, however the midwife also needs to be sensitive towards the mother's psychological, emotional, cultural, religious and spiritual needs. McGrath (2012: 72) discussed fears women expressed during childbirth and offered ways in which childbirth educators could acknowledge and accept women's fears towards finding courage that they need to give birth. It was stated that "fear is a normal part of the human condition" (McGrath 2012: 72). In South Africa, in Brooke's (1991: 6) study on Indian women's birth experiences, it was also found that women expressed fear. Likewise pain experienced by the women during childbirth was seen as a natural element of the delivery process (Lundgren 2002: 34). Additionally, Klabbers, Wijma, Paarlberg, Emons and Vingerhoets (2014: 1) reiterated that fear during childbirth is a normal occurrence.

### **2.3.9 Women's experiences of pain during childbirth**

Birth is a natural process and labour usually commences when the woman experiences pain which intensifies as labour progresses (Sellers 2012: 314;

de Kock and van der Walt 2004: 12-4). Although pain experienced during labour and delivery is regarded as a normal phenomenon (Klabbers *et al.* 2014: 1), women may experience fear and anxiety due to the high intensity of pain during labour. Morson (2013: 77) studied the experiences of women in early labour and stated that anxiety can progress to fear, and that the context in which they are experienced can vary from person to person. The midwife is closest to the mother during labour and birth and needs to assist the woman to control her pain. Leap, Dodwell and Newburn (2007: 23) agreed that a great contributory factor for women to manage pain without fear is support from midwives, particularly a trusting relationship. This is important because fear and intolerable levels of pain are often remembered as a negative experience of birth (Mercer, Green-Jervis and Brannigan 2012: 720). Henderson and Macdonald (2004: 434) added that women experiencing childbirth for the first time are also fearful of the unknown in the hospital environment, as it invades her personal identity and autonomy. It was also expressed by Leap, Dodwell and Newburn (2007: 23) that the majority of women prefer to give birth with the least amount of drugs for pain relief, provided they can manage.

Callister *et al.* (2003) conducted a secondary analysis on the pain experiences of culturally diverse childbearing women through narrative data from studies of the meaning of childbirth. It was articulated that women who were affiliated with religious norms and values appeared to have accepted pain as a necessary and inevitable part of the human experience. Mahlako (2008: 126) explored midwives' responses and attitudes towards women in labour as well as their perception of pain experienced during labour. Callister *et al.* (2003) examined the pain of childbirth with regard to the perceptions of culturally diverse women. Both Mahlako (2008: 126) and Callister *et al.* (2003) concluded that labour pain is unique to each woman, although normal and bearable, and women's responses should not be stereotyped but treated uniquely. In understanding the role of culture in pain, Magnusson and Fennel (2011: 48) stated that pain is perceived as a multi-dimensional experience

because it impacts on people physically, psychologically, socially and spiritually. Magnusson and Fennel (2011: 49) also concluded that it is important to understand a culture's perceptions and experiences of pain before assessing and managing the pain. Lasch (2000: 20) reiterated that in approaching any patient in pain one must avoid stereotyping and be open, sensitive and caring towards a multi-cultural population, as "culture is, above all, an involving process" Lasch (2000: 16). This is a salient point as midwives come across women from different backgrounds and are the cornerstone in helping mothers control pain when in labour. Having an understanding of the cultural meaning of pain and women's pain experiences can therefore lead to more effective and sensitive midwifery care for women in labour and their family members (Callister *et al.* 2003).

In addition Mander (2000: 138) studied a woman's meaning of labour pain. A theme that arose from the findings was that individual's sought to feel good about themselves by using the experience of labour pain to achieve self-fulfilment and personal growth. Midwives therefore need to recognise and incorporate these meanings when attending to women in labour if a satisfying birth experience is to be achieved. Interestingly Kitzinger (1978: 119) also described labour pain as unique and having meaning and purpose. In her study she stated that labour pain and birth are associated with body fantasies which describe the stimulus she receives from her uterus. Kitzinger (1978: 119) wrote that Jamaican women welcome backache in labour, because they interpret it as representative of a gate in the lower spine through which the baby must pass to be born, that is swinging open. Techniques used for pain control, as described by Kitzinger (1978: 120), were relaxation, breathing techniques, being mobile and not lying in the supine position, as well as counter-stimulus by massage, pressure or stroking.

Several research studies have recently given attention to women's experiences of pain during childbirth. In India a survey was carried out by James, Prakash and Ponniah (2012: 195) to assess women's awareness and

attitudes towards labour pain. Whilst most participants at the private antenatal clinic received information about pain relief during labour, others felt that pain should not be relieved as birth is a natural process. It was concluded that these women were well informed about pain relief methods as compared with women in Nairobi, Nigeria and South Africa (James, Prakash and Ponniah 2012: 195). In a similar type of study Shidhaye *et al.* (2012: 134) found that women residing in rural settings in India were not aware that delivery is possible without pain. This was due to a lack of dissemination of information from health workers, further emphasising the need for more holistic nursing and midwifery care.

In the Eastern Cape province of South Africa, Mugambe, Nel, Hiemstra and Steinberg (2007: 16) also studied women's knowledge of, and attitudes to, pain relief during labour. More than half the women interviewed had gained knowledge of pain relief from friends and relatives of past experience of birth, or from textbooks. None knew about inhalational techniques or non-pharmacological methods, except a few who knew about breathing exercises. It was concluded that there was a failure on the part of health authorities, local care givers or patients themselves to provide such information. It was suggested that information could be disseminated through pamphlets, booklets or the use of videos at the antenatal clinics (Mugambe *et al.* 2007: 16d).

Leap (2000) wrote about a midwifery perspective of pain in labour. It was noted that offering pain relief to women in labour was a labour ward culture of the midwife. Pain relief was offered regardless of the type of labour, however it was the woman's choice as to whether she accepted it or not. Beigi *et al.* (2010: 81) assessed women's experience of pain during childbirth in hospitals six weeks after delivery. It was noted that the religious thoughts and personal characteristics of individuals have a special significance in the way they encounter pain. The importance of family and medical support was found to assist the pain to be tolerable.



In a South African study on labour and pain management, van der Westhuizen (2011: 28) reported on the two extremes in the health system in South Africa, viz. the public health system which provides free care to about 80% of the population, and the private health system. Options such as the choice of type of delivery e.g. elective caesarean section, and pain management, differ in both the private and the public setting. According to van der Westhuizen (2011: 28) analgesia in private hospitals in South Africa is limited to drugs, namely Pethidine, epidural analgesia and Entenox gas. Most women in South Africa use alternative and natural approaches to relieve pain. These are breathing, walking, showering, bathing and a support person.

### **2.3.10 Women's birth experiences in hospitals**

Ayers-Gould (2000: 14) said that "the greatest act of humanity is the birth of a child. Yet even that has become the victim of technology". Bruyere's (2012:39) study on cultural birthing traditions in Canada revealed that the birth of a baby was always a sacred and religious tradition accompanied by rituals. Although mothers saw the value of giving birth in hospital, they valued religious traditional rituals such as prayers to welcome the newborn. Bruyere (2012: 42) expressed that the medical model has served to dehumanise the sacred birthing experience. In the United Kingdom most births take place in obstetric-led units, as shown in a study by Russel (2007: 128). Berg *et al.* (2012: 79) aimed to define and develop an evidence-based midwifery model of woman-centred care in Sweden and Iceland. It was pointed out that modern maternity care has progressed towards a more medical model of giving birth.

Smith *et al.* (2004: 117) conducted a study on evidence-based obstetric care in South Africa by using a focused change programme, the Better Births Initiative, at ten hospitals in Gauteng, South Africa. Some important improvements in the practice of midwifery followed after the execution of the

Better Births Initiative. These were a reduction in the use of enemas; shaving and episiotomy; increased use of oral fluids; and companionship during labour. This initiative was also supported by the Provincial Department of Health (Smith *et al.* 2004: 119). Additionally, Iravani *et al.* (2015: 36) expressed that procedures such as vaginal examinations during labour should be performed only when necessary. This is based on best practice.

Other research findings revealed that this system has failed to support normal birth and midwifery approaches to care, as obstetricians at all levels are seen as being in charge of the maternity units and are most influential (Russel 2007: 129). A survey in a hospital in the United States of America on women's birth experiences revealed that some women felt overwhelmed, while others felt the experience as being powerful (White 2007: 28). In an international cross-sectional study Choobmasjedi *et al.* (2011: 1131) emphasised the fear of pain experienced by women from a private and a public hospital in Tehran. The fear of pain led to more women requesting a caesarean section in the private sector than in the public sector, because private hospitals generally allow pregnant women to opt for caesarean section and tend to medicalise birth. Choobmasjedi *et al.* (2011: 1131) also concluded that fear in women at public hospitals may be related to the poor quality of midwifery care at public hospitals, and that fear of pain in both private patients and public hospital patients was associated with a greater desire for a caesarean section. Therefore there is an emphasis on the need for midwives to improve their knowledge to better serve women during childbirth, so that women can feel confident in having safe, satisfying and positive birth experiences. This is salient as Johnson, Padmadas and Matthews (2013: 9) reiterated that poor quality of care can discourage women from seeking care at institutions.

Conversely, technological support was viewed as fundamental by most women at a hospital in rural Tanzania (Shimpuku 2002: 121). Women perceived childbirth as a risky venture. They were aware of possible risks

and complications and have the belief that technological support could save their babies and themselves (Shimpuku 2002: 121). According to Downe (2007: 156) women prefer to deliver their babies in a hospital environment because they perceive it to be safe for themselves and their babies. Downe (2007: 156) added that considering the circumstances and the norms of Western societies in the 21<sup>st</sup> century, it is best for women and babies at risk, as well as those who choose this option to deliver in hospital. Similarly, Clift-Matthews (2007: 464) viewed giving birth in hospital was a norm, because medical involvement is routine in hospitals and so the woman opts for this as a choice. McLachlan and Forster (2009: 359) differed, implying that it is not the best option to deliver in hospital because a considerable amount of women prefer homebirths, or prefer to give birth in a midwifery-led birth centre.

Otis and Brett (2008: 47) indicated that more than half-a-million women who live in underdeveloped countries die each year due to pregnancy-related conditions. This raises concerns about the quality of midwifery care and standards that currently exist in developing countries. Medical care received for labour and delivery in a health care setting can have several advantages over giving birth at home. An example includes the identification of complications; however this may not necessarily be the case in low quality biomedical reproductive care in government health facilities (Otis and Brett 2008: 46-47).

Stephenson *et al.* (2006: 85) examined the influence of individual household and community level factors on the decision to deliver a child in a health facility, in the Ivory Coast, Burkina Faso and Ghana in the Western region of Africa; and in Kenya, Malawi and Tanzania in the Eastern region of Africa. Results revealed similar influential factors in all six countries viz. community-level socio-economic development, female autonomy and fertility norms. It was noted that in Malawi, Tanzania, Ghana, Burkina Faso and the Ivory Coast the percentage of women in the community who had delivered a child

in a health facility had a strong positive influence on a woman's decision to seek care (Stephenson *et al.* 2006: 91). This is similar to a study by Kumbani *et al.* (2012) who focused on both the provision of care as well as how clients perceived perinatal care at a district hospital in Malawi. Data uncovered that women felt respected and were received positively, however they did not know what to expect during childbirth. It was also deduced that women wanted a caring attitude and support from health care workers during this difficult time (Kumbani *et al.* 2012).

A study on the perspectives of Black and Hispanic patients regarding experiences of hospital care in the United States of America revealed inconsistencies in health care, due to racial and ethnic differences between Black and Hispanic patients (Hicks *et al.* 2008: 1234). Both Hispanic and Black obstetrical patients reported positive experiences when family and friends were present for emotional support. Negative experiences were reported by Hispanic patients because they were pressured to have a surgical procedure when they were undecided. Black patients related emotional support as negative experiences when there was limited visiting hours. Hicks *et al.* (2008: 1234) concluded that a culturally diverse workforce is needed, as well as interpreters and the availability of social workers for the satisfaction of care in hospitals. This supports the need for better equipped midwives and health professionals for the improvement of midwifery services to the public, more specifically for women during childbirth.

Gabrysch *et al.* (2009: 724) carried out a study titled "Cultural adaptation of birthing services in rural Ayacucho, Peru", outlining that Ayacucho is one of Peru's regions with the highest maternity mortality ratios. The objective of the study was to increase delivery use, by building a trusting relationship between health care providers and communities and to make services responsive to the communities' needs. The study clearly demonstrated the feasibility of creating and implementing a model of skilled delivery attendance that integrated modern medical and traditional elements. Some examples

were that women were allowed to use oils, herbs and eggs etc. for difficult labour; a normal bed was provided instead of a gynaecological bed; and the vertical crouching position was allowed and facilitated by providing rope and the bench for use during labour (Gabrysch *et al.* 2009: 726). This ensured that the delivery services met the needs of their population. Midwives are the key role players and therefore need guided cultural knowledge, and more importantly, to be culturally sensitive in their care to women.

In rendering a woman-centred approach it is imperative that the midwife understands the social, cultural and context differences so that she can respond to and meet the holistic needs of women (Fraser, Cooper and Nolte 2010: 7). The following sub-section deals with childbirth in the context of belief systems both in the international and local settings.

## **2.4 BELIEF SYSTEMS, ALTERNATIVE MEDICINES AND CHILDBIRTH**

### **2.4.1 International setting**

Valuing diversity in a multi-cultural society is an important aspect (Fraser and Cooper 2003: 17). As Jordan (1983 cited in Mitchell 2001: 1) said “childbirth is an intimate and complex transaction whose topic is physiological and whose language is cultural”. Childbirth is a unique event for each individual in the context of their traditional norms, which is articulated through spiritual, religious and cultural traditions (Fuller 2012: 43). This supports African Canadian women’s experiences of childbirth, which was portrayed as unique and one of the most meaningful experiences that goes beyond the process of being physiological (Etowa 2012b: 28). In a similar view, Etowa (2012b: 28) described the childbirth event as relating to a range of emotional and physiological experiences as well as the taking on of new responsibilities.

It was also noted that there were more cultural rituals and practices around childbearing than any other life experience (Reddy 2009 cited in Etowa

2012b: 29). Fraser and Cooper (2003: 626) added that in addition to all the physiological adjustments that take place during this time, there are also a variety of religious and traditional customs that must be carried out. Due to differences in social circumstances, culture, religion and values, antenatal, childbirth and postnatal care, practices in different societies and cultures differ significantly (Bawadi 2009: 50). Midwives therefore need guided information and knowledge to be sensitive and culturally competent in meeting the needs of women from different religious and cultural backgrounds (Lowe and Struthers 2001: 281).

According to a study in the United Kingdom by Gatrad and Sheikh (2001: F6), the rites of passage are deeply symbolic and complementary in the Muslim community. Soon after birth, and preferably before the Muslim infant is fed, a small piece of softened date or honey is gently rubbed into his/her upper palate by a respected member of the family in the hope that some of the good attributes will be transmitted to the infant (Gatrad and Sheikh 2001: F6). The father or a respected member of the local Muslim community whispers a declaration of faith into the baby's ear, which is done over a few minutes in privacy (Chaudhry 1988: 45; Gatrad and Sheikh 2001: F6). On the seventh day after birth of a Muslim baby, an animal is sacrificed and a feast follows (Chaudhry 1988: 47; Mitchell 2001: 23). Gatrad and Sheikh (2001: F6) stated that the baby's hair is also removed on the seventh day and an equivalent weight in silver is given to charity. This further supports the importance of understanding cultural and religious needs. This will add to midwifery knowledge and sensitise midwives.

Laroia and Sharma (2006: 94) examined religious practices at the time of birth amongst Hindus. Findings revealed that soon after the birth of the baby it is customary for the father to touch and smell the Hindu child, as well as to whisper religious verses (mantras) into the child's ears to promise him or her a safe and comfortable environment. Similarly in the Hindu birth, a family member with good qualities writes 'Aum' on the baby's tongue. According to

Elion and Strieman (2001: 125) the 'Aum' sign is a sacred symbol of the Hindu religion. This is done in the hope that the good qualities are passed on to the infant. If it is a son the father gives the infant butter and honey in the hope of giving the infant wisdom and a long life protected by the gods (Laroia and Sharma 2006: 96). There is also a naming ceremony whereby the baby is given an individual name after consulting a priest or a learned person soon after birth. The name is chosen from a choice of three letters given by the priest, which was determined by careful spiritual and astrological readings (Elion and Strieman 2001: 125).

Wehbe-Alamah (2008: 87) conducted a study on Muslim cultural beliefs in the United States of America which aimed to equip nurses with knowledge of Muslim cultural beliefs. According to Wehbe-Alamah (2008: 87) it was stated that Muslims believe 'health' to be a blessing from God which is related to spiritual, physical, emotional and psychological well-being of the body, mind and soul. Based on the findings related to beliefs during childbirth, it was noted that charms and amulets with words or verses from the Qur'an are usually attached to the newborn's clothing, to protect the baby from the evil eye. Furthermore, anyone who carries the baby is expected to verbalise the name of God in the belief of getting rid of evil (Wehbe-Alamah 2008: 87). Following birth, as in the African traditional religion and Islamic religion, the Hindu child is welcomed into the family by having a traditional ceremony. After delivery the mother and baby are given healing time of forty days, during which she is exempted from household duties and is taken care of by female relatives (Laroia and Sharma 2006: 95).

There is substantial evidence from international studies which revealed that complementary and alternative methods are extensively used during pregnancy and childbirth, and that a holistic approach to childbirth is important (Calvert and Steen 2007: 159). In Sweden Robertson and Johansson (2010: 442-443) pointed out that throughout medical history it has been reported by midwives that complementary and alternative medicine are

used for pain relief during pregnancy, labour and delivery. Acupuncture, warm water baths, intradermal water blocks, transcutaneous electrical nerve stimulation, hypnosis and other methods such as personal support, relaxation methods, touch and massage, are examples of complementary and alternative medicine that were used in Sweden (Robertson and Johansson 2010: 442). Women did use methods such as relaxation, breathing and continuous support, however midwives did not notice these techniques being used (Robertson and Johansson 2010: 446). Significantly, it was noted that midwives were not able to interpret the expressions and wishes of women with culturally different ways of behaving. It was also noted that stereotyping of women according to ethnic origins limited the individual care of women (Robertson and Johansson 2010: 446). This is in line with Magill-Cuerden's (2006: 328) study in the United Kingdom, where it was observed that stereotyping played a major role in maternity care.

Westfall (2001: 47) reported worldwide use of medicinal herbs in extensive literature, one of the countries being North America where medicinal herbs are used. Tonic herbs, such as raspberry leaves, moistens the mouth and assists in uterine contraction; partridge leaves tone and nourish the uterus, thus preventing miscarriages; and Blue Cohosh roots and rhizomes of Bethroot are used for induction of labour and other issues related to childbirth. It was also reported that in contemporary herbal medicine Bethroot is taken as a tea to induce labour. Westfall (2001: 53) concluded that healthcare providers must be aware of herbal medicines as it may prevent the need for invasive techniques, and in the event women get to utilise them.

A quantitative study by Kalder *et al.* (2010: 475) in Germany to assess the use and reasons behind complementary and alternative medicine from the patient's perspective showed that homoeopathy was commonly used during delivery while massage, herbs, acupuncture and vitamins were used in pregnancy. Calvert and Steen (2007: 159) established that homoeopathic remedies assisted women during pregnancy, labour, puerperium, as well as



the baby. This coincided with Goldstein's (2012: 142) experiences of massage and acupressure which assisted the labour process. Field *et al.* (1997 cited in Lundgren 2002: 40) confirmed that massage during labour decreased pain and women experienced shorter labours, shorter hospital stays and less postpartum depression. The reasons for complementary and alternative medicine use was a woman's desire for personal control and also dissatisfaction with conventional treatment. The dissatisfaction with conventional treatment raises questions about current global midwifery care system and its shortcomings.

Adams (2006: 40) stated that complementary and alternative medicine was becoming popular in Australia, although little was known at a grassroots level. In-depth interviews were conducted with midwives working in public hospitals. Although midwives tried to integrate complementary and alternative medicine in general hospital midwifery practice, Adams (2006: 40) indicated that there is a professional boundary and power struggle which remains an intrinsic factor in integrating complementary and alternative medicine into hospital midwifery. Adams (2006: 44) said that complementary and alternative medicine fits comfortably with the midwifery model of care that encourages self choice and empowerment for women. Midwives also expressed that complementary and alternative medicine is not only beneficial to the woman but may also be beneficial to the midwife with regard to her professional role and responsibility, as it enhances a sense of autonomy in their work and enables the midwife to move beyond the control of the doctor (Adams 2006: 44). Adams and Bianchi (2008: 106) revealed that nurses could positively affect the labour progress and comfort of a woman through the use of non-pharmacologic nursing strategies.

In England, Mitchell (2010: 110) wrote that there was evidence with regard to the use of complementary and alternative medicine by women to support normal birth, and by midwives to avoid or reduce caesarean section rates. Women avoided the side effects of technology and chose to use

complementary and alternative medicine, which are perceived as more natural products (Mitchell 2010: 110). Women resorted to complementary and alternative medicine because of dissatisfaction with the usual medical care and a desire for personal fulfilment and more real and valuable relationships with their caregivers (Mitchell 2010: 110).

Attah *et al.* (2012: 377) confirmed that nine plant preparations used by Nigerian traditional cultures had pharmacological properties. Results of the study revealed that nine plant species brought about a contractile effect on the uterus, thereby inducing labour. According to the Centre for Gender and Social Policy Studies (2012 cited in Attah *et al.* 2012: 377), an estimated 85% of the population of the developing countries depend on traditional health care systems. This was due to constraints experienced with accessibility, affordability and availability of health care centres, Nigeria being one of them (Ogbe *et al.* 2009 cited in Attah *et al.* 2012: 377). The use of plant preparations for labour and childbirth reflect the relevance of the cultural importance of it.

#### **2.4.2 The local setting**

According to de Kock, van der Walt and Jones (2009: 2-1) events such as pregnancy and childbirth are challenging events for women, families and communities. It frequently involves traditional beliefs and practices which the midwife should have knowledge of, in an effort to acknowledge, respect, accept and understand women's behaviour. This is behaviour, which is learnt, in human sciences is conveyed by members of a particular society known as culture (Baldwin *et al.* 2004: 4; Kluckhohn and Strodtbeck cited in Bawadi 2009: 23; Leininger cited in Coffman 2004: 100).

Lowe and Struthers (2001: 281) support this view of being connected to and honouring people of the past, present and future, as well as to explore similarities and differences. A local study carried out by du Preez (2012: 29)

on the Batswana community in the rural Northwest Province of South Africa focused on related health practices in pregnancy. Findings revealed that women attended antenatal clinics late due to the fear of being bewitched or giving birth to a baby with abnormalities (du Preez 2012: 29). The Batswana community believed that if a person is jealous of another woman's pregnancy then he or she could invoke evil spirits, which could cause prolonged and difficult labour during birth. A further belief in that study was that if a woman blew forcefully into a bottle it would assist in the expulsion of the baby or the placenta (du Preez 2012: 33).

Giving birth is a natural process and a natural part of life (Mellish and Paton 2010: 49). Searle (1988: 8) stated, however, that the birth process always had special significance in all cultures and the birth process has always been associated with a variety of taboos which protected the mother and the infant. Swanepoel and de Beer (2006: 12) affirmed that the cultural environment of a society is often spoken of as the tradition of people, and that culture creates and contains taboos as well as providing a framework according to which people take action and react in daily life.

Transcultural nursing focuses on holistic care, health and illness patterns with respect to differences and similarities in people's cultural values, traditional beliefs and behaviours. The goal is to provide culturally congruent, competent and compassionate care (Leininger 1997 cited in Narayanasamy 2003: 185) which can only take place when culture, values, expressions and patterns are known, understood and used properly (Jeffreys and Zoucha 2001: 79). The midwifery workforce therefore needs to take heed of the differences amongst people's religious and cultural values, traditional beliefs and behaviours in order to render care to achieve satisfying birth experiences for women. This includes sensitivity and awareness of the safe use of complementary and alternative medicine in childbearing women because there is value in its use (Revell 2012: 58).

De Kock, van der Walt and Jones (2009: 226) and Fraser, Cooper and Nolte (2010: 79) asserted that midwives should make every effort to understand the local culture of the society to which she renders a service. This will allow midwives to take heed of cultural and religious facets of maternity care, to respect the woman's personal preferences about labour and birth, and to give consideration to women's choices (de Kock, van der Walt and Jones 2009: 227). Coffman (2004: 102-108) wrote that the most effective way to accomplish individualised care for patients from diverse cultures is to increase awareness and become enlightened about cultural differences.

In African societies the birth process begins during pregnancy, and it is believed that pregnancy makes a woman impure. Mother and baby are in a state of pollution and are thought to be susceptible to infection and illnesses (Mbiti 1971: 111). During labour and delivery women generally used the squatting position and men are not allowed in the house (Mbiti 1971: 111). Grandmothers, older women or traditional birth attendants attended to the birth, and after birth the mother and her baby were kept private in her hut until she stopped bleeding and until the burial of the placenta (Littlejohn 2010). When the cord of the baby fell off, then it was understood that the baby belonged to the whole community and not only to the mother. In addition, Elion and Strieman (2001: 42) stated that the umbilical cord is buried in a secret place; the belief is this will avoid the child from wandering away from home. In some African traditions a goat or a bull was sacrificed; others slaughtered a sheep where it is believed that not only God is brought into the picture, but also the living dead to rejoice the birth in the family (Mbiti 1971: 114).

Littlejohn (2011) expressed that every birth could be extraordinary, just as the birth of Christ. An example of a Christian sacred home water birth was described as believing in oneself with a deep connection to the universal forces of life. The woman created a sacred space for her labour in a candle-lit darkened room with her husband's support (Littlejohn 2011). This

experience was a reminder of the ancient Celtic ancestry, where a birthing woman knelt on her both knees to give birth. The midwives were thus called 'knee-women' whose duty was to fulfil a spiritual function in welcoming the infant into the world through prayers and chanting and placing water on the baby's forehead, which introduced the baptism ceremony of Christianity (Littlejohn 2011; Searle 1988: 90). The baby was then given a bath with handfuls of water poured over the baby nine times while reciting a prayer (Littlejohn 2011). According to Brookes (1991: 7) Christian babies were named after dedication ceremonies were performed in their churches and an oil massage was given to the baby while over an older kinswoman's knees. Elion and Strieman (2001: 58) wrote that the naming ceremony and the dedication of the baby into the Lord's service are important rituals in the Christian religion. This includes a thanksgiving ceremony and blessing of the child for the safe delivery of the infant with parents and family members. It is important to note, however, that The Holy Bible (1989: 1378) states that premarital sexual relations by females is forbidden because it humiliates the family. This is a belief of the Christian religion where it is not part of the norms and values to fall pregnant out of wedlock.

Another major religion in South Africa is Islam. Muslims are followers of Islam who submit to the will of 'Allah' (God). Islam means 'peace'; central to Islam is oneness, that is God is one and 'He is the author' (Lubbe 2008: 51; Molloy 2008: 443). According to Molloy (2008: 444) it is said that in Islamic belief God has spoken repeatedly through human beings (prophets) and Muslims trace their ancestry to Abraham. Muslims believe that good and evil forces are in continuous battle and that existence on earth is full of choices that lead to serious consequences. One of the important characteristics in Islam is that the woman must be veiled when she goes out of her home. Another Islamic religious norm is that premarital sexual relations by females is strongly condemned because it brings dishonour to the family (Clark 2003: 187).

According to Clark (2003: 169) in the Islamic religion birth is regarded as a major transition in life which has religious significance and is marked by religious rituals. The naming of the newborn and other events are intended to welcome the new child into the community. At birth the father speaks the first prayer (adhan) and second (iqama) calls to prayer in the baby's right and left ears. Naming of the baby also takes place at birth. Furthermore, soon after birth precautions are taken whereby parents attach amulets to the baby's clothes for the baby to be protected from evil spirits. Bawadi (2009: 250) stated that the birth of a baby boy was important as he protects the life of the family name. This finding coincides with Beigi *et al.* (2010: 81) who wrote that in Africa and Asia baby boys are said to be superior. Clark (2003: 170) added that circumcision for males is performed as early as from birth until the age of fifteen years. A postpartum Muslim mother and baby are also expected to undergo a period of seclusion for purification purposes, first to their room with no contacts outside the immediate family, then to the house with broader contacts allowed during this period (Clark 2003: 175). Another ritual is the sacrificial slaughter of a sheep or goat as a gift from the parents to the child. According to Elion and Strieman (2001: 113) two sheep are slaughtered for naming a boy and one for a girl. The meat is then distributed to the poor and also shared amongst the family and friends.

Hinduism originated in India; Hindus believe in a Supreme Being 'Brahma' who appears in different forms. Hinduism embraces numerous religious beliefs and practices (Gatrad, Ray and Sheikh 2004: 1094; Uys and Mulder 1985: 276). As with the Muslim and African traditional religion, the Hindu culture also follows ritual celebrations. The newborn of a Hindu speaking woman wears a black dot on the forehead, from the soot of burned ghee (clarified butter) which is said to protect the child from evil forces. Women of Tamil descent had a pen-knife pinned inconspicuously on the baby's pillow for the baby to be protected (Brookes 1991: 7). Birth cleansing ceremonies are held within a fortnight period whereby mothers had a massage and a hot leaf bath. Thereafter they stood astride a coal fire on which lobaan

(frankincense) was sprinkled (Brookes 1991: 7). According to Hindu sacraments sons are preferred because they carry the family name, and the birth of a girl may cause some anxiety because of the giving of dowries (Gatrad, Ray and Sheikh 2004: 1094). It was also said that in some parts of India women wear red or green glass bangles from the seventh month of pregnancy. The sound of the bangles is believed to reach the uterus and comfort the fetus (Gatrad, Ray and Sheikh 2004: 1095). It is clear from the above described examples that religious beliefs and culture play a major role in the birthing experience.

In the same respect traditional medicine remains an influence in South Africa. According to the Ministry of Health Malaysia (2008) it was estimated by the World Health Organization that 80% of people worldwide use herbal medicines as their main source of healing for various aspects of their primary health care. Mahlako (2008: 110) also highlighted that participating midwives at the hospitals in South Africa reported the use of herbal medicines; one of them was 'isihlambezo'. It was also stated that 'isihlambezo' assists with labour at the ninth month of pregnancy and expulsion of the baby at delivery. Traditional healing has become very well known since the promulgation of the African National Congress government in 1994 (Sellers 2012: 719; Thornton 2009: 17). "African traditional healing competes with and borrows from many other modes of healing, including New Age therapies (healing with crystals and essential oils, massage, Reiki), Chinese, Indian and European traditional medicines which utilise herbs and other therapies" (Thornton 2009: 19). A wide range of such remedies is available in almost all South African pharmacies and markets.

One of the functions of traditional health practice is to prepare a woman for childbirth physically, emotionally and psychologically (Thornton 2009: 21). Thornton (2009: 19) outlined three forms of healing that are practiced by African Traditional healers and their clients. There are sangomas who have 'graduated' from the period of tuition and healing; inyangas who use or sell

herbal remedies; and the practice of faith healing in the form of 'African syncretic Christianity' by the 'Amaprofeti' (prophet). Truter (2007: 58) stated that the inyanga or diviner acted as a consultant in cases of difficult labour or where a complication occurred.

Traditional healers share knowledge with each other through clear teaching, apprenticeship, practice and example. The traditional birth attendant is a person who engages in traditional health practice. As posited by Sellers (2012: 721) she is usually a woman who is registered under the Traditional Health Practitioners Bill. In some cultures in the Limpopo province, traditional birth attendants are still practicing and delivering approximately 120 babies on an annual basis, thus confirming that traditional birth attendants are still in practice. Ngomane and Mulaudzi (2010: 36) stated that care in midwifery settings was substandard as compared with home births and being supervised by traditional birth attendants. Pretorius and Greef (2004 cited in Ngomane and Mulaudzi 2010: 36) concurred saying that even if women required medical intervention they preferred to consult traditional birth attendants. Participants in Ngomane and Mulaudzi's (2010: 35) study regarded traditional birth attendants as competent practitioners, who were able to prevent complications such as obstructed labour. It can thus be noted that midwives in public hospital settings need valuable evidenced- based information to improve their knowledge, as religious and cultural beliefs are of significance to women during childbirth.



## **2.5 CONCLUSION**

This chapter presented the experiences of childbirth within the nursing and religious or spiritual contexts. The literature reviewed boasts a wealth of information mainly from international studies, which highlighted what women expect from a midwife and the importance of culturally sensitive nursing and midwifery care. Although a natural process, childbirth is a unique event for each individual in the context of their religious norms. Therefore it is imperative for nurses and midwives to become aware of and to become enlightened in terms of religious and cultural differences, which are pertinent for satisfying birth outcomes. Chapter three presents the design and methods that guided the study and which directed the researcher towards data collection techniques.

## **CHAPTER 3**

### **RESEARCH METHODOLOGY**

#### **3.1 INTRODUCTION**

The primary objective of this study was to explore and describe the experiences of childbirth in women from diverse spiritual backgrounds in South Africa. This included women from the Christian, Islamic, African Traditional Religion and Hindu worldviews. A qualitative approach underpinned the methodology that guided this study. Qualitative research in the nursing profession began in the 1970s and has continued to grow since (Burns and Grove 2011: 73). Although nursing established itself scientifically through quantitative research methodologies, more recently qualitative methodologies have gained momentum, and has been seen to be most pertinent in midwifery studies (Moore 2009: 57). In this chapter the rationale for the choice of the qualitative research design and the research methods are discussed. The data collection process, including the type of data collection tool used viz. the interview guide, is also presented. Attention is also given to the sampling process, the population sample and the procedures for data collection and analysis.

#### **3.2 RESEARCH DESIGN**

This study is qualitative, explorative, descriptive and contextual in nature and does not follow a particular discipline (Polit and Beck 2012: 505). Gray (2009: 177) affirmed that qualitative research is flexible in nature with no predetermined steps to be followed. The qualitative, explorative, descriptive and contextual research design was best suited for this study as it could provide rich, descriptive information of how women from Christian, Islamic, African Traditional Religion and Hindu backgrounds experienced childbirth at

public hospitals in the uMgungundlovu District of Kwazulu-Natal (Polit and Beck 2012: 505). Qualitative research is scientific in nature and allows for a systematic exploration and understanding of a topic from the chosen set of population included in the study (Polit and Beck 2008: 17).

Burns and Grove (2011: 20) and O' Leary (2010: 114) supported the idea that qualitative research is conducted to describe and understand human experiences. Childbirth is a unique and individual experience for every woman, a human life experience which has historically been seen as meaningful and interesting. It is not easy to quantify human emotions, however rich, meaningful and important information attained from qualitative approaches can contribute to nursing knowledge, which cannot be attained through quantitative approaches (Burns and Grove 2005: 52) Sandelowski (2000: 335) states that "all inquiry entails description, and all description entails interpretation". Qualitative description is more interpretive than quantitative description, yet less interpretive than phenomenological or grounded theory (Sandelowski 2000: 336). This study entails the description of the childbirth experiences of women from different spiritual backgrounds, as well as interpretation of the data received from them.

A research design provides a framework for the collection and analysis of data (Bryman 2012: 45). Burns and Grove (2011: 49) further described it as a blueprint in order to carry out the study and which maximises control over facets that may have an impact on the outcome of the study. The design cannot be exactly replicated as in a quantitative research design, which is standardised according to a preset procedure (de Vos *et al.* 2011: 66). Flexibility in the qualitative approach stems from the fact that one is also able to adjust to what is being learned during data collection (Polit, Beck and Hungler 2001: 207). In the context of the present study the researcher was able to probe further to elicit a deeper understanding of the childbirth experience from each woman's perspective.

### **3.3 RESEARCHER ROLE AND REFLEXIVITY**

An important aspect in qualitative research is the role researchers take and how they position themselves in the approach to the data in their study (Creswell 2013: 216; Barbour 2014: 37). As stated by Polit and Beck (2012: 178) reflexivity is described as the process of reflecting critically on one's self, and of analysing and taking note of personal values that could have an impact on the collection and interpretation of data.

It must be noted that the researcher is midwifery trained and a nursing educator. Part of the nursing educator's role is to provide clinical accompaniment for students in the clinical area. The researcher's role in the clinical area relates to the fact that she mentored student midwives in the maternity departments, as well as taught midwifery. On several occasions when discussing patient care and support to mothers during childbirth, the topic about having respect for different cultures surfaced. The researcher has to take cognisance, however, of how her presence as being part of the setting could have an influence on the data that was collected from the participants (Polit and Beck 2012: 179; Barbour 2014: 37). This is similar to bracketing, which is described as a process of identifying and temporarily setting aside preconceived beliefs and opinions. Although bracketing is difficult and cannot be achieved entirely, the researcher put aside her own ideas, beliefs, values, opinions, knowledge and experiences, in order to give a true reflection of the experience of childbirth from the participant's perspective (Polit and Beck 2012: 495).

The nursing profession is underpinned by a humanistic order which encompasses values and beliefs from a holistic and meaningful point of view, which is synonymous with qualitative methodologies (Omery 1983: 50). The researcher brought with her the assumption that women have certain expectations from midwives when they come into hospital. Considering that women came from different cultural and spiritual or religious backgrounds,

the researcher had to be sensitive as to how her assumptions influenced the data collection and analysis. Additionally, the researcher follows the same religion as some of the participants in this study. In order to prevent being biased throughout the research process, the researcher constantly reminded herself to be aware of her own preconceived beliefs and values in relation to the participants (Polit and Beck 2012: 495). In practising this consistent self awareness, the researcher was able to enhance the quality of this study (Polit and Beck 2012: 180). Peer review and debriefing was also used to reflect on the research process and the difficulties that were experienced (Creswell 2014: 202).

In order to focus on the study, the researcher decided that the most appropriate method for data collection was interviewing. The study commenced after all processes with regard to the study design and procedures were approved by the Durban University of Technology Institutional Research Ethics Committee (Appendix 6). Permission was also granted from the KwaZulu-Natal Department of Health Research Committee (Appendix1), and the uMgungundlovu health district manager (Appendix 2), to conduct the research at their institutions.

The interviews were planned to be at a suitable time for the participants and the health services being offered. Mothers were interviewed face-to-face using a semi-structured interview guide to elicit valuable information. The interview guide was designed to collect rich information and was examined by the researcher's supervisors to discuss any problems and concerns. The researcher also ensured that the same interview guide was used for all the participants to ensure consistency, and that all the questions in the interview guide were covered during the interviews. Mothers were also informed that the interviews would be audio-taped in order to capture all the information they shared. This allowed the researcher to listen carefully as to what was being said, per the tone of voice and the expressions that came across. Detailed notes were written for the participants who refused to be audio-

taped, although each participant was given a full explanation of the use of the recorder by the researcher. This was respected. The researcher transcribed the audio-taped interviews, and the detailed notes for the interviews that were not recorded were typed by the researcher. Thematic analysis was used to analyse the data. Themes and patterns that emerged in the data were uncovered through this process (Polit and Beck 2012: 562).

This journey began with an inquiry into one of the most special and personal events that is unique and individual for every woman. All facets of a woman, namely the spiritual, social, physiological, psychological and emotional needs are inter-related when rendering a holistic and a satisfying birth experience. This is salient for midwifery as nurses and midwives work closely with women and attend to all their needs during childbirth. Rich information and themes listed in chapter four were extracted, therefore illuminating the research topic by means of dense description (Henning, Van Rensburg and Smit 2004: 142).

### **3.4 STUDY SETTING**

This study was conducted in the Msunduzi municipal area in the uMgungundlovu District of Kwazulu-Natal. According to the Kwazulu- Natal uMgungundlovu District Profile (2011: 3) the uMgungundlovu District consists of traditional farmland communities, informal rural settlements and upmarket urban areas. The main language spoken in the Umgungundlovu district is IsiZulu (79%), followed by English (16%), IsiXhosa and Afrikaans (1%) (Kwazulu- Natal uMgungundlovu District Profile 2011: 4).

There are nine public hospitals in the uMgungundlovu District of KwaZulu-Natal. Four of the hospitals render a comprehensive health care service, including maternity services, to a multi-cultural population. Participants in this study were chosen from three of the four public hospitals that render maternity services. These are district-regional, regional-tertiary and district

hospitals which were in close proximity to the researcher. Clinics in the uMgungundlovu District are affiliated to the hospitals as these are referral health facilities. Post-natal mothers usually have their six week health check at their local clinics or hospital.

### **3.5 STUDY POPULATION**

A population is described as people who comprise of similar characteristics and who are eligible to be included in the study (Polit and Beck 2012: 274). This study consisted of all women who had given birth naturally in the selected hospitals and had completed the six week period after delivery. According to Sellers (2012: 514) the six week period after delivery allows the woman's body to return to its normal state and restoration of normal body function usually takes place. Fraser and Cooper (2003: 626) asserted that the six week period also relates to a range of cultural customs and traditions that must be carried out, in addition to all the physiological adjustments that take place during this time. Participants in this study included mothers who had completed the six week period after delivery. These were mothers who attended their local clinics or hospital for their six week health check. This was done to ensure that they were both physically and psychologically well to participate in the study.

### **3.6 STUDY SAMPLE**

Qualitative research requires specifically selected smaller samples instead of larger samples, as the focus is more on experiences, events and settings than on people. Qualitative studies focus on the quality of the data obtained rather than on the sample size. Rich and detailed information is sought in order to gain a richer understanding of the phenomenon of interest (Sandelowski 1995 cited in Burns and Grove 2011: 312; O'Leary 2010: 160). Participants need to have experienced the phenomenon and be able to emulate their experience of childbirth. The five major religious groups

identified are African Traditional Religion, Christianity, Islam, Hinduism and Judaism (South African Government Information 2011/12; Bhagwan 2010: 301). Women from the Islamic, Christian, African Traditional Religion and Hindu background were chosen as participants for this study. This was of importance because women from different religious or spiritual backgrounds may have different belief systems and follow different practices. Some of the participants in this study who have a Christian background also followed some of the traditional Zulu beliefs and practices.

Race and age were not important in this study; however participants ranged from 20 - 37 years of age. In order to ensure the privacy of each woman's personal background details the researcher described this aspect as generally as possible. Three of the women were professionals; one an immigrant from North Africa and also a professional; two were university students; one a scholar; six women were employed and others were mostly unemployed. Participants resided in locations which were in close proximity to their local health clinics and hospital. The researcher met each participant at her routine six week postnatal health check to conduct the interview. In this way any inconvenience for the participant was avoided.

### **3.7 SAMPLING PROCESS**

Purposive sampling appeared to be the most viable strategy in terms of selecting the participants for this study. The postnatal mothers who had natural births were purposively selected from three public hospitals in the uMgungundlovu district of Kwazulu- Natal. They were considered knowledgeable about the study and were considered to be information-rich cases that could bring value to the study. They therefore best served the purpose of the study (de Vos *et al.* 2011: 391; Creswell 2013: 156). Purposive sampling has also been defined as judgemental, selective or purposeful sampling (Burns and Grove 2011: 312; de Vos *et al.* 2011: 391).



Bryman (2012: 418) asserted that purposive sampling, also known as typical case sampling, exemplifies a dimension of interest related to the intention of the research. The type of purposive sampling used in this study was criterion sampling, which involved cases that met a predetermined criterion of importance (Polit and Beck 2012: 519). Participants in this study were well versed with the English language and hence there was no need to engage an interpreter. The inclusion and exclusion criteria as detailed in this chapter informed the sampling method.

### **3.7.1 Inclusion criteria**

According to Burns and Grove (2011: 291) inclusion criteria are referred to as eligibility criteria that participants must possess to be included in the sample.

The inclusion criteria in this study consisted of the following characteristics:

- Mothers from the following religious backgrounds: Islam, Christianity, African Traditional Religion and Hinduism.
- Primiparous women (having borne one viable baby) (Tiran 2008: 184) and/or multiparous women (having borne more than one viable infant) (Tiran 2008: 148).
- Mothers who have had natural births.
- Mothers who had completed the six week post natal period, but within three months of delivery.
- Mothers who have had live babies.
- Mothers who were physically and psychologically well.
- Mothers who were able to speak and understand English.

### **3.7.2 Exclusion criteria**

Exclusion sampling criteria are characteristics that can cause a participant to be excluded from the sample population. The exclusion criteria in this study included:

- Mothers who were still physically unwell after the postnatal period (six weeks after delivery).
- Mothers who had traumatic births, including caesarean sections.
- Mothers with post-natal depression.
- Mothers whose newborn child was seriously ill.
- Mothers who have had a stillbirth.

### **3.8 Context of the study and sample**

In accordance with the primary aim of this study, the participants sought were from the following spiritual backgrounds: Islam, Christianity, African Traditional Religion and Hinduism. They were eligible for the actual inclusion in the sample as they fitted the inclusion criteria. This gave the researcher an opportunity to listen to different perspectives of the childbirth experience. Furthermore, the researcher's assumption was that mothers who belong to the above backgrounds experience childbirth in their own unique way in relation to their own traditional and spiritual or religious beliefs and values. This idea is supported by Cox (2011:37), who asserted that women may have unique cultural perceptions and the experience of childbirth may be influenced by the woman's personal conditions, cultural beliefs and attitudes and societal factors.

Given that the primary objective was to explore the experience of childbirth from each mother's perspective, a study sample was sought to reflect the population in order to obtain rich data until data saturation. As Patton (2002 cited in de Vos *et al.* 2011: 391) stated "there are no rules for sample size in qualitative inquiry", however sample size depends on the purpose of the inquiry and saturation. Although this sample was limited, data was collected until saturation.

Burns and Grove (2011: 312) emphasised that qualitative research focuses on an in-depth understanding of a specially selected sample and not on the generalisation of the findings as in quantitative research. de Vos *et al.* (2011: 316) added that the context in which the person experiences an event stems from his or her own 'life world'. This supports the argument that human behaviour cannot be understood without valuing the context in which it takes place (Burns and Grove 2011: 73; de Vos *et al.* 2011: 316).

### **3.9 Sampling method**

Participants were selected according to the ethical protocols of research. Ethical approval was received from the Institutional Research Ethics Committee of the Durban University of Technology (Appendix 6). Permission to select postnatal mothers was first obtained from the KwaZulu-Natal Department of Health (Appendix 1), the uMgungundlovu health district manager (Appendix 2), and from the respective hospital managers (Appendices 3(a), 3(b), 3(c)). On receiving permission as mentioned above, the following steps were taken to select the participants for this study:

#### **Step 1:**

The researcher approached the midwifery matron and the operational manager in charge of the postnatal wards of the respective hospitals. This was done to make them aware of the study to be conducted and the process involved. They were given a full explanation of the nature of the study so that they were enlightened about the type of participants to be chosen for the study.

## **Step 2:**

The operational managers of the postnatal wards identified the mothers who had natural births and could be potential participants. The researcher then introduced herself to the mothers and respectfully acquainted herself with them. They were then informed about the purpose of the study. A respectful approach allowed participants the opportunity to decide if they wanted to be involved in the study or excluded from the study. This was important as the initial approach to a potential participant strongly affects their decision to participate (Burns and Grove 2005: 360).

Following this initial approach an informal screening interview was done with each mother who agreed to participate, before being discharged from hospital. This was done by the researcher in a private room in the ward, which was arranged with the operational manager in charge of the ward. The researcher respectfully enquired from each mother about her religious background. In this way the researcher was able to determine whether they were eligible to participate in the study. The inclusion criteria were used to select participants. The criteria for selection according to the inclusion criteria as mentioned previously, was of vital importance to guard against emotional upsets during interviewing.

Each prospective participant (postnatal mother) was then given a letter of information sheet which further informed her of the purpose of the study, its objectives and the benefits of the study. The letter emphasised the importance of voluntary participation and the right to withdraw from the study whenever she wished. The mother was assured that there would be no harm through participation. Each individual mother was also given the opportunity to ask questions. When the mother agreed to participate, each participant was asked to sign an informed consent form (Appendix 4) which confirmed her consent to participate in the interview process.

Confidentiality and anonymity were assured and the participant was informed that she would be given a pseudonym to protect her identity. Following this, each participant was informed that the interview would be conducted at the clinic or hospital soon after her routine six week post-delivery health check. Arrangements for a private room in which to conduct the interviews were made with the operational managers in charge of the respective clinics. Participants were also informed that if they were not comfortable with the interviews being conducted soon after the six week postnatal check then another appointment would be scheduled, provided that it was within three months of giving birth. As Schwartz (2014: 43) asserted, “over time some details of a story become lost”. Therefore the time period of birth was salient in obtaining the most accurate account of the woman’s birth experience.

The participant’s contact details were obtained during the initial screening and consent process to set up appointments for their interviews. Each participant was then contacted by telephone a week before her six week postnatal health check. This was to check if she was still amenable to participation and to confirm appointments for the interview. A final call was made to the participants two days before each interview to confirm availability and to provide final details about the time, venue for interview and to answer last minute queries, as per Gray’s (2009: 379) suggestions. In this study four mothers were not ready and felt more comfortable being interviewed at the ten week baby immunisation visit at the clinic. This was respected and taken into consideration. The rest of the eighteen participants were interviewed at their six week routine postnatal health check.

### **3.10 Pilot study**

A pilot study was done so that the researcher could reflect on issues such as the amount of time taken, the prompts, as well as question clarity (O’Leary 2010: 200). This enabled building the researcher’s confidence in preparation

for the interview sessions (Bryman 2012: 263). The pilot study in qualitative studies is generally an informal process as compared with quantitative studies, whereby a statistically correct pilot study has to be done (de Vos *et al.* 2011: 394-395).

Mothers involved in the pilot phase were able to relate an adequate amount of information, however the first open ended question read: "Can you share with me the experience of childbirth?" At the very first informal interview of the pilot study the mother enquired as to whether she should talk about 'her' experience or about childbirth in general. The researcher immediately refined the question and it read: "Can you share with me your experience of childbirth?" The rest of the questions were understood by the mothers who were involved in the pilot study. Mothers who participated in the pilot study were not selected for the actual research study. This was to ensure that there was quality interviewing during the main inquiry, thus the researcher became familiar with the practical setting, making contact and conducting the interview, as well as to become familiar with the questions to be asked (de Vos *et al.* 2011: 395).

A group of academic personnel who are experts in the field of nursing and midwifery, and who were familiar with the topic area, were also engaged in reviewing the interview guide. This was done to solicit constructive feedback on the quality of the questions in the interview guide. The experts viewed the information received from the mothers. Modifications were made as necessary, in order to optimise the nature of the questions and for questions to follow a logical sequence. The information received from the participants was analysed by the researcher. This was done to ensure that relevant information could be attained for the main study (de Vos *et al.* 2011: 394). The semi-structured interview guide questions were then approved by the Durban University of Technology: Institutional Research Ethics Committee (Appendix 6).

### **3.11 DATA COLLECTION PROCESS**

There are multiple data collection methods in qualitative research viz. observation, interviewing, photographs, documents, artefacts, maps, genealogies and social network diagrams (Polit and Beck 2008: 385). Interviewing was best aligned with the primary aim of this study. Moore (2009: 69) argued that interviews are a proven data collection method, whilst Bryman (2012: 469) and de Vos *et al.* (2011: 342) affirmed that the interview is perhaps the most widely used method in qualitative research. O’Leary (2010: 194) described interviewing as a means of gathering information whereby researchers search for answers in an open-ended manner. These answers are related to a number of questions, areas of interest, topics or themes. Interviews are thus ‘interactional’ and explore meaning in greater depth as compared with other procedures (Burns and Grove 2011: 351; de Vos *et al.* 2011: 342).

Considering that semi-structured one-to-one interviews give the researcher and the participant flexibility (de Vos *et al.* 2011: 342; Bryman 2012: 471), it was deemed the most appropriate method for data collection in this study. Semi-structured interviews consist of a set of prearranged questions with no fixed order to guide the interview (Burns and Grove 2011: 351, de Vos *et al.* 2011: 342). An interview guide (Appendix 5) with open-ended questions was prepared by the researcher to guide the interviews for data collection in this study. A description of the interview guide follows.

#### **3.11.1 The interview guide**

The main intent of the interview guide was to enable women to relate their experiences of childbirth and to reflect on this experience from their own perspective. The initial question on the interview guide was open-ended to allow participants to share their own views, expressed in a way that was

meaningful to them. In this study the advantage of a predetermined interview guide allowed the researcher to develop appropriate probing questions that were pre-worded in a sensitive and respectful way (de Vos *et al.* 2011: 352). Probing has been described as a prompting question which is used to draw together more information or to elaborate on specific questions (Brink *et al.* 2012: 158). The intention of probing is therefore to extract more useful or detailed information from a respondent in an interview than that which was volunteered in the initial reply (Polit and Beck 2012: 310).

The first question of the interview guide enabled participants to reflect on their experiences of childbirth and allowed their thoughts to flow freely. This enabled them to articulate their experiences and to express their views as they pleased. The participants spoke about their experience of labour commencement until delivery in hospital, and care that they received thereafter. The subsequent questions and the probing questions allowed the researcher to obtain more in-depth information about the feelings and emotions regarding their experiences, their values, beliefs and practices, as well as what childbirth signified personally and for the family to have a baby. This was required to fulfil the purpose and objectives of the study. The content of the interview guide (Appendix 5) was aligned with the research questions.

### **3.11.2 The interview setting**

The interview setting was arranged in a quiet environment which gave the researcher and participant privacy for the interview. In all instances the interview was in a room at the local clinic or the hospital. Prior arrangements were made with the operational manager to secure a private and comfortable room for the interviews as described in section 3.9. The researcher ensured that she arrived at the hospital or clinic timeously, which ensured punctuality (Polit and Beck 2012: 310). She also checked that the venue had comfortable chairs and that there were refreshments, at least thirty minutes



before the scheduled interview. These were suggestions made by Gray (2009: 379) for interviews. Participants were well-versed in the English language as per the inclusion criteria and hence there was no need to engage an interpreter, although there was an interpreter on standby.

### **3.11.3 The interview process**

Interviews took place between August and September 2013, per arrangement between the participant and the researcher. The interviews were conducted personally by the researcher who is an experienced nurse, skilled midwife and lecturer. The researcher prepared a private room together with the tape recorder and the writing material at the clinic thirty minutes before the arrival of the participant. On arrival at the clinic each participant was welcomed, made comfortable on a soft chair, and was given light refreshments. Each mother was given a chance to ensure that her baby was fed and was comfortable. The participant was given an opportunity to ask questions and to clarify any concerns. Before the actual interview commenced the researcher wrote down each participant's demographic details; these included her age, religious background, and the number of children she had. Each participant was also reminded that she was allocated a pseudonym to protect her identity and to maintain confidentiality and anonymity. Pseudonyms were written on the interview guide form for each participant, which further protected her identity. Participants were also asked for verbal consent to record the interview.

Initially a total of twelve participants were included in this study. Three participants consented to tape recording. Nine participants refused to be audio taped and agreed to spend more time at the interview. This was respected to avoid any discomfort, undue stress and emotional upset that could affect data collection. In order to confirm that no new information emerged, the researcher interviewed a further ten participants who consented to being audio taped. A total of 22 participants were interviewed

for this study. Each interview lasted between 45 and 75 minutes. Data was collected until there was data saturation (Polit and Beck 2012: 521). Guest *et al.* (2006 cited in Bryman 2012: 426) explained that data saturation referred to the number of interviews “needed to get a reliable sense of thematic exhaustion”. Polit and Beck (2012: 522) describes this as “informational redundancy”. None of the participants needed to be referred for counselling as they were emotionally stable. Participants were thanked for being part of the study.

The same interview guide was used for all the participants, which ensured consistency with all the participants (Flick 2009: 64). The interview commenced by asking the participant to share her childbirth experience. This very first question was broad and open-ended and read: “Can you share with me your experience of childbirth?” The researcher intervened for clarification (as needed) at a convenient time, taking care not to disturb their thought processes. The interviews were undertaken in a polite and tactful manner that allowed good rapport between the participant and the researcher.

Notes were taken by the researcher herself for those participants whose interviews were audio taped; however it was done in a way that did not distract the interviewee. O’Leary (2010: 203) agreed that having a third person to assist at the interview may have an effect on the participant and the interview process. Each participant was listened to intently. Soon after the interview the researcher also made detailed notes, so that the immediate effects of what the researcher heard, saw, experienced, and observed had been captured (de Vos *et al.* 2011: 359). This was beneficial in capturing emotions, preconceptions, expectations and prejudices and prevented information loss (de Vos *et al.* 2011: 359; Polit and Beck 2012: 543).

Nine participants did not consent to the audio taping of their interviews. The researcher explained to the participants that notes had to be taken during and soon after the interview to capture the information, as suggested by

Burns and Grove (2011: 86). This was agreed to by all the participants who did not consent to audio-taping of their interviews. The researcher listened to each participant very closely during each interview for tone, manner and emotive expression, and made notes. On completion of each interview the researcher read the notes, reflected on the expression, the tone of voice, took note of the pauses and made detailed notes. Further clarification about the notes taken after the interview was made with each individual participant if needed before the session ended.

### **3.12 DATA CAPTURING AND DATA ANALYSIS**

In qualitative research a large amount of data is captured. Data management involves reducing the large amounts of data into smaller, manageable segments. Data analysis is described as a meticulous and rigorous method through which data is structured and organised in a coherent manner and through which the data is given meaning (Gray 2009: 493, Burns and Grove 2011: 94, de Vos *et al.* 2011: 397). Data was analysed by using the strategy of thematic analysis which best suited this study. Data collection and data analysis in this study were done simultaneously. This strategy enabled the researcher to search for themes, categories and patterns as soon as data collection commenced. (Polit and Beck (2012: 556).

After completion of every interview, each audio-taped interview was listened to carefully in order to capture what was said and how it was said by each participant. Tone, inflection and pauses were also listened to (Burns and Grove 2011: 93). Braun and Clarke's (2006: 16) six phase guide to thematic analysis was used to analyse data in this study.

In the first phase the researcher became familiar with the data. It was then transcribed word-for-word as accurately as possible by the researcher (Burns and Grove 2011:93). This was done by the researcher with rigour to ensure that the exact words of the participant was captured. Although this process is

time consuming, the researcher ensured accuracy in reflecting the interview experience (Polit and Beck 2012: 557). The researcher also set aside all her ideas and beliefs and reflected with openness on the data obtained from the participant's perspective (Polit and Beck 2012: 495; Speziale and Carpenter: 2007: 27). After transcribing the information the tape was listened to again and the written transcript read simultaneously. This process enabled the researcher to become familiar with the data and to get a sense of the interview as a whole. Each transcript was copied. Important initial ideas were noted and written down. Field notes that were taken during the interviews were also sorted, arranged and typed.

The detailed notes from interviews that were not audio-taped were sorted immediately after the interview. The researcher reflected on the tone of voice, what the participant said, how she said it, and related it to the written notes from the interview and made further notes. Notes were also made in the margins so that information loss about what was heard and seen could be avoided. The detailed notes were then typed and copied. The typed notes were read and re-read several times to get a general sense of the information (Creswell 2014: 197).

Phase two consisted of generating initial codes. This was done manually by the researcher by colour coding segments of data in each transcript that resembled patterns and was meaningful. All similar patterns of segments of data were then grouped together, and highlighted in different colour codes so that they could be easily identified. These were then grouped together and saved in a separate computer file. This enabled the researcher to identify the similarities and the differences in the text as well as potential themes.

Phase three commenced when all data had been coded and collated. The researcher then reviewed all the grouped colour coded extracts under the initial themes. This was done to check for meaningful units and to identify trends and patterns in relation to the data (Braun and Clarke 2006: 22).

Phase four was followed by further refining of the themes into categories and sub-categories. This was done by rereading initial themes and colour coded segments, and also to ensure that the data and the themes cohered in a meaningful way.

Phase five required defining and naming the themes. During this phase the researcher reread the collated data to ensure that the categories and sub-categories cohered with the theme meaning. Each theme was then given a name. The categories and sub-categories were organized with the appropriate themes in a table form. This ensured proper organization of the data and the identified themes.

Following the above phases of coding and categorising information, in the sixth phase the researcher reported in a written account of how the themes, categories and sub-categories were inter-related using actual quotations from the participants.

Thematic analysis not only entails description but to a certain extent interpretation of the meaning of the data (Sandelowski 2000: 335). The themes, categories and sub-categories that are presented in the next chapter in Table 4.2 will be discussed.

### **3.13 TRUSTWORTHINESS**

According to Polit and Beck (2012: 174) trustworthiness is described as the extent to which qualitative researchers want to reflect the truth. Trustworthiness is an important element in qualitative research because the findings should actually reflect the experiences of participants from their perspective. Research cannot add value to nursing practice if there is inaccuracy and misinterpretation of findings. To ensure trustworthiness in this qualitative inquiry the criteria of credibility, transferability, dependability, confirmability and authenticity were used.

### **3.13.1 Credibility**

Credibility refers to enhancing confidence in the truth of the data as well as the descriptions and interpretations of them (Polit and Beck 2012: 585). Participants in this study were purposively sampled and were accurately identified and described throughout the research process. The researcher ensured that the same interview guide was used to interview all the participants in the main study. This means that participants who were interviewed for the pilot study purposes were not included.

According to Polit and Beck (2012: 591) member checking is important for establishing credibility in qualitative research. This was done on an ongoing basis through probing information until there was data saturation, and participant's meanings were understood. This ensured prolonged engagement and building a trusting relationship and rapport during data collection with the participants (Creswell 2013: 250). Ongoing reviews of the emerging themes, coding process and interpretation of the data were done by the researcher and supervisors until an agreement was reached on a final data analysis and no new themes emerged. Other means of ensuring credibility were numerous reviews of the written notes, audiotapes, as well as returning to the participants with the results.

### **3.13.2 Confirmability**

Polit and Beck (2012: 585) refer to confirmability as objectivity, which is the potential for two or more independent people to assess the data with regard to accuracy, relevance and meaning. The results derived from the research must reflect the participant's perspective in the context of the phenomenon under study, and not the researcher's. Discussions about the analysis and results were also held by the researcher and the research supervisors. Objectivity was maintained and the findings were confirmed with the researcher's supervisors. An audit trail of audiotapes, field notes,

transcriptions and all documentation relating to the study is kept under lock and key for five years.

### **3.13.3 Dependability**

Dependability refers to the stability of data over time and over conditions (Polit and Beck 2012: 585). In this study the researcher ensured that a systematic description of the method of sampling, data collection, data analysis and data interpretation was attained. This was ensured by storing data in their original form, viz. the typed and the transcribed material were the exact replica of the original data. Documents such as correspondence letters, signed consent forms, the interview guide, the interview summaries, as well as the audio tapes were stored safely in a locked steel cabinet and will be kept for five years for future auditing.

### **3.13.4 Transferability**

Transferability refers to the degree to which findings can be transferred or be applied in other settings or groups (Polit and Beck 2012: 585). The element of transferability was accomplished by the provision of rich, descriptive data in the research report. Data was supported by the results and inserting direct quotations from the participants into the report. The current study was carried out at three public hospitals in the uMgungundlovu District of KwaZulu-Natal. Based on the experience of the researcher in the profession, the researcher is confident that although a small sample was used, this study can be applied in other hospitals in the uMgungundlovu District of KwaZulu-Natal.

### **3.13.5 Authenticity**

According to Polit and Beck (2012: 585) authenticity is described as the extent to which researchers fairly and faithfully show a range of realities by conveying the feeling tone of participants. In this study it was ensured that an

adequate amount of data was obtained and excerpts of participants' exact words were used, thus adding to a rich description and interpretation of the data. This would enable readers to understand the context in which the chosen sample for the study experienced the phenomenon.

### **3.14 ETHICAL CONSIDERATIONS**

Ethics entails procedures and criteria that researchers should adhere to when conducting research studies on humans as participants. This consists of professional, legal and social commitments (Polit and Beck 2012: 727). The researcher adhered to the principles of research ethics and obtained ethical clearance from the Durban University of Technology prior to data collection. The Durban University of Technology: Faculty of Health Sciences' Research and Higher Degrees Committee had reviewed the research proposal, after which final ethical clearance was obtained from the Institutional Research Ethics Committee (Reference number: 042/13). Given that this study was based on women's experiences of childbirth, it was important that participants were treated sensitively (de Vos *et al.* 2011: 115).

Participants completed a written informed consent form (Appendix 4) so that they were fully informed about the nature of the research study and the connotations at the very beginning, as Bryman (2012: 140) and Polit and Beck (2012: 157) recommended. They also received an information letter included in Appendix 4 which informed them about the details of the study. Confidentiality was maintained by not disclosing any personal information about the participants to any person. The supervisors checked the transcribed and the written data. Participants were given pseudonyms which protected their identity and therefore confidentiality was maintained.

#### **3.14.1 Beneficence**

Beneficence is described as safeguarding and promoting the patient's interests whilst allowing the research to produce benefits for the participants



and for society as a whole (Dhai and McQuoid-Mason 2011: 14; Polit and Beck (2012: 152). The aim of this study was to explore how childbirth is experienced by women from different spiritual backgrounds at a public hospital in the uMgungundlovu District of KwaZulu-Natal.

The topic under study required that participants share a personal account of their experience of childbirth. Participants could become emotional considering that they came from different social and cultural backgrounds. In this study mothers who had upsetting birth experiences were not included, as mentioned in the exclusion criteria. This minimised the risk of mothers becoming emotional and sensitive. All the interviews were conducted during clinic hours at clinics affiliated to hospitals and community health referral centres in the uMgungundlovu district in KwaZulu-Natal. Psychologists and counsellors are available at these health care centres. Provisions were made for the referral of any participants who became emotional and required counselling. The researcher kept contact numbers of participants if they agreed to be contacted again to continue with the interview process. Where contact numbers were not available, mothers could decide if they wanted to reschedule appointments or withdraw from the study completely.

### **3.14.2 Non-malificence**

Dhai and McQuoid- Mason (2011: 14) and Polit and Beck (2012: 152) refer to this principle as the minimisation of harm to humans. Participants in this study were assured that they could withdraw from the study at any time due to it being a voluntary engagement. It was also ensured that there was no harm or physical discomfort to be caused to them during the study. Participants' permission was obtained to record their interviews. Where recording of the interview posed a problem the audiotape was turned off and written notes were taken after receiving permission from the participant. This ensured that the researcher did not record the interview against the participants will, which avoided emotional stress.

### **3.14.3 Respect for human dignity**

This principle entails the right to self determination and the right to full disclosure (Polit and Beck 2012: 152). Dhai and McQuoid-Mason (2011: 14) describe this as the basis of informed consent and respecting confidentiality. The right to full disclosure means that the researcher fully describes the nature of the study, the right to refuse participation, the researchers' responsibilities and the risks and benefits. In this study participants could make voluntary decisions about whether to participate or not to participate. They had the right to ask questions and to withdraw from the study at any time. Each participant was informed about the nature of the study at the initial contact with her, as described in section 3.9.

### **3.14.4 Justice**

The principle of justice refers to the right to fair treatment and the right to privacy (Dhai and McQuoid-Mason 2011: 15; Polit and Beck 2012: 155). The researcher ensured that all participants were treated properly by respecting their culture, morals, values and beliefs. Privacy was maintained throughout the study and participants were assured that the information they provided was going to be treated and stored in strictest confidence (Polit and Beck 2012: 156). Interview data would be kept under lock and key for five years and would be destroyed thereafter. Participants were given pseudonyms and the names of the hospitals were not mentioned throughout the study. This maintained the principle of justice.

## **3.15 LIMITATIONS**

- Nine participants refused to be audio taped. This limited the researcher from listening to the women's voices, the tone, inflection and pauses repeatedly as with the audio taped interviews.
- The written and typed notes were the only means of referring to the interviews of participants that were not audio taped.

- The researcher was not able to reach all participants to validate the findings. This was due to time constraints and a possible change in the participant's contact details.
- Logistical and financial challenges restricted increasing the footprint to all four hospitals.

### **3.16 CONCLUSION**

This qualitative study explored and described the experience of childbirth amongst women from different spiritual backgrounds in South Africa: Hinduism, Christianity, Islam and African Traditional religion. The qualitative approach was the guiding design for this study. Semi-structured face-to-face interviews was the method of choice to collect important and in-depth information to elucidate the participant's experience. Thematic analysis was used to analyse the data thus ensuring proper organization, description and interpretation of the data. This method allowed for the unveiling of the descriptions and essence of this memorable event of childbirth among Hindu, Christian, Islamic and women who followed the African Traditional Religion. It can thus be noted that the birth experience is a deeply faceted event that women can and will always remember throughout their lives. The following chapter presents the findings of the study.

## **CHAPTER FOUR**

### **PRESENTATION OF THE FINDINGS**

#### **4.1 INTRODUCTION**

This chapter presents data collected from this study. The purpose of this study was to explore and describe how women from diverse spiritual worldviews viz. Christian, Muslim, African Traditional Religion and Hindu backgrounds experienced childbirth. The study was conducted at public hospitals in the uMgungundlovu District of KwaZulu-Natal. This study endeavoured to explore the unique and personal meaning of the childbirth experience in women from these religious groups, the level of care received and how spirituality influenced and impacted on the experience. Semi-structured interviews were used to gather data, which was analysed through a process of thematic analysis and coding. The data is presented according to themes, which were divided into categories and sub-categories. Collective meanings of the data are presented. Themes served to illustrate the essence of women's responses. By relating their childbirth experiences from both their personal and spiritual worldviews, rich descriptive data was obtained.

The childbirth experiences of 22 women who were interviewed are presented. There were eleven primiparous women and eleven multiparous women who participated in this study. The participants comprised of six women from the African Traditional Religion, four of whom were Traditional Zulu and two were Xhosa women; four Hindu women; seven Christian women; and five women with an Islamic background. All the participants had normal deliveries and interviews were conducted within three months of delivery. All participants could communicate in English, therefore an interpreter was not required. All 22 women were enthusiastic and participated wholeheartedly in the research study. Three of the women were

professionals; two were university students; one was an immigrant from North Africa; one woman was self-employed; two were permanently employed in the clerical field; three women had temporary employment in small business enterprises; one woman was a scholar; and others were mostly unemployed. Their ages ranged between 20 and 37 years. The women's demographic details are presented in Table 4.1.

**Table 4.1: Demographic profile of participants**

<b>Participant</b>	<b>Age in years</b>	<b>Number of children</b>	<b>Period of interview after delivery</b>	<b>Religion</b>
Participant 1 (P1)	22	1	6 weeks after delivery	Muslim
Participant 2 (P2)	28	2	10weeks after delivery	Traditional Zulu
Participant 3 (P3)	21	1	6 weeks after delivery	Christian
Participant 4 (P4)	26	2	6 weeks after delivery	Xhosa
Participant 5 (P5)	25	1	6 weeks after delivery	Christian
Participant 6 (P6)	30	1	6 weeks after delivery	Muslim
Participant 7 (P7)	32	2	6 weeks after delivery	Hindu
Participant 8 (P8)	20	1	6 weeks after delivery	Muslim
Participant 9 (P9)	37	3	10 weeks after delivery	Hindu
Participant 10	32	3	6 weeks after	Hindu

(P10)			delivery	
Participant 11 (P11)	28	2	6 weeks after delivery	Traditional Zulu
Participant 12 (P12)	25	3	10 weeks after delivery	Christian
Participant 13 (P13)	26	2	6 weeks	Hindu
Participant 14 (14)	20	1	6 weeks	Traditional Zulu
Participant 15 (P15)	21	2	6 weeks	Christian
Participant 16 (P16)	20	1	6 weeks	Muslim
Participant 17 (P17)	21	1	6 weeks	Christian
Participant 18 (P18)	23	1	6 weeks	Muslim
Participant 19 (P19)	34	3	6 weeks	Christian
Participant 20 (P20)	25	1	6 weeks	Christian
Participant 21 (P21)	23	2	10 weeks	Xhosa
Participant 22 (P22)	23	1	6 weeks	Traditional Zulu

The next section presents the findings. The data has been grouped into five themes, ten categories and thirty nine sub-categories which were identified from the responses of the participants. These are presented in Table 4.2 below.

**Table 4. 2: Derived themes**

<b>Themes</b>	<b>Categories</b>	<b>Sub-categories</b>
1. The meaning of childbirth.	1. The symbolic meaning of childbirth.	The significance of childbirth within a spiritual context.  The birth of a baby boy. The birth of a baby girl.
2. Experience of labour and birthing.	2. Emotions.	<i>Positive emotions:</i>  Feeling empowered.  Amazement.  Happiness, joy.  Excitement.  Sense of achievement.  Sense of motherhood.  <i>Negative emotions:</i>  Sadness. Fear.  Disappointment.  Fatigue.
3. Needs during labour.	3. Comfort needs.	Pain relief.  Labour and delivery positions.  Unnecessary medical interventions.
	4. The need for communication.	Language barriers.  The need to be listened to.

	5. Expectations.	Participation in decision-making.  Being in control during the birthing process.  The need for respect.
	6. The need for support.	Presence of the midwife and doctor.  Partner and family presence.
	7. The need for information.	Orientation to hospital and ward policies.  Explanations about medications, interventions and progress of labour.
4 Different spiritual beliefs and practices.	8. Spirituality as a coping mechanism.	All about God and praying.  Praying to Sai Baba.  Kept on believing  Recite mantras.  Pray to ancestors
5. Customs and cultural practices.	9. The use of alternative medicines before, during and after birth.	Have a herbal steam.  Used sesame oil.  Drank isihlambezo.  Jeera water is given.



	10. Rituals before, during and after birth.	Amulet. Naming ceremonies. Prayer to welcome the baby. Whispering in the ear. Slaughtering of sheep. Protection from evil.
--	---	---

The themes, categories and sub-categories are discussed below; the meaning of each category is presented by using the participants' verbatim excerpts.

#### **4.2 PRESENTATION OF THEMES**

##### **Theme 1: The meaning of childbirth.**

##### **Category 1: The symbolic meaning of childbirth.**

**Sub-categories: Significance of childbirth within a spiritual context; birth of a baby boy; birth of a baby girl.**

The first main theme was the meaning of childbirth, from which the category of symbolic meaning was derived. The significance of childbirth within spiritual context, the birth of a baby boy and the birth of a baby girl were the sub-categories of the symbolic meaning of childbirth.

The significance of childbirth within the spiritual context emerged as the sub-category viz. the meaning of childbirth. These meanings were revealed in the words of participants as follows:

*"It's a given gift from God for a woman, and mentally you are expecting a joy"* (P12: Christian).

*"For my family it is a new addition to the family and a blessing to have a baby in the Muslim family"* (P8: Muslim).

*"A baby is a blessing in the house. In our Zulu tradition a baby is considered as an angel, as the baby lights up the house"* (P2: Traditional Zulu).

*"Oh! And we also pray to God because to have a baby at home in the Zulu family, it's a blessing"* (P22: Traditional Zulu).

*"They say that every child is a blessing from God, and God brought this child into the world for some reason, he just wouldn't give us a child for nothing"* (P13: Hindu).

The birth of a baby boy was another sub-category within the category of the symbolic meaning of childbirth. The significance of the birth of a baby boy is expressed in the following quotations:

*"A boy will carry the surname of the father and becomes the head of the family"* (P2: Traditional Zulu).

*"Being a baby boy my husband's surname will continue and carry the family name and also continue with the religion"* (P7: Hindu).

The birth of a baby girl was another sub-category derived from the category of the symbolic meaning of childbirth. The significance of the birth of a baby girl was evident in the following statements:

*"It is a blessing from God. Girls are the light of the house"* (P1: Muslim).

*“It was a blessing to have a baby girl in the house as she resembles a light of the house, which means that the family will progress in life” (P7: Hindu).*

These quotations reflect the spiritual significance of either the birth of a baby girl or a baby boy. They refer to this as a joy which has a special meaning for families irrespective of whether they were from the Islamic, African Traditional Religion, Hindu and Christian backgrounds. Fraser and Cooper (2007: 655) also described the birth of a baby as bringing absolute joy to mothers, and emphasised this birth as “a blessing being bestowed upon a family”. A review of the literature on spiritual experience reflects that it coheres with feelings of joy, bliss and transcendence (Bhagwan 2002: 176).

## **Theme 2: Experience of labour and birthing**

### **Category 2: Emotions**

**Sub-categories: Positive emotions included feeling empowered; amazement; happiness; joy; excitement; sense of achievement; sense of motherhood. Negative emotions included sadness; fear; disappointment and fatigue.**

Labour and birthing was the second main theme. The category of emotions coalesced from this theme, and the sub-categories related to emotions included feeling empowered; amazement; happiness; joy; awe; excitement and a sense of achievement; a sense of motherhood; sadness; fear; disappointment and fatigue.

### **Positive emotions**

The first sub-category of positive emotions was feeling empowered. Feeling strong and feeling empowered assisted participants to believe in themselves,

thereby accepting the labour and delivery process. Just the thought of waiting for their babies elicited positive feelings in most of the participants.

The following response elicited feeling empowered:

*“I felt so proud of myself and being a woman I think you can do anything because I feel if you can give birth you know, then you can say that you have achieved something so great in life. I was so excited. The most important thing for me was that I gave birth naturally”* (P22: Traditional Zulu).

Another participant felt a sense of amazement:

*“It’s one of those amazing moments. Personally it’s exciting because actually you can’t wait to meet your child and it’s really, really exciting it’s really awesome. It’s a nice experience“* (P17: Christian).

*“I’d say it was something that I couldn’t and still can’t compare to anything else”* (P20: Christian).

The excerpts below display happiness and excitement:

*“It was the most wonderful experience I ever had. Just the thought of waiting for this baby to come into this world I think was so great. I was so excited. It was the happiest experience”* (P22: Traditional Zulu).

*“Umm’ what can I say? A beautiful experience to give life to someone. It’s empowering to give birth to a girl. I could have went through it ten times over”* (P18: Muslim).

*“Even though I am still young I will have to manage. I was happy because I have someone to actually live for”* (P3: Traditional Zulu).

From these excerpts it is apparent that the childbirth experience is a hugely joyous and powerful event. The thought of waiting for their babies to be born, instilled optimism and made them feel encouraged through the childbirth experience. These findings are consistent with the findings of Cook (2010: 54), who reported that the event of childbirth was empowering despite the pain experienced.

A sense of motherhood was another sub-category related to positive emotions. The thought of having to take care of their babies made some participants feel inspired and responsible for someone special with whom they have a special connection. The following statements support this:

*“Thank you Lord for everything, and to hear this small tiny voice cry like that but after the pain and the stitches then it just sinked in I’m a mother and I’m someone’s mum and I was so excited”* (P20: Christian).

*“It was a big sigh of relief. I am happy and proud to be a mother with a good frame of mind knowing that I can take care of my child”* (P7: Hindu).

*“I was really excited becoming a mother and having this child. I was looking forward to it. It did turn out really nice, lovely. It changed my entire life around, my life personally, the way I look at my mother now, I have so much more respect because I understand the pain and everything she’s been through much more better and as a woman this experience made me grow so much”* (P1: Muslim).

*“I feel more of a mother. If I get a girl... I feel like more grown, more grown compared to girls my age. But I’m happy. It makes me want to do things more”* (P15: Christian).

The above statements reflect that participants identified the childbirth experience as one which strengthened their identity as a mother and their

role into motherhood. Participants also felt a sense of belonging and a purpose to life. Furthermore, their bringing a new life into this world elicited a sense of maturity and made it a gratifying experience.

### **Negative emotions**

Negative emotions was a sub-category of emotions which included feelings of sadness, fear, disappointment and fatigue. Participant's voiced feelings of sadness and disappointment in the following excerpts:

*"At first I was a bit sad though, because they told me boy (laughs) and it was a girl" (P18: Muslim).*

*"The only pleasant, the only time there was anything pleasant was when they put my baby in my arms, that's the only time I felt a sense of calmness, relaxation, and then a lot of love" (P18: Muslim).*

Participants also reported fear during their childbirth experience:

*"I was scared mostly of the pain" (P15: Christian).*

*"I felt very alone and scared and neglected throughout my experience".  
Furthermore I was not given anything for pain" (P10: Hindu).*

*"I do love kids but I never gonna have another one" (P20: Christian).*

*"For me giving birth was just it, it is Gods creation. A woman was made to give birth and go through the process, you know, but yeah that's what kept my mind at ease, that this was about what a woman is for, but that didn't help, the pain still made me decide if this could be my first and last baby" (P18: Muslim).*

These responses reflect pain that is an inseparable dimension of childbirth and brings with it fear and anxiety. Despite the fact that pain experienced during labour and childbirth is a normal phenomenon (Lundgren 2002: 34) it does induce fear which midwives must be cognisant of. McGrath (2012: 76) and Fraser and Cooper (2003: 659) noted that the main fear experienced by women is one of a loss of control particularly where she has experienced past distress and hurt. Henderson and Macdonald (2004: 434) added that women experiencing childbirth for the first time were more fearful particularly of the unknown of both the experience and the hospital environment.

Fatigue was another sub-category identified amidst negative emotions. One participant felt that it was a tiring experience at first, but related the childbirth experience as being a unique experience. She expressed:

*“It was a good, different experience, very tiring at first”* (P1: Muslim).

Other participants reported the following, a combination or mixture of varied emotions. These were as follows:

*“Personally it’s very painful. It’s a journey. It’s a very exciting journey, painful journey, but I feel it’s a phase. I was excited at the same time but was worried. But I made it, did make it. You have to go through morning sickness, you have to go through nine months, labour, you have to have your sleepless nights and your sore breast and you know....”* (P15: Christian).

*“I had combined feelings like sad, joyful, happy”* (P3: Traditional Zulu).

*“It’s just so overwhelming! It’s, I don’t know. You kind of scared but then you not, you kind of excited but then you not, you just in between. You don’t know how it’s gonna feel like giving birth”* (P17: Christian).

The above responses reflect that despite childbirth being a painful experience, it was also an exciting journey that participants looked forward to. These findings linked to the mixture of emotions resonate with those made by Lliadou' (2012: 385) and Wilde-Larsson *et al.* (2011: 1168), who reported that the birth of a baby cause women to experience a mixture of highly significant emotions and discovery.

### **Theme 3: Needs during labour**

#### **Category 3: Comfort needs**

**Sub-categories: Pain relief; labour and delivery positions; unnecessary medical interventions.**

Another category that was derived from the data was comfort needs, which included the sub-categories of pain relief, labour and delivery positions, and unnecessary interventions.

In relating their experience of pain during labour, participants expressed the following:

*"The pain was worse than my first two labours. I cried tears because it was a different pain compared to my other two labours, furthermore I was not given anything for pain"* (P10: Hindu).

*"It was so bad I couldn't control the pain, it was terrible. It was worse than my first child, it was terrible, but I was excited and happy and my baby was going to be born and that she was going to be with me, but the pain was terrible. It was traumatizing. It was bad"* (P13: Hindu).

*"But I had no kind of pain relievers, nothing at all"* (P15: Christian).



*“I was in so, so much pain by that time, I was thinking of doing a Caesar also and then I spoke to the doctors. They said, no, I can’t do the Caesar because it’s my first baby, so I had to wait until I give birth naturally” (P5: Christian).*

The last excerpt was supported by Choobmasjedi *et al.* (2011: 1131) who reported that the fear of pain experienced by women during labour and childbirth, led to many women requesting a caesarean section. They also wrote that women at public hospitals experienced fear due to the poor quality of midwifery care at public hospitals (Choobmasjedi *et al.* 2011: 1131).

The statements above affirm that despite the range of positive emotions experienced, there was also a great deal of fear and anxiety brought on by pain, for which pain relief was essential.

Another sub-category of comfort needs that emerged was labour and delivery positions. Participants expressed their feelings about giving birth in certain delivery positions:

*“Also we give birth when we squat. In hospital they make us lie down on the bed and put the machine on. I think they do this because they don’t have to stay with us. Midwives are supposed to stay with us when we are in labour. They tell us to walk around a lot but near to giving birth they put us in bed” (P22: Traditional Zulu).*

*“I was not allowed to walk around, I was tied down to my bed because I was 5 cm dilated, and a drip was put up for me” (P10: Hindu).*

*“I think they should just give you choices. Here it’s just one method for delivery. You have to lie in the bed and go through the same procedure, but then with ...hospitals they may be let you maybe squat, or whichever way that’s kind of relieving to you. So I think maybe if they could offer that and*

*train nurses to become familiar with that concept, then it could be better, because with me what I noticed, well, I kind of read a lot, so I know information from different sources. What I actually experienced, I knew about different positions to give birth like, you could lie on your back, you could use a water tub, you could squat facing down on all fours, you can actually give birth like that, and I kind of proved to myself especially when I was in labour. I couldn't lie on my back it was just too painful, and then I figured out if I can't lie on my back now how about when I give birth it's gonna be even worse but then I figured that if I sit up straight, or maybe go on all fours, I will feel relieved and I wish I could give birth in that position because I could feel that I could do everything as it was an easier method for me, but then since they can't offer that here I had to go through the back thing, to lie on the bed. That position is not comfortable for everyone because I had a hard time pushing. I had a hard time just going through the process" (P17: Christian).*

The above excerpts indicate that some of the participants have certain preferences with regard to delivery positions which give them a sense of comfort. Those who preferred a squatting position, have support in the literature, by authors such as Sellers (2012: 370) and Allison (2005: 6) who wrote that throughout the world, women generally used the squatting position during labour and delivery. It is said that ambulation and the squatting position enhance the bearing down abilities and the expulsive efforts during the second stage of labour. Given support for same in the literature suggests the need for midwives to reconsider the more traditional positions that may be utilized for their convenience, as opposed to comfort needs of the mother in labour.

The following quotations are representative of the sub-category of unnecessary interventions in the category of comfort needs during labour. For example, one of the participants felt that repeated vaginal examinations were unnecessarily carried out and believed they could cause infection. The participant said:

*“When doctor came on his rounds he examined me and said that I was 3cm dilated and said that I should be transferred to labour ward. I was given an enema. Soon after the doctor examined me the sister repeated the examination. This was repeated every 5 minutes. I felt that it could introduce infection” (P12: Christian).*

Another participant related the following:

*“It was just intense, and they kept inserting fingers too. They don’t quite give you time to relax, and let them do their thing, they just rush you. It’s not too good” (P17: Christian).*

In the following statement another participant said:

*“I was then accompanied to labour ward, given an enema...Yeah an enema! but I thought...never mind...the pain was terrible!, and the pain became worse. ‘I felt a heavy feeling’. I was just told to walk around a lot” (P8: Muslim).*

The above excerpts can be interpreted in varied ways. It is possible that certain medical interventions as discussed above were unnecessary and women are more aware of the associated risks. Hence medical personnel need to be more cognisant of this level of unwarranted intrusiveness so as to ensure patient comfort. On the other hand however it is possible that mothers are not aware of the need for legitimate repeat interventions due to a lack of preparedness before birth. It is critical then that midwives engage and inform mothers properly of procedures to be carried out where such intervention is necessary.

#### **Category 4: The need for communication**

##### **Sub-categories: Language barriers; the need to be listened to.**

A further category derived from the theme labour and birthing was the need for communication. The sub-categories of communication were language barriers and the need to be listened to.

The following issues were conveyed with regard to language barriers.

*“It would be really nice if nurses could go through a course of Zulu at least”*  
(P9: Hindu).

*“They must learn about different cultures and their behaviour”*  
(P11: Traditional Zulu).

*“The nurses shout at their patients in labour ward”* (P4: Xhosa).

The need for both cultural sensitivity as well as positive communication was evident in the excerpts above. Moreover the data reflected that mothers had a need to be partnered with a midwife who was of the same spiritual background and who spoke the same language. This was reflected in the following statement below:

*“I had the right nurse (midwife) because she was also a Xhosa nurse. I was comfortable because she knew my culture”* (P4: Xhosa).

Data from the interviews reflected that participants needed to be listened to by the midwife and medical staff. This was a sub-category of communication. The excerpts from the data reflect this:

*“So anyway we go into the labour ward, they put me on the bed, they now handing over, that nurse is not going to sit with me at seven o’clock, because she wants to go home, so she left me there and I said to her, please help me, help me, baby is coming. I’m telling them baby is coming, I can feel him there now, and my water still has not broken. The nurse said, “Just wait, I have to fill in this file now”. Now I said okay, “just breathe, just breathe”, and I’m saying, yes I’m trying to breathe, and I feel I need to push now, now they saying, “Don’t push” (P7: Hindu).*

*“In the next 30 minutes I felt the head coming. “The doctor said ‘don’t push’ and I replied that the baby is coming itself. The CTG was set up and I was put onto the bed. The head was already out and they still asked me not to push but they don’t listen to you because you are the one that is experiencing it and you can’t help it” (P11: Traditional Zulu).*

These findings suggest the disjuncture between patient experience and what medical personnel believe should be routinely followed. It reflects that hospital staff do not see each case as being unique. Midwives therefore need to recognise and be aware of individual patient needs and the fact that each experience of labour can progress differently. Hence instead of dictating the pace of delivery according to what they may be schooled into, they need to be sensitive to each mother’s experience of labour and pain as it progresses. Communication is pivotal to being aware of this and to strengthening the relationship between mother and midwife.

### **Category 5: Expectations**

**Sub-categories: Participation in decision-making; being in control during the birthing process; respect.**

A further category termed expectations was also extracted from the data. Three sub-categories were identified in relation to this viz. participation in

decision-making, being in control during the birthing process and the need for respect.

Participation in decision-making referred to the fact that participants expected and wanted to be actively involved in the childbirth process. As one participant said:

*“I went to the hospital for a check up. It was at 38 weeks. A CTG was done and it was said that the baby was distressed. This was at ANC and the doctor said that I should go for a caesarean section immediately, but I refused. I said that it was only one result that the doctor assessed and I was not happy to go for a caesarean section. I said that he should assess me on at least two results before deciding for a Caesar. I trusted my body. I said that I could not make that decision alone because I was married and needed to consult with my husband. I had no other family in South Africa” (P12: Christian).*

The above statement reflects that participants believed that they needed to be consulted in decision making. It also reflects that family as well needed to be involved in such decision making, especially spouses. Hence it is crucial that both midwives and doctors ensure that mothers have a voice in decisions that do not ultimately compromise their safety, and that spouses are consulted when decisions related to medical interventions are made.

Another sub-category that was extracted from the data was that of being in control during the birthing process. This related to being in control of one's body during the labour process. This is reflected in the quotation below:

*“Labour started on Tuesday when the contractions became regular, progressive and stronger every ten minutes. At around 7-8 pm contractions were getting stronger and I went to hospital. The nurse examined me and said that I was 3 cm dilated. A CTG was done. A drip was set up and I was*

*given oxygen and then transferred to the lying-in ward. My body told me that I am ready to deliver” (P12: Christian).*

*“I was told that I was still 2cm dilated at 20:50 at night. At 21:30 I just felt that this baby had to come out and then the nurse that checked me said she wasn’t too sure and said that I couldn’t be 10 cm dilated so quickly but then she checked that I was in labour, and I was rushed up to labour ward in a wheelchair” (P1: Muslim).*

In a similar vein McGuinness (2006: 328) wrote that mothers often follow their bodily instincts and are aware of what to do and when, based on their body’s reaction.

Respect was the other sub-category that flowed from the main category of expectations. Expectations in this context, referred to what participants had expected from the delivery process, from the hospital facility and also expectations of the midwives. This was reflected in the following statements:

*“I watched a delivery on television and it was completely different from what I expected and experienced. While I was trying to concentrate on my delivery there were too many people (nurses) around and too many questions being asked at once. I would have preferred more privacy but had to follow the instructions and rules of the nurses in the labour ward. There was no privacy even for other women because I could see them deliver. I would have preferred one nurse to attend to me if it was possible because I did not feel satisfied with my experience” (P3: Christian).*

*“Midwives need to respect and understand other cultures and to be more polite to gain co-operation from patients” (P9: Hindu).*

*“Nurses must be more polite when communicating. You are compelled to do what the nurses say and follow the rules. The nurses need to be patient”. “A*

*male nurse delivered my baby. Culturally we are not allowed to have a male doing our delivery. We are different from other cultures and we are fussy about males attending to us” (P8: Muslim).*

*“I did not expect what I experienced. Nurses attitudes need to change, they must be more polite. It’s a calling, if you don’t have patience and sincerity to care rather not do the job at all. It’s of no use being angry with the patients. Even though the nurses are overworked there is no need for the bad attitudes. They need to give more respect and support and to be more polite and treat us as individuals” (P10: Hindu).*

*‘Nursing is a calling and nurses should have a professional attitude”  
(P12: Christian).*

*“They should open up private rooms for each individual religion or may be having one room where you can just go in there with your patient, just to have that privacy of your religion. Some people do get offended and with our religion, it’s whoever accepts the prayer. Even if you in the ward everything is open if you accept the prayer, its fine if you don’t that’s fine” (P15: Christian).*

Multiple issues are evident in the excerpts above. Mothers believed and expected to be treated respectfully as patients. This is consistent with ethical midwifery practice that upholds and respects the patients’ needs and wellbeing. Several participants extended the notion of respect to include the need for midwives to be professional, approachable and polite. Kumbani *et al.* (2012) confirmed that health care workers need to display a caring and supportive attitude towards their patients.

For some of these participants respect for the patients meant not only a polite demeanour and respectful attitude, but also respect for their privacy and respect for privacy within the context of their spiritual beliefs. This was



particularly true for the Muslim participant who was faced with a male midwife. This is contradictory to Islamic beliefs which place extreme emphasis on the fact that other men should not see women's bodies. There were also expectations of the private spaces for prayer which reinforces the need for spiritual aspects to be more carefully considered in the hospital context.

### **Category 6: The need for support**

**Sub-categories: Presence of the midwife; doctor; partner and family presence.**

Support was another category derived from the data. The sub-categories that flowed from this included the need for support from the midwife, the doctor, partner and family.

Participants reported a tremendous need for emotional support and expected that the midwife provides same consistently throughout the experience. The following statements support this notion:

*"I would have also preferred to have a nurse (midwife) with me because I was alone. I needed the support because it was not easy to go through the experience alone because I felt it was my first experience" (P8: Muslim).*

*"They need to give mothers support, by talking to us. We need them to be with us. They must not take their own time to do things. They must treat the mothers with respect and not shout at them. Yeah, we need their support also, a lot of it, and not be told that one must call them when you are ready to deliver only, and be left alone waiting" (P13: Hindu).*

*"Like I didn't have the support from the people around me, because there was no one else there with me, like a family member or something, it was just*

*me, so now you need that from the nurses and the midwives and whoever is around, in trying to help you, that personal support, not only that medical part of it” (P18: Muslim).*

The above statements confirm the need for perhaps greater physical support but more importantly emotional support. Participants expressed the need to feel reassured and comforted. Adams and Bianchi (2008: 109) also emphasised the need for emotional labour support saying it was reassuring and contributed to the feeling of being loved and cared about.

Participants also appeared to feel unsupported due to being shouted at. This conveys a lack of respect which must be addressed in midwifery practice. Hence whilst midwifery education emphasises respect and care, further education and training needs to happen to remind midwives of the need for a respectful relationship, particularly within the context of such a deeply personal experience. The excerpts above also reflected a certain element of being isolated and alone during the labour. These findings further reflect a disjuncture between the caring advocated for as part of nursing practice and what is currently appearing at public hospitals. The fact that mothers do not have support from family particularly spouses reinforces the need for a more empathic and genuine level of care to be provided by the midwife.

The benefits of care are also evident in the data which lends further support for this facet in midwifery practice. Some participants experienced support and care which led to a more positive experience. This is reflected in the following statements:

*“The experience was very good...because they assisted me very well, and the sisters were always there because my father wasn’t here and my mother couldn’t be here. She came late, so they helped me until I delivered”*  
(P19: Christian).

*“Umm’, the pleasant things. Yeah, some of the expectations were met, like the nurses were like so supportive. For me they were very supportive”*  
(P5: Christian).

*“The nurses treated me very well and I had no problems whatsoever. They were always checking on me every four hours, making me comfortable, having my bedding changed and checking that I had my meals. I was like so dehydrated and they woke me up to check on me regularly”* (P1: Muslim).

Other participants felt the need for the doctor to be present. One said:

*“A student nurse delivered my baby. It was to qualify her for her 4<sup>th</sup> year in becoming a nurse. It was one of the tasks she had to do. I was scared because I thought like how could a student nurse, I expected a doctor, but I didn’t really think that things are so different now and it turned out very well because she knew what she was doing”* (P1: Muslim).

The other important sub-category related to partner and family presence. Participant’s valued family support during the childbirth experience, especially when family members where in certain instances, were allowed to remain with them in the labour ward. This was evident in the following statements:

*“The baby’s father was allowed in the delivery room. It was our first child and he wanted to be with me because it was my first time to experience birth”*  
(P6: Muslim).

The strong need for family presence was articulated particularly through the dissatisfaction, that their partners were not allowed in during the process of labour but only during delivery. Participants expressed how this had affected them as follows:

*“I felt very alone and neglected throughout my experience” (P10: Hindu).*

*“They did not allow my mother or my partner to remain with me. They allowed my partner only at delivery. I needed the support because it was not easy to go through the experience alone because I felt it was my first experience” (P8: Muslim).*

*“I know that your husband is allowed to come in while you giving birth. They didn’t even allow him to come in. You need someone with you by your side” (P13: Hindu).*

These excerpts from the data reaffirm the importance of presence of family. Various scholars have reinforced the importance of support from family and hospital staff during childbirth (Hodnett 2002: s160; Lundgren 2002: 34; Brown 2007; Moore 2009: 2; Kennedy 2011: 77; Etowa 2012a: 27; Goldstein 2012: 138). Whilst the public hospital context may not always lend itself to enabling family presence, it is crucial that midwives be more sensitive to this need and allow same wherever possible, and for a longer period of time as opposed to just at delivery. Intentional engagement with the patient and entering into a spiritually caring relationship that allows for connectedness with other significant others is an important part of spiritually based nursing care (Chandramohan 2013: 95).

### **Category 7: The need for information**

**Sub-categories: Orientation to hospital and ward policies; explanations about medication, interventions and progress of labour.**

Additionally, the need for information emerged as a further significant category in the data. Orientation to hospital and ward policies and information particularly about medications to be administered, interventions and progress

of labour were the sub-categories that coalesced from the category, information.

With regard to orientation to hospital and ward policies, most participants' views were reflected in the following statement below:

*“Nurses should get information from their patients as to how they feel, and also put up posters of what is the routine of the labour ward so patients can read and understand”* (P3: Christian).

There was also a need for information related to medication being used, interventions and progress of labour. The following quotations expressed the need for an explanation with regard to medication being administered:

*“Yeah I was given an injection; I don't know what it was for because they never explained. They just like ‘just give her an injection’”* (P17: Christian).

*“So the doctor decided, now they need maybe to put a drip and give an injection, I don't know for what. Yeah, by then, it was 6 o'clock and by twenty to seven the pains were more and then the nurse came, she checked me again, she said I'm 9 cm and prepared everything for me to give birth, and then I gave birth shortly thereafter”* (P5: Christian).

With regard to information about the progress of labour the participants' overall feelings were captured as follows:

*“The nurse wanted to perform a vaginal examination while I was having a contraction. Anyway after the nurse was done I had to ask the nurse about my progress, otherwise I would not even know about my progress. Nurses (midwife) need to be more explanatory to patients that are in labour. The information should be reinforced to mothers in labour and this will help mothers to co-operate during labour and delivery”* (P7: Hindu).

*"I needed more explanation as this was my first experience of having a baby. My mother and sister told me about certain things that they knew about labour but nurses didn't tell me anything. All the midwife said was that I should just walk a lot"* (P8: Muslim).

*"I did not know what to expect, but because my sister is a registered nurse I got some information from her. I was not given any information by the nurses. I did not know what to expect during birth"* (P3: Traditional Zulu).

*"Well, 'umm', luckily I had my mother-in-law with me throughout my whole pregnancy and didn't really get advice from nurses or doctors, she knew what to do when I felt pain or when I got sick, everything like that"* (P18: Muslim).

The importance of being given explanations was reaffirmed through the following statements:

*"The nurse (midwife) gave me a bed and gave an explanation of my condition. Soon after that the baby was born"* (P12: Christian).

*"They (midwives) tell us about what to expect and about when you go there, what you must do and what they going to do to you"* (P14: Traditional Zulu).

*"Nurses (midwives) took good care of me and told me about signs of labour and what to expect when my labour starts, so I more or less knew what to do and I felt I was co-operative. They also told me to breathe a lot and not to push and bear down prematurely"* (P2: Traditional Zulu).

From the above excerpts it is evident that explanations regarding medical intervention and procedures was crucial to preventing fear and allaying distress. It also provided reassurance regarding the process as it unfolded. Collectively these are important factors that patients must be made aware of. Midwifery training and education should therefore prepare midwives to

provide such information, rather than being mere facilitators of the birth experience. Pugh (2014: 98) concurred saying that an awareness of what is happening is crucial to the best outcomes for both mother and baby.

#### **Theme 4: Different spiritual beliefs and practices**

##### **Category 8: Spirituality as a coping mechanism**

**Sub-categories: All about God and praying; praying to Sai Baba; kept on believing; recite mantras; pray to ancestors.**

The third theme that emerged from the data on childbirth experiences related specifically to different spiritual beliefs and practices. Spirituality as a coping mechanism emerged as a category in the data and the sub-categories that flowed from this were: all about God and praying; praying to Sai Baba; kept on believing; recite mantras; pray to ancestors.

With regard to the category of spirituality as a coping mechanism during the childbirth experience, participants' said the following:

*"It was a spiritual experience for me because it is all about God and praying and reciting prayer for everything to go well and for the pain to ease"*  
(P8: Muslim).

*"I was just concentrating on waiting for the baby to come. Having positive thoughts carried me through. I asked myself... How did I do it? It seemed like I had help from above"* (P2: Traditional Zulu).

*"I was just praying to Sai Baba whom I worship. I just kept on talking to him 'Baba please protects my baby and me'"* (P10: Hindu).

*“It was a spiritual experience for me because I was only praying to God for my baby to be healthy and I kept on believing that my baby was going to be alive. I said Thank you God” (P11: Traditional Zulu).*

*“It was a spiritual experience for me because I prayed when I was in labour and it is customary to read and recite mantras to assist with delivery and to have a healthy baby. I also wanted to keep my chains on my neck but the midwife asked me to take everything off and send it home. Its our important Gods and Goddesses pendants we keep that help us to get through in life, that’s what we believe in and it helps us” (P9: Hindu).*

*“I actually, what helped me was I had a book, a Christian book ‘A cry that God is waiting to hear and answer’. So my mother is a holy person. I’m not so holy but anyway I decided so I told her send something for me to read, and this book came. I somehow opened to this page that had about childbirth. It says on that specific page I was reading it doesn’t matter how hard and how long you pray, it’s how much of faith you have in it. Childbirth is very painful, but if you say you going to get through this faster... I still say ...and that’s what caused my 2 cm to go to 10 cm so fast. And yeah, so I followed the book and I prayed and normally for the first one I was... For this one I stayed calm. I prayed; I prayed; I prayed. I said God please make this easy, go fast and make it easy. Honestly speaking, the second birth was much less painful than the first birth, it went normal” (P15: Christian).*

As is evident from the quotes above, women from all spiritual backgrounds experienced childbirth as a sacred experience. Prayer, chanting, reading, reciting from scripture and the use of sacred amulets were found to assist to be the most significant spiritually based activities used by participants to cope with pain and anxiety. They were also found to focus on God or meditatively establish a connection with the Divine. Eminent researchers in the field of health and spirituality have also attested to the link between the spiritual activities used by participants above and coping and dealing with pain,



anxiety and physical distress (Koenig 2013; Chandramohan 2013: 95). Callister and Khalaf (2010: 16) found in particular in their study also that women relied on God and believed that having faith in God would influence their birth outcomes for a more positive experience. Hence not only did women see the experience as a spiritual one, but they also tended to draw on their spirituality as a source of strength during this experience.

Participants from an African Traditional Religion expressed clearly the role of the ancestors in the childbirth experience and post –delivery. This can be seen in the following excerpts:

*“Traditionally we Zulus pray to our ancestors to guide us through labour. The belief is that the child is given to us by the forefathers. We practice ‘Impepho’ which means consulting with our ancestors to bring a healthy baby into the world”* (P2: Traditional Zulu).

The literature highlights particularly the importance of the ancestors who are seen as Divine Beings in the context of African Traditional Religion (Bhagwan 2002: 170). Women from this background will therefore resort to praying to their ancestors to help deliver a baby who is considered the “highest gift from God” (Mbiti, 1975: 32). Birth “reflects the activities of Gods work” and is deeply revered amongst African communities (Asante and Mazama, 2005: 125).

## **Theme 5: Customs and cultural practices**

### **Category 9: The use of alternative medicines before, during and after birth.**

**Sub-categories: Have a herbal steam; used sesame oil; drank isihlambezo; jeera water is given.**

Intertwined with the use of spiritually based activities that draws on God and Divinity as sources of strength, was the use of traditional or alternative therapies by women in the sample. The sub-categories that emerged were: Have a herbal steam; used sesame oil; drank isihlambezo; jeera water is given. This was evident in the following statements:

*“During labour we have a normal bath and it is customary to have a herbal steam or to smoke the room until you sweat to facilitate and accelerate the labour process. I used sesame oil for my back massage (usually the woman’s mother-in-law does the massage) because husbands are not allowed during delivery” (P12: Christian).*

*“Before birth I just drank a lot of holy water that my pastor used to bless even when I was going to come here to labour ward and then after birth I had lots of pains as though I’m going into labour again and then my aunt got me this medicine it has a Zulu name... You just buy it and then you boil it and it eases all the pain and even when like after the stitches when you feel tight it loosens all the pains and yeah even when you bleeding heavy it helps with all that and it clears actually your bladder, yeah” (P20: Christian).*

*“She gave me some ‘Isihlambezo’ (liquid made up of several herbal ingredients) to drink before I came into hospital, they say to make the labour come quickly” (P22: Traditional Zulu).*

*“During labour jeera water (water with cumin seeds) is given to the woman to accelerate the labour process” (P8: Muslim).*

*“The pain was intermittent at home and my mother told me that it was ‘cold pain’ and advised me to keep warm. She gave me coffee mixed with butter to relieve the pain” (P10: Hindu).*

*“During labour I drank jeera water with some butter in it, which my mother gave to me. They said that the pains come quicker, but it is only taken when you in labour and not when you don’t have labour, must be active labour” (P13: Hindu).*

The above reflect that most spiritual worldviews are underpinned by traditions and practices associated with easing pain during childbirth. These include the use of traditional medicines and therapies such as massage with oils that are believed to ease pain and enable an easier birth experience. Hence whilst the highly medicalized hospital environment may rely primarily on pharmaceutical based medication, there must be a more welcoming and respectful space for the use of traditional therapies that will not jeopardize the health and well-being of both the mother and baby. Studies abroad have also documented extensive use of alternative methods. For example empirical work undertaken by Calvert and Steen (2007: 159) and Robertson and Johansson (2010: 442-443) found that complementary and alternative methods were extensively used during pregnancy and childbirth. Goldstein (2012: 142) also reported that massage assisted the labour process, which lends further support for its use as was evident in the current study. It is also important to take cognisance of research that has documented that complementary and alternative medicine has served to prevent the need for invasive techniques (Westfall 2001: 53; Mitchell 2010: 110). Hence it is crucial then that midwives be more aware of alternative therapies used by women from diverse groups and its potential benefits and risks in the childbirth process.

It also appeared that spiritual beliefs influenced choices with regards to accepting pain relief medication during childbirth. It would appear that most women have spiritual beliefs which propound the notion that childbirth is a natural process and hence pain relief medication is unnecessary. Viewed in this context midwives need to be aware and midwifery education needs to educate midwives that often refusal or reluctance to utilise pain medication, may be grounded in spiritual beliefs as opposed to personal reluctance. Where this happens and if it does not compromise the health and safety of mother and child, midwives need to be more respectful of such spiritual choices.

These spiritual beliefs are particularly evident in the statements below. As can be seen even alternative therapies are in some instances discouraged due to religious beliefs.

*“The Semetic culture does not allow one to have any unnatural pain relief medication. The belief is that it will disturb the natural process”* (P12: Christian).

*“No alternative therapy or medicines are used”* (P4: Xhosa).

Given that spirituality influences heavily the choice to accept pain relief medication use and also influences the use of certain culturally derived traditional therapies, midwives must have a more enhanced awareness of how religion influences same in clinical practice. These are crucial factors in understanding patients' reluctance to use Western medicine and to prevent patients from being construed as being difficult.

The data also reflected that pain was viewed as a natural phenomenon in childbirth from a spiritual perspective. This further influenced decisions to go through the process without any medical intervention or to use any alternative therapies. This was evident in the following statements:

*“In our culture, the pain that you have to have the baby you must feel pain; it supposed to be a normal thing. That God gave us women, we are born to have those pains before we have the baby” (P14: Traditional Zulu).*

*“Our belief is that nothing should be taken for labour pain. We just pray that everything will go well” (P9: Hindu).*

### **Category 10: Rituals before, during and after birth.**

**Sub-categories: Amulets; naming ceremonies; prayer to welcome the baby; whispering in the ear; slaughtering of sheep.**

Spiritual practices before, during and after birth was another salient sub-category that emerged from the data. Participants from all four of the religious groups studied, viz. Islam, Hinduism, Christianity and African Traditional Religion all expressed that some type of ritual had to be performed for both their babies and themselves. In the following sub-sections data from these groupings specifically are presented. The next sub-section contains data from participants from an Islamic background:

*“An amulet made with green cloth during which time quotes are read from the Qur’an (Muslim holy book). The green cloth was tied around the left thigh so that delivery progresses quickly. This really helped because my membranes ruptured” (P1: Muslim).*

*“We will bury her nails and my afterbirth, because the Muslim religion believes that it shouldn’t be thrown away, and should be buried because the afterbirth, it was with her during my whole pregnancy, it was something that was growing with her, so they bury that, and they bury the new hair and the nails, and then ‘Adhan’ will be read in her ears. We also have to sacrifice, called ‘Harkika’. That’s when you slaughter a sheep, done as soon as possible. For a female child the offering is one sheep or ox. For a male child*

*two sheep or ox are slaughtered. I haven't done this yet, but will soon. What you do with the meat is that you keep a portion for yourself and the rest you can distribute it to whoever"* (P1: Muslim).

The first excerpt reflects the huge importance placed on spiritual rituals to enable a more pain free and easier birth experience. It is therefore important that there is greater sensitivity to some of the rituals and practices adopted by certain spiritual groups during the birth experience. Such rituals and practices should be respected as part of a holistic approach to spiritual care in nursing practice (Chandramohan 2013: 32).

The second excerpt cohere with Clark (2003: 169) and Gatrad and Sheikh's (2001: F6) description regarding Muslim rituals. They said that at birth the father or a respected member of the local community speaks the first prayer (adhan) and second 'iqama' (calls to prayer) in the baby's right and left ears. Chaudhry (1988: 47), Mitchell (2001: 23) and Elion and Strieman (2001: 76) writings with regard to other religious groups said that the new born is welcomed into the family through a celebration. In the Muslim community they noted that two sheep are slaughtered for naming a boy and one for a girl and the meat is then distributed to the poor and shared amongst the family and friends.

The data also reflects that there are certain spiritual practices and rituals that are adopted with regard to new born babies. This is evident as follows:

*"For baby a small knife (amulet) is pinned on baby's clothes which assist with protection. Black bangles and kajal (black eyeliner), used on eyes to keep baby away from evil"* (P1: Muslim).

Wehbe-Alamah's (2008: 87) study on Muslim religious beliefs also found that charms and amulets with words or verses from the Qur'an are usually attached to the newborn's clothing to protect the baby from the evil eye.

The following reflected the experiences of Hindu participants, particularly the importance of the Guru or Hindu priest in the childbirth process:

*“I was in pain and at 8.30 pm my membranes had ruptured. At this time the priest came to pray for me, but he was not allowed in. We were told to go outside. The priest read some mantras, turned a clove three times around my entire body and pulled my right and left big toes. This was done to accelerate the labour process. Soon after, the baby was born. I did not even think about the pain” (P9: Hindu).*

Gurus are revered Hindu priests or leaders and have knowledge of sacred mantras that they chant according to different problems faced by Hindus. They may either recite these themselves or teach them to their followers or devotees (Bhagwan 2010: 301). It was interesting to note that although the priest was not allowed in, the mother was permitted to go out to engage in prayer and Hindu rituals that accelerated the birth process. This suggests that some midwives are respectful and sensitive to the spiritual needs of patients in the medical milieu.

It also appeared that religious traditions and customs influenced post-delivery recovery. Fraser and Cooper (2003: 626) highlighted that there are a range of religious and traditional customs that must be carried out simultaneously with all the physiological adjustments that take place post-delivery.

*“My mother used garlic peels and burned ‘Samrani’ (lobaan) and I had to stand over the smoke to protect and heal and dry my episiotomy sutures” (P10: Hindu).*

There were also a range of rituals undertaken for the baby as well. These were as follows:

*“The baby was the first granddaughter. A nine-day prayer had to be performed which was the naming ceremony. They cook three varieties of vegetables. An elderly woman whispers the name in the baby’s ears so baby will know her name as she grows. She and baby are not allowed to go anywhere for 40 days. Baby’s hair is taken out on the 40<sup>th</sup> day. A black and white rooster is sacrificed. The significance of the black rooster is to worship a goddess so that all evil and bad luck is taken away. The white rooster also worships a goddess to bring in luck for growth and good health for the baby”* (P9: Hindu).

*“I said to them (midwives) that after he was born, I’d like to put his dot on and I have his knife with me, and I would like to put his knife on. She said, ‘no problem, you can do all of those things’, and she let me do it. My culture was respected because I was allowed to put a black dot on the baby’s forehead and to pin a small knife (amulet) on the baby’s clothes. These are used to protect the baby from evil”* (P7: Hindu).

*“My husband went to the temple the next day and he saw the priest, and gave him what time he was born, and then from there the priest gave him some names and alphabets that he could choose baby’s name from, and that’s how we did all of that”* (P7: Hindu).

*“When the baby is born we must stay in the house for like 40 days and then we have to take out the hair and everyday we have to burn ‘lobaan’ incense in coal so baby does not get sick once you put ‘lobaan’ smoke on baby. Baby and I are not allowed to go anywhere. I was not allowed to eat dhal, breyani, beans, drink any minerals or eat any hot curries or any mango. They said the baby gets yellow jaundice or running stomach, baby gets sick”* (P13: Hindu)

Evidence regarding naming rituals for new born babies is also evident in the literature. Laroia and Sharma (2006: 95) highlighted that post-delivery rituals



were very important in Hinduism. Elion and Strieman (2001: 76) stated that the baby is given a unique name after consulting a priest or a learned person. The name is chosen from a choice of three letters given by the priest, which is determined by careful spiritual and astrological readings as per the Hindu religion.

The most common elements that reflect Christianity and Christian beliefs and practices were as follows:

*“I think they (God) gave me a lot of strength because when you believe in something, it will probably happen. Yes, and I believe that when I went to labour ward I would deliver a happy and healthy baby, that’s what happened. As we go home we have to make like a prayer to welcome the baby and thank God for everything”* (P19: Christian).

*“Our family, I’m from a Christian background. I’m planning to christen my baby two to three months from now. My husband and my mother chose the name, so it’s from the Bible”* (P15: Christian).

Prayer to thank God following the birth of a new born appears equally as important as during childbirth. Elion and Strieman (2001: 58) supported participants’ reports that rituals in the Christian religion include the naming ceremony and the dedication of the baby into the Lord’s service. This is a thanksgiving ceremony and blessing of the child for the safe delivery of the infant.

The cultural beliefs and practices of the African Traditional Religion were reflected in the data as follows:

*“Partners are allowed in the delivery room but traditionally for us in the Zulu culture males are not allowed, only women are allowed to be with us”*  
(P2: Traditional Zulu).

*“They allowed him to come in but he didn’t come in, only women must come to see the mother and the man must come inside the house only after three months to see the child” (P21: Xhosa).*

Littlejohn’s (2010) study on African Traditional birth in South Africa also found that grandmothers and older women attended to birth, and also after birth the mother and her baby were kept secluded until she stopped bleeding, and until the placenta was buried.

*“After baby was born my mother put green strings around the baby’s waist for protection from evil. ‘Impepho’ is also practiced after birth and the ancestors are called upon to help you and baby heal, and to give thanks to God” (P2: Traditional Zulu).*

*“Xhosa culture’s belief is that the placenta is buried in her own home if she is not married i.e. at her mother’s home. Once the cord has fallen off it is buried with the placenta in your mother’s home. The reason for this is that you can go to that place to call for the ancestors. This is a very important place in the yard because it calls for spirits to protect the baby. The baby is also then shown to other women and family. They use some strong smelling leaves to burn in the fire. Then they put your baby over the fire...carry the baby over the fire. The smoke must go all over the baby. They do this to the baby so that the baby can be free from evil and also to be strong as he grows” (P4: Xhosa).*

*“We wait until placenta comes out and then we call ancestors and then we burn ‘Impepho’ and talk to the ancestors” (P14: Traditional Zulu).*

According to Asante and Mazama (2005: 124) African societies participate in extended rituals with regard to the disposition of the placenta, which is considered a sacred link between mother and child. Elion and Strieman (2001: 42) also noted that the umbilical cord is buried in a secret place with

the belief is that it will avoid the child from wandering away from home. Littlejohn (2010) also wrote that burying of the placenta and cord is of great importance in the African tradition.

Participants also raised the issue of how religious views interfaced with giving birth out of wedlock. These are potential psychological issues that may emerge and affect mothers during the childbirth process. The notion of having a baby out of wedlock was raised as follows:

*“In the Christian faith the belief is that one should not have a baby before marriage, but the family was supportive” (P5: Christian).*

*“Firstly I had to have a baby when I was married. Although I’m not married yet I am in the process of getting married ‘hmm’. My parents were kind of surprised and mostly my pastor was kinda shocked and very disappointed I’d say. And my family and people that we live with everyone just accepted the baby and everything was just okay” (P20: Christian).*

*“I had a hard time. I was not married. When I was pregnant I was not accepted by my family but eventually they did accept me. The child’s father chose not to be part of my life” (P1: Muslim).*

*“I was not married and in my tradition we are supposed to be married before having a baby, but thank God I was accepted by my family” (P8: Muslim).*

The above statements reflect how certain religious groups view premarital sex and the birth of a baby out of wedlock. In particular the Muslim and Christian religious groups believe that this is violation of their religious values (Clark 2003: 187; Bhagwan 2002: 168). Based on this midwives should be alert to the lack of family support especially for unmarried mothers and endeavour to provide greater psychological comfort where such distress is evident.

### **4.3 CONCLUSION**

In this chapter the data obtained from women with Christian, Islamic, African Traditional and Hindu backgrounds was analysed and presented in the form of themes, categories and sub-categories. Participants described their childbirth experience from a personal perspective within the context of the hospital, and specifically how their spiritual beliefs and practices interfaced with various issues during and after childbirth. Chapter five follows with a discussion of the presented findings, including recommendations, limitations, suggestions for future research and conclusions.

## **CHAPTER FIVE**

### **DISCUSSION OF THE FINDINGS, RECOMMENDATIONS AND CONCLUSIONS OF THE STUDY**

#### **5.1 INTRODUCTION**

Childbirth is a deeply personal experience and is characterised by a multitude of unique psychological and physiological factors. More importantly, there has been a growing awareness of the need to consider holistically other factors such as spiritual and or religious factors as they also influence and can act as a support system both during labour and post-delivery. This led to the impetus for the current study which arose due to a need to explore the childbirth experience holistically and to inquire how spirituality influenced and impacted on certain dimensions of the childbirth experience of women. Hence women from diverse spiritual worldviews viz. Christianity, Islam, African Traditional Religion and Hindu were selected to participate in the study. They were selected from public hospitals in the uMgungundlovu District of KwaZulu-Natal.

The findings presented in Chapter four revealed that there were five significant main themes, ten categories and thirty nine sub-categories that reflected the data. These were identified from the interviews held with participants' with regards to their experience of childbirth and what role their spiritual beliefs and practices played during and after childbirth. As noted in Chapter 1 culture emanates from religion and religion and religiosity is subsumed within spiritual experience and spirituality (Bhagwan 2002: 68). Hence issues of religion and culture cannot be separated from spirituality and the discussion is undertaken within the context of the operational definitions elucidated in Chapter 1.

The five main themes were found to cohere with the seven dimensions of the conceptual framework of Lowe and Struthers (2001: 280) presented in Chapter one. The latter emphasises aspects such as holism, spirituality and tradition. The discussion that follows is focussed on the major findings related to the themes, categories and sub-categories that were presented in Chapter four. The themes, categories and sub-categories are interrelated with and have answered the research questions set out at the onset of the study. Relevant literature is integrated into the discussion and the chapter ends with conclusions, brief recommendations, the limitations of the study and suggestions for future research.

## **5.2 DISCUSSION OF THE FINDINGS**

Twenty-two women aged between 20 to 37 years formed the sample for this study. This age range included both primiparous and multiparous women. The majority of the participants, however, were between 20 to 25 years of age, which reflects the common childbearing age of most women.

The main themes drawn from the data were: the meaning of childbirth; experience of labour and birthing; needs during labour; different spiritual beliefs and practices and rituals before, during and after delivery. The ten categories generated from this included the symbolic meaning of childbirth; emotions; comfort needs; the need for communication; expectations; the need for support; the need for information; spirituality as a coping mechanism; the use of alternative medicines before, during and after birth and rituals before, during and after birth. The sub-categories that flowed from the category of the symbolic meaning of childbirth were the significance of childbirth within a spiritual context, the birth of a baby boy and the birth of a baby girl. The sub-categories of the category of emotions were positive emotions, which included feeling empowered; amazement; happy; joyous; exciting; sense of achievement; and sense of motherhood. Negative emotions included sadness; fear; disappointment and fatigue. Pain relief,

labour and delivery positions, and unnecessary medical interventions were the sub-categories of the category of comfort needs. Language barriers and the need to be listened to were sub-categories of the need for communication. The sub-categories of expectations were participation in decision-making and being in control during the birthing process.

The category of the need for support was underpinned by the sub-categories of presence of the midwife, doctor, partner and family presence. Orientation to hospital and ward policies, explanations about medication, interventions and progress of labour were sub-categories of the category of the need for information. The sub-categories of the category of spirituality as a coping mechanism were all about God and praying; praying to Sai Baba; kept on believing, recite mantras and pray to ancestors. The category of the use of alternative medicines before, during and after birth included subcategories of have a herbal steam, used sesame oil, drank isihlambezo and jeera water is given. The category of rituals before, during and after delivery consisted of amulets, prayer to welcome the baby, whispering in the ear, slaughtering of sheep and protection from evil.

## **5.2.1 THE CHILDBIRTH EXPERIENCE**

### **The meaning of childbirth**

Rooks and Ernst (1999: 19) wrote that childbirth is valued as an emotionally, socially, culturally and spiritually meaningful life experience. They added that the birth of a baby makes women feel stronger and also strengthen bonds between the mother, family members and the newborn. Hence a child's birth is significant for both mother and family. Berg, Ólafsdóttir and Lundgren (2012: 79) and the WHO (2005b: 5) supported this view, saying that the childbearing experience has been considered as a significant life experience in a woman's life and that of her family.

The data also indicated that the newborn, regardless of whether it was a male or a female, was perceived to be a blessing for all women and their families. The data further reflected that women from the Islamic, African Traditional Religion, Hindu and Christian backgrounds all believed that the birth of a baby boy was extremely significant, as a male would carry his father's name and continue the family lineage. There was a strong consensus across participants from all the religious groupings that male babies preserve the family heritage by passing on the family name from generation to generation. Bawadi (2009: 250) reiterated this by saying that the birth of a baby boy was significant, as he is seen to "protect the life of the family name". Beigi *et al.* (2010: 81) noted that in Africa and Asia baby boys are said to be superior. Baby girls were viewed as blessings but in a different way. Both Hindu and Muslim mothers said that in their religious worldview a baby girl was perceived as being a 'light' of the home. They described baby girls as being symbolic of blessings, prosperity and peace in the home. This section of the discussion relates to the first objective of the study as it sheds light on how the birth of a baby had personal significance, significance for the family and the religious meaning of the birth of a baby boy or girl.

Childbirth was found to hold a personally significant meaning for each woman and for their family. In describing the meaning of childbirth, participants from all spiritual backgrounds studied described having a baby as a joyful experience, but particularly a huge blessing from God. Clark (2003: 191) echoed this by writing that the birth of a child is a joy for all families which is often seen in sacred terms. All the participants believed that bringing life into this world had a special meaning. This meaning extended itself to the family, as participants indicated that the meaning of the birth of their child was extended to include a deeper significance for the family as well. Hence it was not solely a personal experience but an experience that held significance in multiple ways for significant others. Viewed holistically the experience itself then can be seen as a spiritual one, particularly within the context of the definitions elucidated in Chapter 1.



## **Experience of labour and birthing**

The study also found that participants from all four spiritual backgrounds in the study had experienced a multitude of emotions during their labour and birthing experience. This resonates strongly with the literature, as Schneider (2013: 46), Lliadou (2012: 385) and Sellers (2012: 142) all described labour and the birthing experience as being an experience, that provokes a multitude of profound emotions. Data from the study reflected that participants experienced both a range of both positive and negative emotions during childbirth.

The most common emotions included anxiety and fear that all participants were found to experience. Despite this however they also all felt a sense of joy and excitement and expressed that giving birth was an amazing experience. The childbirth experience was also described as providing a sense of accomplishment and fulfilment and enabling a sense of motherhood, despite any difficulties or pain experienced during the birth. These emotions suggest that participants feel a sense of fulfilment once they have had their babies, and a sense of gratification as both a mother and a woman. Parratt (2002: 10) concurred saying that that when mothers give birth naturally they feel good about themselves. These findings shed further light on the first objective in the study.

One of the participants described her pregnancy and childbirth experience as a journey. She related her experience holistically, describing the physical difficulties brought on by morning sickness, the pain experienced during labour and how it had affected her psychologically and emotionally. This reflects similar findings made by Mensah *et al.* (2014: 32) who reported that mothers view labour and delivery as “a physical and emotional journey.” Feelings of sadness, happiness, being overwhelmed and fearfulness were the general mixture of emotions experienced by participants in the current study. Participants who were first-time mothers also realised that the mixture

of emotions, especially the fear of pain, were all part of the childbirth experience. Several authors support the view that the childbirth experience provokes mixed emotions (Wilde-Larsson *et al.* 2011: 1168; Sellers 2012: 142; White 2007: 28; Jukelevics 1990: 11). In fact Simkin (2006: 4) concluded that there was no other single experience that could bring about such intense, demanding sensations and emotions.

The data further suggests that labour progresses differently for each woman and pain is experienced in varying degrees differently by all women. This reaffirms the notion that childbirth is a unique experience for each woman. Midwives therefore need to take cognisance of this and be mindful of the fact that each mother in labour experiences pain differently, and should therefore be treated differently. This is particularly true given the fact that participants had voiced that midwives were insensitive to their experience of pain or believed that their labour was progressing differently from what they were experiencing.

Mahlako (2008: 126), explored midwives' responses and attitudes towards women in labour as well as their perception of pain experienced during labour. They found that although in most cases although bearable, labour pain is unique to each woman and women's responses should not be stereotyped but treated uniquely. Most participants feared pain regardless of whether they were a first-time mother or not. One of the first time mothers shared that she would 'never' have another baby as a result of the intensity of pain experienced. Although pain experienced during labour and delivery is regarded as a normal phenomenon (Klabbers *et al.* 2014: 1), women may experience fear and anxiety due to the high intensity of pain during labour. Morson (2013: 77) related that anxiety can progress to fear, and the context in which they are experienced can vary from person to person.

The study also found that fear and pain affected primarily first-time mothers, which emphasises the need for midwives to be more sensitive and

considerate of this. Educational training should therefore focus on enabling midwives to allay the fears of first time mothers more and to provide support and comfort to those who are distressed. This is important because fear and high levels of pain are often remembered later and seen as a negative experience of birth (Mercer, Green-Jervis and Brannigan 2012: 720). Physical pain was a dominant theme, which suggests that most mothers had to cope with this without much assistance from midwives or awareness of alternative remedies. This also suggests that mothers at public hospitals may not have been adequately prepared during antenatal classes for delivery or not attended these classes at all. Several scholars have documented the poor quality of midwifery care at public hospitals (Choobmasjedi *et al.* 2011: 1131) and where mothers themselves are unprepared, labour and birth experience can be experienced negatively. It is therefore important for midwives, who are the closest health professionals to women in maternity care, to be sensitive to the emotions and issues of physical discomfort through an empathetic approach (Barnfather 2013: 32).

Magnusson and Fennel (2011: 48) added importantly that the way in which pain is dealt with is multi-dimensional in nature. In this context the data suggests that religion and culture influences how some mothers perceive and deal with pain. This was evident in the context of the current inquiry, particularly amongst mothers from the African Traditional Religion and Hindu backgrounds. Participants from both these religious backgrounds believed that pain during labour is normal and mothers have to endure the pain of labour and delivery. Hindu mothers expressed that no pain relief medication should be taken, and one should pray and believe that mother and baby will be healthy and well after delivery. These findings resonate with those made by Callister *et al.* (2003) who studied the pain experiences of culturally diverse childbearing women, through narrative data. They found that women who were religiously inspired appeared to have accepted pain as a necessary and inevitable part of the childbirth experience. This is an important finding and suggests the need for midwives to take these religious

and cultural factors into account in the context of pain management during delivery. Culturally sensitive knowledge empowers midwives to be more respectful when patients decline pain relief thereby, enabling a more holistic view of labour and birth and how it interfaces with issues of religion and spirituality. Needless to say however the safety and well-being of both mother and baby should not be compromised as part of ethical decision making when taking care of a mother in labour, at birth and after delivery.

Another important issue that emerged from the data is that women expressed the need for freedom to give birth in certain delivery positions. All the participants concurred that the experience of being tied down to a bed was restrictive and detracted from it being an easier and satisfying experience. Sessions (2013: 50) agreed by saying that ambulating freely during labour and birth allowed women to be in better control, leading to a more positive birth experience. One salient feature in the data was that mothers from the African Traditional Religion, preferred to deliver their babies in the squatting position. It is possible that this is common practice amongst women from rural African contexts and should be respected even within the public hospital context. Allison (2005: 6) supported this saying that it is normal practice in certain traditional cultures, as it is believed that the squatting position eases the delivery process. Hence midwifery care may emphasize a restrictive bed position which may be more convenient to health practitioners, midwives should revisit this and encourage and allow women to adopt positions that are most comfortable for them. Sellers (2012: 335) supported this strongly stating that all women need to have a birth plan, which is developed with the assistance of the midwife. The position for delivery is one of the issues that must be incorporated into this discussion and where culture and personal preference dictate other positions it should be respected. The data suggests that women from an African Traditional background are those who may particularly want to squat, as opposed to lying in bed during labour and delivery and hence midwives should be sensitive towards these needs.

Participants from all spiritual backgrounds expressed dissatisfaction with unnecessary interventions that were performed on them, e.g. frequent vaginal examinations and the use of enemas. Evidence-based practice suggests that these examinations should only be performed when necessary (Iravani *et al.* 2015: 36; Smith *et al.* 2004: 117). These are further issues that must be brought into midwifery education and training and be respected as part of a sensitive approach to improving quality care which prioritises patients' needs and feelings.

Positive communication, and particularly having a midwife who spoke the same language, appeared to be another crucial factor for midwives to be aware of when caring for patients from diverse religious or spiritual backgrounds. This relates to the second objective of the study. South African Statistics SA (2014) reported that Africans constitute 80.2% of the population of South Africa and are made up mainly of those from the African Traditional Religion background (South African Government Information 2011/12). Given that midwives may not always be from the same background, suggests the importance of midwives having greater preparedness to deal with patients from these backgrounds. This is important not only to ensuring language proficiency but also sensitivity towards certain religious or spiritual factors that interface with the birth experience. Data from the study confirmed that all mothers indicated feeling comfortable with midwives who shared a similar religious background. Given staff shortages this may not always be possible but should be implemented where possible. More importantly however all midwives should be trained to deal with patients from backgrounds that are diverse to their own. de Kock and van der Walt (2004: 13-2) supported this saying that midwives must take into consideration factors such as communication, customs, attitudes and beliefs when attending to women in labour, because these factors have a major influence on their birth experience. According to the South African National Department of Health (2015: 49) midwives need to communicate clearly with women and be supportive and encouraging to gain co-operation. Fair and Morrison (2011:

24) concurred that effective communication between the patient and health care professional has been made known to enrich satisfaction with health care. Language is thus crucial during this hugely sensitive process, which may also strengthen the understanding of certain religious and spiritual customs and traditions.

Listening is a crucial aspect of communication. It is crucial that midwives listen to mothers during labour and delivery (Adams and Bianchi 2008: 109). Most participants in this study expressed that both the midwives and the doctor did not listen to them, as when they felt they were ready to deliver their babies, they were ignored. Chokwe and Wright (2013: 5) reported that at state and private hospitals in South Africa there was often poor communication between patients and midwives. Thorstensson *et al.* (2012: 8) indicated that nurses are too busy completing paperwork instead of actively listening to and attending to mothers during the labour process. This supports data in the current study, where participants reported that midwives were busy completing information on their files, instead of attending to them. Adeyemo (2013: 18) concluded that midwives at public hospitals, ignore the views of mothers for effective and satisfying birth experiences which suggests a deeper reflection on this for the purpose of a more satisfying birth experience.

Participants expected to be included in the decision making processes of the childbirth experience. Data reflects that they have a deep need for them and family to be actively involved in decision-making processes regarding comfort and medical intervention. Noseworthy, Phibbs and Benn (2013: e47) supported this saying that the partner and family play a significant role in many of the decisions made around childbearing. They wrote that factors such as individual practices, local hospital cultures, medicalised birth and staff shortages determine the way in which care decisions are made which prompts the need for heightened awareness of this. Their study indicated a culture of stereotyped decision-making and care in public hospitals because

midwives follow the rules of the hospital, resulting in individual needs of mothers' being overlooked. In most instances hospitals carry out functions in accordance with policies and procedures, and midwives endeavour to do their best to maintain these standards. The culture of the labour ward environment in public hospitals is also led and directed by obstetricians. Russel (2007: 129) agreed that obstetricians often take charge of the maternity units and are most influential. Despite this it is crucial that the mother is not overlooked and that her physiological, psychological and spiritual needs are respected within this environment.

Being in control during the birthing process was found to be an important dimension of a positive birth experience. Some participants reported that they followed their instincts, which made them aware of an imminent delivery. Others felt that they had lost total control over their bodies which brought on a sense of fear. McGrath (2012: 76) noted that the main fear experienced by mothers is a loss of control. Although women receive physiological care primarily, midwives need to be aware of a mother's psychological needs and spiritual needs so as to ensure a holistic and positive experience (Cook 2010: 54). In promoting natural birth and positive and rewarding experiences, midwives also need to enable women to have faith, to trust their own instincts and listen to their bodies, as asserted by McGrath (2012: 75).

The study found that most mothers had a need for midwives to treat them with respect and dignity. They believed that this should not be superficial and should extend beyond a polite demeanour to that of a deeper respect for their individual unique physiological needs but also their spiritual beliefs. Lowe and Struthers (2001: 281) argued that religious tradition is important because it assists in the nursing process, as each mother has different spiritual values, beliefs and practices, that interface with the childbirth process. Magill-Cuerden (2007a: 126) lent further support for this saying that when a woman and her family come into hospital their unique worldviews must be

considered. She affirmed that whilst this can be challenging in busy and stressful clinical areas, respect for these issues is paramount.

A few of participants in the present study agreed that they were attended to by midwives, with a pleasant demeanour which made their childbirth experience pleasant and positive. It would appear in some of these instances, that there is some consideration for spiritual beliefs and practices. A Hindu mother in the study, for example was allowed to attach amulets to her baby's clothes for protection from evil, shortly after birth.

Other participants, however, believed that midwives needed to have a more professional attitude towards mothers, saying that 'nursing is a calling'. Halldorsdottir and Karlsdottir (2011: 806) supported their view, writing that a midwife's professionalism is an important factor in empowering women during the childbearing process. The five principal factors that make up the midwife's professionalism are professional caring; competence and wisdom; empowering interaction and partnership; together with the midwife's personal and professional development. These factors encapsulate maintaining the dignity of the woman giving birth (Halldorsdottir and Karlsdottir 2011: 811). Maintaining the dignity of women during the childbirth process is crucial to a satisfying birth experience. In this vein Simkin (2002 cited in Callister 2006: 8) concluded that women have long-lasting memories of professional care received during labour and delivery, which demands that such care be cognisant of all the facets of a mother's life, despite the busy environment of public hospitals.

The issue of privacy was strongly voiced by Muslim mothers, who expressed that women who follow Islam cannot have males deliver their babies. This is consistent with the Islamic spiritual worldview where women are not permitted to even reveal their faces in public. The fact that some participants encountered a male midwife, suggests that hospitals ignore the spiritual beliefs of patients. Whilst this may be attributed to a lack of awareness of



these spiritual dimensions and staff shortages, Muslim women who are raised conservatively will be placed in a very uncomfortable position, where such spiritual beliefs are ignored.

Sensitivity towards spiritual beliefs is an important dimension of respectful nursing care that will ultimately impact on having an easier birth experience. Bawadi's (2009: 252) study on Muslim women's experience of childbirth in the United Kingdom, revealed that these women believed that they should cover their body and wear a hijab (cloak) and can only expose her body for medical purposes. Even within the latter it is crucial that female midwives be assigned to caring for Muslim women in labour.

Other spiritual aspects that came to the fore within the data, was that participants had expressed a need for a separate, quiet room to pray in. Again whilst public hospitals in particular may struggle to create such separate spaces, midwives must be respectful of a patient's need to pray when requested. Meditation and prayer have been supported as crucial parts of spiritual care in nursing practice, by Chandramohan (2013: 95). She emphasised that the spiritual and religious needs of patients should not be overlooked, as part of holistic nursing practice and that private or personal prayer was an important factor in enhancing well-being and recovery, in the hospital context. Although not referring directly to prayer de Kock and van der Walt (2004: 13-2) stated that an essential part of labour ward practice, by midwives was to provide adequate privacy for mothers during labour, so that women are taken care of with dignity and respect. Given the need for prayer, it is crucial then that midwives be sensitive to potential requests for privacy to pray or meditate from women in labour.

An important thread in the data was that the experience of a fulfilling and positive birth experience, hinged primarily on the relationship between the mother and the midwife, and the midwife's presence. Mitchell (2001: 8) described the midwife as "empowering the mother". Midwives then are the

cornerstone, in assisting mothers to have satisfying birth experiences. Hence their presence in the labour room is of utmost importance to creating a therapeutic relationship with the mother. This resonates with the views of Lundgren (2002: 42), who wrote that the midwife's presence provides companionship; she shares the responsibility of childbirth; is open-minded; to listen to and be sensitive to the wishes and needs of the woman. These roles suggest that midwives be educated and trained then to be sensitive to spiritual and cultural factors as they interface with the childbirth experience. Hence from respect of the need not to have a male midwife where this is seen as violating religious beliefs, to the point of enabling a space for meditation when in pain, midwives will have to be prepared to address the spiritual factors as well.

All participants who were first time mothers expected the delivery room to be a private one in a quiet space. Most mothers in the current sample felt dissatisfied with this experience. This suggests the need for at a quiet and peaceful space, in order to a satisfying and positive experience. Lundgren (2002: 41) extended this argument of physical space to the genuine presence of the midwife which would require stillness and silence. Whilst the latter are not always possible particularly in the realm of public hospitals strategies must be put in place to create such an environment in the future.

It was also evident in the data that participants were dissatisfied with their childbirth experience, due to the lack of support particularly from the midwife. Many participants expressed, that they would have preferred to have a midwife with them throughout the labour and delivery process and thereafter. Merg and Carmoney (2012: 74) wrote that the midwife and the woman share a special relationship and that a woman who feels supported, feels more confident, thereby gaining control of herself. Due to staffing issues this is not always possible unless there is a possibility of a private birth experience. This can be overcome however by midwives who are aware of the need for a constant reassuring presence and who endeavour to provide this particularly

when women need this. A reassuring and comforting relationship is an element of spiritual care as articulated by Chandramohan (2013: 95).

The United Nations Population Fund Report (2011: 8) has reported a worldwide shortage of health care workers, a high increase in the number of patients and a demand for more nursing staff, which highlights constraints in public hospitals. This however can be overcome as Bowers (2002: 742) and Lundgren (2002: 34) suggested that midwives must be more present and supportive during the difficult moments during childbirth.

Participants who were first time mothers also emphasized the need for the doctor to be more present in the delivery room. Iravani *et al.* (2015: 36) also found that women needed the presence of both the midwife and doctor in the labour and delivery room. Iravani *et al.* (2015: 36) wrote that the doctor's presence, often allays fears and anxiety that women may feel during labour and delivery.

Support and reassurance from family was also seen as important. A study at South African state hospitals by Brown *et al.* (2007) revealed that women did not have a companion during childbirth at most public hospitals. It was found that busy labour wards and the sharing of cubicles by women restricted companionship. Lliadou (2012: 385) emphasised the importance of having an empathic partner present, who offers advice, information, comfort and other ways of relieving stress during labour and birth. Lowe and Struthers (2001: 281) concurred stating that caring should extend beyond physical care to encompass the emotional, psychological, spiritual and cultural aspects as well. The need for connectedness is a significant factor in the literature on spirituality, which emphasizes that humankind need to have a sense of connectedness with others particularly during difficult times (Bhagwan 2002: 68).

The data also supported the need for patients to be informed about the routine of the labour ward and the medication being administered. They also felt a need to be informed about the progress of labour and medical interventions being used. Nawal and Goli (2013: 6) asserted that birth preparedness enables a positive birth experience. Adams and Bianchi (2008: 109) concurred that if women are to become confident they need labour support, such as instructional or informational support.

### **5.2.2 DIFFERENT SPIRITUAL BELIEFS AND PRACTICES**

Different spiritual beliefs and practices formed another major theme of this study, which coheres with the third objective of the study. The data reflects strongly the spiritual and religious significance of childbirth. A predominant finding was that participants viewed childbirth as a spiritual event. This is consistent with Bruyere's (2012: 39), study which found that women experienced childbirth as a spiritual phenomenon. In her study she pointed out that the birth of a baby was always accompanied by spiritual rituals such as prayer and welcoming ceremonies for the newly born baby.

The present study also found that prayer as a spiritual activity, had provided participants with tremendous comfort, tranquillity and the ability to deal with pain and discomfort during childbirth. The burgeoning literature on spiritual activities as part of enabling coping and well-being in the nursing context lends support for this finding (Chandramohan 2013: 95). All the participants believed in a personal God, who provided them with strength and blessings to cope. Callister and Khalaf (2010: 19) reported that the use of prayer was a powerful way of coping during childbirth. Women in the current study described how their spirituality was strengthened and how their religious faith became more meaningful within the context of labour and delivery. Lowe and Struthers (2001: 283) wrote that prayer was an important spiritual activity during the childbirth experience, as the women in their study believed that by devoting themselves to God and prayer, they could cope with both the

negative and positive aspects of their experience. They said that they prayed intensely while awaiting the arrival of a normal healthy baby. They reported as did women in the present study, that this was an important means of coping by connecting oneself to God. These findings lend support for the need to enable opportunity for prayer despite current overcrowded public hospital contexts. This must be factored into future planning of such wards and where possible supported when mothers may have the space for this.

Support for a change in paradigm from sole physiological care to one which embraces the psychological and spiritual facets is evident both in this study and other contemporary scholarship. Maxwell's (2009:35) study on spirituality in traditional midwifery found for example that African-American women believed that childbirth enabled a direct connection with God. Lydon-Lam (2012: 21) and Adams and Bianchi (2008: 109) similarly said that pregnant women and women in labour found their personal spirituality to be a huge source of guidance, blessings, strength and confidence. Women in these studies used similar spiritual practices to the women in the present study viz. prayer, chanting and reciting from scriptures.

It was disconcerting to find however that a Hindu participant in the current study was instructed by the midwife to remove a holy neck chain with the picture of a Goddess on it. These are used traditionally for chanting and praying. It strengthens the notion that whilst midwives may be prepared for the physiological dimensions of care, there still needs to be a more conscious effort towards providing spiritually sensitive care where possible. Fuller (2012: 45), who assessed cultural and spiritual practices in childbearing women, wrote that Filipino, Mayan and Guatemalan women used chanting and reciting to cope with labour pain. This further strengthens the need for sensitivity towards the role that amulets and chanting beads may play in coping in a health context. Thus where it does not interfere with safety and well-being greater sensitivity towards spiritually based activities must be enabled.

Quality, holistic care thus requires that midwives be aware of women's religious and spiritual backgrounds and those respectful and safe spaces be created for women to engage in their spiritual practices during childbirth. Spirituality is thus an important facet of the childbirth experience and midwives must be trained to be sensitive to, and respectful of, particular spiritual activities women may want to engage in during the childbirth process and create opportunities for this in a way that does not compromise the safety of the baby. Midwives strive to attend to the physical aspects of care, in terms of ensuring a healthy mother and baby. Giving birth in hospitals is stressful, and remains challenging for midwives who are trying to create a space for as natural a birth experience as possible for women (Davis and Walker 2010: 608). In this milieu midwives often however overlook the emotional and religious or spiritual needs of mothers. Hindu and Muslim mothers both expressed the need for space to pray alone or with family members in the labour ward. This obviously poses a structural problem in busy hospitals, however it is important that physical space for prayer or meditation be allowed even if it is for just the mother alone and when the safety of the baby is not compromised. Whilst participants across religions in this study used spirituality as a coping mechanism they also engaged in the use of alternative medicine.

Mothers from across diverse spiritual backgrounds all still follow certain spiritual and religious traditional practices and beliefs. They also come into hospital with the hope that midwives are aware of and will be respectful of such practices. This reinforces the need for midwives to be more aware of the alternative practices used during childbirth. This coheres with the conceptual framework of Lowe and Struthers (2001: 281) which posits that the association with tradition is significant because it helps in the nursing process.

### 5.2.3. CUSTOMS AND CULTURAL PRACTICES

Complementary and alternative medicine was used by most participants in the present study, to relieve pain or hasten the birth process, which resonates with the fourth objective. Mothers spoke of massaging their own backs or having their backs massaged by their family members if they were allowed in the labour ward. Goldstein (2012: 142) and Field *et al.* (1997 cited in Lundgren 2002: 40) concurred that massage assisted the labour process and relieved pain during labour. None of the mothers spoke about midwives or nursing staff assisting them with back massages. It appeared that some of the participants were aware of deep the breathing techniques during labour. One of the participants shared that she was given information on this and this contributed to her being able to use these techniques during the labour and delivery process.

Some of the examples of alternative medicine used in this study included a customary herbal steam bath to accelerate the labour process. One participant used sesame oil for a back massage. Gabrysch *et al.* (2009: 726) and Fuller (2012: 46) also reported that oils and herbs were incorporated into the care of women during labour. Another participant who belonged to the Christian faith, drank blessed Holy water from her pastor to assist her to cope through the labour process.

Participants who followed the African Traditional Religion had taken 'Isihlambezo' (a liquid made up of several herbal ingredients) to drink. This was taken orally to accelerate labour. Mahlako (2008: 110) also noted that midwives at the hospitals in South Africa, had reported the use of herbal medicines; one of the herbal medicines used was 'isihlambezo'. It was also highlighted that 'isihlambezo' assists with labour and expulsion of the baby at delivery. A Hindu participant had coffee mixed with butter given by her mother, which is also said to accelerate labour. A common finding among the Hindu and the Muslim participants was the use of jeera water (water mixed

with cumin seeds) to accelerate the labour process. Participants who did not use alternative medicines however reported faith in prayer.

The need for respect towards spiritual practices emerged strongly in the data. While some mothers related that they were able to observe and implement their spiritual practices and rituals, others were not able to do so. This suggests that it is the midwives themselves, who create an enabling space for this despite the lack of private space. Thus midwives should always be sensitive to a mother's spiritual beliefs and practices and attempt where possible to enable them to use their spiritual activities. This concurs with the earnest request by Chandramohan (2013: 102) that spiritually based care and activities receive greater space in contemporary nursing care.

What was interesting to note was that mothers from the different spiritual groups in the study shared some common spiritual practices. Brookes (1991:7) reported in her study that both Hindu and Muslim women in KwaZulu-Natal engaged in similar religious rituals to protect the newborn baby from evil forces.

The study also found that mothers from some of the spiritual groups involved in the study indicated that they used the ritual of slaughtering an animal to welcome the newborn into the family. This was true for the African Traditional Religion, Hindu and Islamic groups. Another common practice amongst participants who adhered to Hinduism and the African Traditional Religion was that after delivery, the women were secluded for approximately forty days. This allowed for healing to take place after delivery. African scholar Mbiti (1971: 111) wrote that the mother and baby are in a state of pollution and are thought to be susceptible to infection and illnesses. This practice coheres with the normal physiological process that takes place six weeks after delivery. Sellers (2012: 514) supported this, saying that the six week period after delivery allows for the woman's body to return to its normal state and for the restoration of normal body function.



Other spiritual practices are also carried out after delivery. The present study revealed that amongst Islamic women and the adherents of the African Traditional Religion they share a common practice with regard to burying the placenta. These unique spiritual practices call for greater sensitivity towards mothers from diverse spiritual backgrounds, both before and after delivery. Fraser and Cooper (2003: 626) supported this view saying that despite physiological adjustments that take place during this time, there are also a variety of religious and traditional rituals that must be carried out.

### **5.3 RECOMMENDATIONS**

Based on the findings of the current study, the following recommendations can be made:

#### **5.3.1 Recommendations for nursing practice and education**

- Childbirth is a holistic experience which requires then a holistic and multi-dimensional approach to care. This means a deeper reflection and more earnest consideration not only of the physiological aspects of care but also the psychological and spiritual dimensions as well. Hence education and further training must re-honour this holistic approach with a view to a more integrated approach to midwifery care that prepares midwives to also deal with the psychological and spiritual dimensions.
- Midwives need greater educational preparation and training with regard to knowledge of diverse spiritual or religious worldviews and the values, rituals and customs that underpin childbirth within these worldviews. The latter will enable a more empowered midwifery base who can practice with greater spiritual sensitivity and allow where possible spiritual activities to be practiced which support and enhance the childbirth experience.

- The data from this study also confirms the highly unique experience that each mother encounters which suggests that midwives be more aware of the potential disjuncture between education and practice and the unique differences from one patient to another. Education and training must emphasize this so that a more individualised approach is adopted so that mothers feel more respected and cared for.
- The study also highlighted the hugely significant role that spirituality plays as a resource in terms of helping to cope and deal with pain and anxiety. The fact that almost all the mothers leaned heavily towards prayer, meditation and chanting emphasizes the role that spiritually based activities play in patient well-being. Given the tremendous support growing in the literature for spiritual care, it is recommended then that spirituality and spiritual care be interweaved into midwifery education.
- Midwives need to take heed of the information together with physical and emotional support offered to women during all phases of the antenatal, labour and delivery periods. Information allows greater awareness and preparedness for pain and medical interventions thereby relieving anxiety and promoting a more relaxed experience.
- Where possible public hospitals should try to change clinical environments into warmer, quieter and more caring spaces. It is also crucial that midwives be trained to interact with mothers such that they provide information regarding medication and medical interventions being used, so that there is informed decision-making. This too needs to be strengthened in nursing education.

### **5.3.2 Recommendations for policy makers**

- The data also suggests a need to reflect greater on the professional standards of midwifery care. Given some of the negative experiences found it is crucial that mothers have a voice regarding their experiences so that quality care is optimal. This can be effected through regular evaluations or feedback in the form of questionnaires. This can be completed by mothers before their discharge from hospital. This would illuminate how standards of care can be uplifted and incorporated into policy. This is in keeping with Halldorsdottir and Karlsdottir (2011: 816) who emphasised that professional standards in midwifery should be continuously reviewed.
- With the forthcoming transformation of nursing education, policy makers need to include issues of spiritual and cultural sensitivity into the nursing course curriculum. This is especially given that South Africa consists of diverse religious groups. Furthermore greater professional preparedness regarding traditional and complementary and alternative medicine should be considered. Midwives need to be educated about the alternative healing approaches used by different religious and cultural groups. The midwifery curriculum should always be adapted to the specific needs of the country (United Nations Population Fund 2011: 6).

### **5.3.3 Recommendations for nursing research**

- New evidence-based information regarding spiritual and cultural practices and use of traditional medicines at the interface of midwifery care should be disseminated to midwives and other health professionals dealing with women in maternity units. In-service education, courses, seminars and workshops can be arranged at institutional level to create awareness of this. The incorporation of new

knowledge into both the theory and practice of midwifery is important to keep midwives and other health professionals updated.

#### **5.3.4 Recommendations for further research**

- Whilst the present study explored women's experiences of childbirth in public hospitals, this inquiry can be extended to private hospitals to explore differences.
- A greater diversity in terms of cultural backgrounds will also provide more information regarding spirituality at the juncture of childbirth and provide greater knowledge regarding alternate therapies and spiritual care activities for midwifery education.
- A survey of patients with regards to the adequacy of public hospitals in terms of infrastructure and other aspects is also deserving of attention.

#### **5.4 LIMITATIONS**

Although this study enabled rich data to be collected in relation to the research questions it has some limitations of which were discussed in Chapter three. The other major limitations are as follows:

- This study was concentrated in one geographical region. Although data was collected to saturation, future research should be done in other geographical areas to see if findings resonate with other mothers of these diverse spiritual groups.
- A small sample was used thus results cannot be generalised.
- Collection of data using the English medium could have limited other participants who could have given more information when using their home language.

## 5.5 CONCLUSIONS OF THE STUDY

This study unearthed rich information pertaining to the experience of childbirth, as shared by women from diverse religious groups in a South African context. What emerged overall is that childbirth is not merely a deeply personal and significant experience, which has physical dimensions, but is also a psychosocial and spiritual experience that is deserving of consideration by midwives. Walsh (2006: 662) rightly stated that “It’s the harnessing of midwifery skills to assist a woman to fulfil her potential to do physiological birth process and for me to be alongside her in that”.

The data revealed that when individual, emotional, psychological or spiritual factors are ignored it has a negative impact on the mother’s birth experience. It is therefore crucial for midwives to be empowered with knowledge of diverse spiritual groups and adopt a spiritually sensitive and culturally competent approach to care (Mitchell 2001: 123). Understanding, accepting, accommodating, having respect, being aware of and integrating spiritual beliefs, behaviours and practices is vital to promoting a holistic and satisfying birthing experience. This coheres with the guiding framework of Lowe and Struthers (2001: 281) which is underpinned by holism and caring. The data further emphasised that mothers placed emphasis on aspects such as respect and dignity, particularly empathic professional, care. Given the sensitive and vulnerable position mothers are placed in it is important that midwives be more aware of their connectedness with each mother to provide reassurance and a more pleasant hospital experience.

Maternity wards at public hospitals are midwife-led, although doctors are in charge. The study found that although the public hospital environment is busy and short-staffed, midwives at certain public hospitals still do demonstrate respect for mothers’ spiritual or religious backgrounds. Kaphle, Hancock and Newman (2013: 1179) argued that there is room for

interweaving religious and medical ideas in the midwifery profession. They developed a women-centred model of care that includes respect for cultural dimensions whilst protecting the safety of women. This study highlighted the important aspects at the interface of childbirth. It illuminated the physical, psychological and religious or spiritual dimensions and supports the need for midwives to holistically recognise mothers' needs during this experience. Moreover, it highlighted that religion and spirituality play an important support factor and needs to be considered with sensitivity by midwives. Midwives therefore need to practice individualised sensitive care to ensure a holistic, positive and satisfying birth experiences for mothers at public hospitals. The recommendations below highlight suggestions to advance this area of the study and to advance in particular a more holistic approach to midwifery care.

*“Nursing care comes in many forms. Sometimes it is the ability to make someone feel physically comfortable by various means. Other times it is the ability to improve the body’s ability to achieve or maintain health. But often it is an uncanny yet well honed knack to see beyond the obvious and address, in some way, the deeper needs of the human soul”.*

Donna Wilk Cardillo

## REFERENCES

Abu-Ras, W. and Laird, L. 2011. How Muslim and Non-Muslim Chaplains Serve Muslim Patients? Does the Interfaith Chaplaincy Model have Room for Muslims' Experiences? *Journal of Religion and Health* (online), 50(1): 46-61. Available: <http://www.jstor.org/stable/41349765> (Accessed 24 July 2015).

Adams, J. 2006. An exploratory study of complementary and alternative medicine in hospital midwifery: Models of care and professional struggle. *Complementary Therapies in Clinical Practice* (online), 12: 40-47. Available: <http://www.elsevierhealth.com/journals/ctnm> (Accessed 27 August 2012).

Adams, E. D. and Bianchi, A. L. 2008. A Practical Approach to Labor Support. *Journal of Obstetric, Gynecologic and Neonatal Nursing* (online), 37: 106-115. Available: <http://jognn.awhonn.org> (Accessed 24 May 2013).

Adeyemo, F. O. 2013. Comparative Analysis of Health Institutions on the Attitude and Practice of Midwives towards Pregnant Women during Child Delivery in Ogbomoso, Oyo State, Nigeria. *Journal of Nursing and Health Science* (online), 1(3): 14-19. Available: <http://www.iosrjournals.org/iosr-jnhs/papers/vol1-issue3/D0131419.pdf> (Accessed 19 October 2013).

Allison, C. 2005. Birth's encrypted messages. *Caribbean Quarterly* (online), 51(3/4): 1-10. Available: <http://www.jstor.org/stable/40654517> (Accessed 26 July 2012).

Andrews, M. M. and Boyle, J. S. 2008. *Transcultural concepts in nursing care*. 5<sup>th</sup> ed. Philadelphia: Wolters Kluwer/Lippincott Williams & Wilkins.

Asante, K. and Mazamba, A. 2005. *Encyclopedia of Black studies*. Michigan: Sage

Askari, F., Atarodi, A., Torabi, S. and Moshki, M. 2014. Exploring Women's Personal Experiences of Giving Birth in Gonabad City: A Qualitative Study. *Global Journal of Health Science* (online), 6(5): 46-54. Available:

<http://search.proquest.com.dutlib.dut.ac.za/docview/1540080445/fulltextPDF/D027256275EA4816PQ/1?accountid=10612> (Accessed 05 July 2015).

Attah, A. F., O'Brien, M., Koehbach, J., Sonibare, M. A., Moody, J. O., Smith, T. J. and Gruber, C. W. 2012. Uterine contractility of plants used to facilitate childbirth in Nigerian ethnomedicine. *Journal of Ethnopharmacology* (online), 143: 377-382. Available: <http://www.journals.elsevier.com/journal-of-ethnopharmacology> (Accessed 27 August 2012).

Ayers-Gould, J. N. 2000. Spirituality in Birth: Creating Sacred Space within the Medical Model. *International Journal of Childbirth Education* (online), 15(1): 14-17. Available:

<http://search.proquest.com/nursing/docview/212855101/fulltextPDF/13EF4B08200433BD173/35?accountid=10612> (Accessed 29 June 2013).

Baldwin, E., Langhurst, B., McCracken, S., Ogborn, M. and Smith, G. 2004. *Introducing Cultural studies*. Revised ed. Great Britain: Henry Ling Ltd.

Barbour, R. 2014. *Introducing Qualitative Research. A Students Guide*. 2<sup>nd</sup> ed. Los Angeles: SAGE.

Barnfather, T. 2013. Can intuitive knowledge be taught in midwifery practice? *British Journal of Midwifery* (online), 21(2): 31-36. Available: <http://dutlib.dut.ac.za:2062/ehost/pdfviewer/pdfviewer?vid=4&sid=7e6dcaca-136d-4cee-a1c8-25d9be6fc234%40sessionmgr114&hid=126> (Accessed 28 June 2013).

Bawadi, H. 2009. Migrant Arab Muslim Women's experiences of Childbirth in the UK (online), Doctor of Philosophy, De Montfort University.



Available:<https://www.dora.dmu.ac.uk/bitstream/handle/2086/3039/Thesis.pdf?sequence=1>(Accessed 3 December 2012).

Bazant, E. S. and Koenig, M. A. 2009. Women's satisfaction with delivery care in Nairobi's informal settlements. *International Journal for Quality in Health Care* (online), 21(2): 79-86. Available: <http://intqhc.oxfordjournals.org/content/21/2/79.full.pdf+html> (Accessed 24 June 2013).

Beck, C. T. and Watson, S. 2010. Subsequent childbirth after a previous traumatic birth. *Nursing Research* (online), 59(4): 241-249. Available: <http://journals/IWW.com/nursingresearchonline/toc/2010/07000> (Accessed 7 May 2013).

Behruzi, R., Hatem, M. Goulet, L. and Fraser, W. 2011. The facilitating factors and barriers encountered in the adoption of a humanized birth care approach in a highly specialized university affiliated hospital. *BMC Women's Health* (online), 11(53): 1-15. Available:<http://www.biomedcentral.com/1472-6874/11/53> (Accessed 19 June 2012).

Beigi. A. N. M., Broumandfar, K., Bahadoran, P. and Abedi, A. H. 2010. Women's experience of pain during childbirth. *Iranian Journal of Nursing and Midwifery Research* (online), 15(2): 77-82. Available:<http://ijnmr.mui.ac.ir/index.php/ijnmr/article/view/229/224> (Accessed 19 October 2013).

Berg, M., Ólafsdóttir, O. A. and Lundgren, I. 2012. A midwifery model of woman-centred childbirth care – In Swedish and Icelandic settings. *Sexual & Reproductive Healthcare* (online) 3 (2012): 79-87. Available: <http://www.sciencedirect.com/science/article/pii/S1877575612000183> (Accessed 27 August 2012).

Beyers, J. 2010. What is religion? An African understanding. *Theological Studies* (online), 66(1). Available: <http://www.hts.org.za> (Accessed 19 April 2013).

Bhagwan, R. 2002. The Role of Religion and Spirituality in Social Work Practice: Guidelines for Curricula Development at South African Schools of Social Work. Ph.D., University of Natal.

Bhagwan, R. 2010. Content areas for curriculum development: spirituality and social work. *Social Work/Maatskaplike Werk* (online), 46(3): 299-310. Available:<http://socialwork.journals.ac.za/pub/article/view/160/147> (Accessed 22 July 2015).

Bowers, B. B. 2002. Mothers' Experiences of Labor Support: Exploration of Qualitative Research. *Journal of Obstetric, Gynecologic and Neonatal Nursing* (online), 31 (6): 742-752. Available: <http://prdupl02.ynet.co.il/ForumFiles/3947234.pdf> (Accessed 19 June 2012).

Braun, V. and Clarke, V. 2006. Using thematic analysis in psychology. *Qualitative Research in Psychology* (online), 3(2): 1-41. Available: [http://eprints.uwe.ac.uk/11735/2/thematic\\_analysis\\_revised](http://eprints.uwe.ac.uk/11735/2/thematic_analysis_revised) (Accessed 05 July 2015).

Brink, H., van der Walt, C. and van Rensburg, G. 2012. *Fundamentals of Research Methodology for Health Professionals*. 3<sup>rd</sup> ed. Cape Town: Juta and Company Ltd.

Brookes, H. B. 1991. Experiences of childbirth in Natal Indian women. *Curationis* (online), 14 (4): 4-9. Available:<http://www.curationis.org.za/index.php/curationis/article/download/38/278> (Accessed 19 April 2013).

Brown H. 2007. Continuous support for women during childbirth: RHL practical aspects. *The WHO Reproductive Health Library*; Geneva: World Health Organization.  
Available:<http://apps.who.int/rhl/archives/hebguide/en/index.html#> (Accessed 19 April 2013).

Brown, H., Hofmeyr, G. J., Nikodem, V. C., Smith, H. and Garner, P. 2007. Promoting childbirth companions in South Africa: a randomised pilot study. *BMC Medicine* (online), 5(7): 1-19. Available:  
<http://www.biomedcentral.com/1741-7015/5/7> (Accessed 12 October 2013).

Bruyere, M. 2012. Cultural Birthing Traditions in the first nations peoples of Canada: Are Traditions Being Displaced by Modern Medicine? *International Journal of Childbirth Education* (online), 27(1): 39-42.  
Available:<http://dutlib.dut.ac.za:2062/ehost/pdfviewer/pdfviewer?vid=6&sid=712db10e-9705-4f8e-b4c9-8c107fd2ac31%40sessionmgr114&hid=126e>  
(Accessed 29 June 2013).

Bryman, A. 2012. *Social Research Methods*. 4<sup>th</sup> ed. New York: Oxford University Press.

Burns, N. and Grove, S. K. 2005. *Practice of Nursing Research: conduct, critique and utilization*. 5<sup>th</sup> ed. St. Louis: Mo. United States of America: Elsevier/Saunders.

Burns, N. and Grove, S. K. 2011. *Understanding Nursing Research: building an evidence based practice*. 5<sup>th</sup> ed. United States of America: Elsevier/Saunders.

Callister, L. C. 2006. The Meaning of Giving Birth and Mastery of the Experience. *International Journal of Childbirth Education* (online), 21(3): 7-8.  
Available:  
<http://search.proquest.com.dutlib.dut.ac.za/nursing/docview/212862662/fulltext>

[xtPDF/C8ACFD659E7A40B6PQ/29?accountid=10612](http://xtPDF/C8ACFD659E7A40B6PQ/29?accountid=10612) (Accessed 05 July 2015).

Callister, L. C. and Khalaf, I. 2010. Spirituality in Childbearing Women. *The journal of Perinatal Education* (online), 19(2): 16-24. Available: <http://web.ebscohost.com.dutlib.dut.ac.za:2048/ehost/pdfviewer/pdfviewer?vid=15&hid122&=sid=7d18ffbd-4bd1-4f66-a903-b62f4062cd1b%40sessionmgr14> (Accessed 3 June 2012).

Callister, L. C., Khalaf, I., Semenic, S., Kartchner, R. and Vehvilainen-Julkunen, K. 2003. The Pain of Childbirth: Perceptions of Culturally Diverse Women. *Pain Management Nursing* (online), 4(4). Available: [http://www.medscape.com/viewarticle/465812\\_5](http://www.medscape.com/viewarticle/465812_5) (Accessed 25 September 2015).

Calvert, J. and Steen, M. 2007. Homeopathic remedies for self-administration during childbirth. *British Journal of Midwifery*, 15(3): 159-165.

Campinha-Bacote, J. 2003. Many Faces: addressing diversity in health care. *Online Journal of Issues in Nursing* (online), 8(1): manuscript 2. Available: <http://ana.nursingworld.org/MainMenuCategories/ANAMarketplace/ANAPeriodicals/OJIN/TableofContents/Volume82003/No1Jan2003/AddressingDiversityinHealthCare.aspx> (Accessed 31 July 2012).

Canda, E. R. and Furman, L. D. 1999. Spiritual diversity in social work practice: The heart of helping. New York: The Free Press.

Chandramohan, S. 2013. Spirituality and spiritual care amongst professional nurses at public hospitals in KwaZulu-Natal. Masters in Technology: Nursing, Department of Nursing, Durban University of Technology. Available: [http://ir.dut.ac.za/bitstream/handle/10321/1107/CHANDRAMOHAN\\_2013.pdf?sequence=1](http://ir.dut.ac.za/bitstream/handle/10321/1107/CHANDRAMOHAN_2013.pdf?sequence=1) (Accessed 12 September 2015.)

Chaudhry, R. A. 1988. *Muslim Festivals and Ceremonies* (online). London: Islam International Publications Ltd.

Available: <http://www.alislam.org/library/books/muslim/festivals/ceremonies.pdf> (Accessed 27 April 2013).

Chokwe, M. E. and Wright, S. C. D. 2012. 'Caring as a core concept in educating midwifery learners: A qualitative study'. *Health SA Gesondheid* (online), 17(1), 653-669.

Available: <http://www.hsag.co.za/index.php/HSAG/article/view/653/771> (Accessed 12 July 2013).

Chokwe, M. E. and Wright, S. C. D., 2013. Caring during clinical practice: Midwives' perspective. *Curationis* (online), 36 (1): 1-7. Available: <http://dx.doi.org/10.4102/curationis.v36i1.93> (Accessed 23 October 2013).

Choobmasjedi, S. G., Hasani, J., Khorsandi, M. and Ghobadzadeh, M. 2011. Cognitive factors related to childbirth and their effect on women's delivery preference: a comparison between a private and public hospital in Tehran. *Eastern Mediterranean Health Journal* (online), 18(11): 1127-1133. Available: <http://search.proquest.com/docview/1270850938/fulltextPDF?accountid=10612> (Accessed 30 June 2013).

Clark, M. 2003. *Islam for Dummies*. New Jersey: Wiley Publishing Inc.

Clift-Matthews, V. 2006. Modern Midwifery: how do midwives cope? *British Journal of Midwifery*, 14(11): 632.

Clift-Matthews, V. 2007. What is real choice? *British Journal of Midwifery*, 15(8): 464.

Coffman, M. J. 2004. Cultural Caring in Nursing Practice: A Meta-Synthesis of Qualitative Research. *Journal of Cultural Diversity* (online), 11(3): 100-109.

Available:

<http://search.proquest.com.dutlib.dut.ac.za:2048/docview/219343975/fulltext/PDF/1382EB06C7D10E649FF/47?accountid=10612> (Accessed 27 July 2012)

Cohen, H. 2004. Supporting Midwife's role should be top of the agenda. *British Journal of Midwifery*, 12(7): 427.

Cohen, A. B. 2011. Religion and Culture. *Online Readings in Psychology and Culture* (online), 4(4): 1-11. Available: <http://scholarworks.bvsu.edu/orpc/vol4/iss4/8> (Accessed 01 October 2015).

Cook, K. M. 2010. The Role of Choice and Control in Women's Childbirth Experiences (online). Master of Arts, Wilfrid Laurier University. Available: <http://scholars.wlu.ca/cgi/viewcontent.cgi?article=1966&context=etd> (Accessed 20 May 2015).

Corry, P. and Jolivet, R. 2009. Doing the Right Thing for Women and Babies: Policy Initiatives to Improve Maternity Care Quality and Value. *Journal of Perinatal Education*, (online), 18(1): 7-11. Available: <http://web.ebscohost.com.dutlib.dut.ac.za:2048/ehost/pdfviewer/pdfviewer?vid=7&hid=122&sid=1564b302-3ff6-4307-9e55-383b0d84c909%40sessionmgr4> (Accessed 25 August 2012).

Coward, H. and Sidhu, T. 2000. Bioethics for clinicians: 19. Hinduism and Sikhism. *Canadian Medical Association Journal* (online), 163(9): 1167-1170. Available: <http://www.cmaj.ca/content/163/9/1167.full> (Accessed 24 May 2015).

Cox, J. E. 2011. The Lived Experience of Childbirth among 21<sup>st</sup> Century Cuban Women in a Florida Hospital (online). Doctor of Philosophy. The Catholic University of America. Available:

[http://aladinrc.wrlc.org/bitstream/handle/1961/9304/Cox\\_cua\\_0043A\\_10160display.pdf?sequence=1](http://aladinrc.wrlc.org/bitstream/handle/1961/9304/Cox_cua_0043A_10160display.pdf?sequence=1) (Accessed 05 June 2015).

Creswell, J. W. 2013. *Qualitative Inquiry & Research Design. Choosing among Five Approaches*. 3<sup>rd</sup> ed. Los Angeles: SAGE.

Creswell, J. W. 2014. *Research Design. International student Edition. Qualitative, Quantitative, and Mixed Methods Approaches*. 4<sup>th</sup> ed. Los Angeles: SAGE.

Crowe, S., Utley, M., Costello, A. and Pagel, C. 2012. How many births in sub-Saharan Africa and South Asia will not be attended by a skilled birth attendant between 2011 and 2015? *BMC Pregnancy and Childbirth* (online), 12(4): 1-9. Available: <http://www.biomedcentral.com/content/pdf/1471-2393-12-4.pdf> (Accessed 20 July 2013).

Crowther, S. 2014. Foregrounding Spirituality and Joy at Birth in Antenatal Education. *International Journal of Childbirth Education* (online), 29(4): 8-14. Available: <http://search.proquest.com.dutlib.dut.ac.za/docview/1609199204/fulltextPDF/FD6E5F5B4625406DPQ/50?accountid=10612> (Accessed 16 July 2015).

Crowther, S. and Hall, J. 2015. Spirituality and spiritual care in and around childbirth. *Women and Birth* (online), 01(001). Available: <http://www.sciencedirect.com/science/article/pii/S1871519215000037> (Accessed 17 June 2015).

Dahlen, H. G., Barclay, L. and Homer, C. S. E. 2010a. The novice birthing: theorising first-time mothers' experiences of birth at home and in hospital in Australia. *Midwifery* (online), 26: 53-63. Available:

<http://www.sciencedirect.com.dutlib.dut.ac.za/science/article/pii/S026661380800020X> (Accessed 04 July 2015).

Dahlen, H. G., Barclay, L. and Homer, C. S. E. 2010b. 'Reacting to the unknown': experiencing the first birth at home or in hospital in Australia. *Midwifery* (online), 26: 415-423. Available:

<http://www.sciencedirect.com.dutlib.dut.ac.za/science/article/pii/S026661380800020X> (Accessed 04 July 2015).

Davis, D. L. and Walker, K. 2010. Case-loading midwifery in New Zealand: making space for childbirth. *Midwifery* (online), 26: 603-608. Available: <http://www.sciencedirect.com/science/article/pii/S0266613809000072> (Accessed 27 August 2012).

de Kock, J. and van der Walt, C. 2004. *Maternal and Newborn Care*. Lansdowne: Juta and Co. Ltd.

de Kock, J., van der Walt, C. and Jones, C. M. 2009. *Maternal and Newborn Care*. 2<sup>nd</sup> ed. Lansdowne: Juta and Co. Ltd.

Dencker, A., Taft, T., Bergqvist, L., Lilja, H. and Berg, M. 2010. Childbirth experience questionnaire (CEQ): development and evaluation of a multidimensional instrument. *BMC Pregnancy and Childbirth* (online), 10 (81). Available: <http://www.biomedcentral.com/1471-2393/10/81> (Accessed 8 March 2013).

Department of Health. 2011. *Kwazulu- Natal uMgungundlovu District Profile*. (online). Available: <http://www.health-e.org.za/wp-content/uploads/2013/06/Umgungundlovu-District-Profile-pdf> (Accessed 10 August 2016).



de Vos, A., Strydom, H., Fouche, C. B. and Delport, C. S. L. 2011. *Research at grassroots: for the social sciences and human service professions*. 4<sup>th</sup> ed. Pretoria: Van Schaik.

Dhai, A. and McQuoid-Mason, D. 2011. *Bioethics, Human Rights and Health Law. Principles and Practice*. Cape Town, South Africa: Juta.

Doherty, E. 2010. Midwifery Care: reflections of midwifery clients. *The Journal of Perinatal Education* (online), 19 (4): 41-51. Available: [http://scholar.google.co.za/scholar?q=Doherty.+E.+2010.Midwifery+Care%3A+Reflections+of+Midwifery+Clients.+The+++journal+of+perinatal++Education+%28online%2919%284%2941-51&btnG=&hl=en&as\\_sdt=0%2C](http://scholar.google.co.za/scholar?q=Doherty.+E.+2010.Midwifery+Care%3A+Reflections+of+Midwifery+Clients.+The+++journal+of+perinatal++Education+%28online%2919%284%2941-51&btnG=&hl=en&as_sdt=0%2C) (Accessed 26 July 2012).

Downe, S. 2006. *Normal Childbirth: Evidence and Debate*. Edinburgh: Churchill Livingstone. Available: <https://books.google.co.za/books?hl=en&lr=&id=zgjhoc8LjCgC&oi=fnd&pg=PA41&dq=spirituality+nursing+childbirth&ots=K5sroV70IW&sig=69gKruAD2tEe5PyTkeOhqCrGmz4#v=onepage&q=spirituality%20nursing%20childbirth&f=false> (Accessed 04 July 2015).

Downe, S. 2007. Hospital is the best place for women to give birth. *British Journal of Midwifery*, 15(3): 156.

du Plessis, D. 2005. Women's experiences of a vaginal delivery conducted by a private midwife. *Health S A Gesondheid* (online), 10(3): 23-35. Available: <http://www.hsag.co.za/index.php/HSAG/article/viewFile/199/190> (Accessed 23 October 2013).

du Preez, A. 2012. Understanding the Phenomenon of Dikgaba and Related Health Practices in Pregnancy: a study among the Batswana in the rural

North West Province of South Africa. *Royal College of midwives. Evidence based midwifery* (online), 10(1): 29-35. Available:

[http://issuu.com/redactive/docs/ebm\\_march\\_2012](http://issuu.com/redactive/docs/ebm_march_2012) (Accessed 29 July 2012).

Eckersley, R. M. 2007. Culture, spirituality, religion and health: looking at the big picture. *Medical Journal of Australia* (online), 186(10): S54-S56. Available:

[https://www.mja.com.au/system/files/issues/186\\_10\\_210507/eck11061\\_fm.pdf](https://www.mja.com.au/system/files/issues/186_10_210507/eck11061_fm.pdf) (Accessed 24 May 2015).

Edwards, G. 2007. New roles for midwives devalue traditional skills. *British Journal of Midwifery*, 15(1): 6-7.

Elion, B. and Strieman, M. 2001. *Clued up on Culture. A helpful guide for all South Africans*. Cape Town. Juta Garieb Publishing Company.

Etowa, J. B. 2012a. Black Women's Perceptions of Supportive Care during Childbirth. *International Journal of Childbirth Education* (online), 27(1): 27-32. Available:

<http://search.proquest.com.dutlib.dut.ac.za:2048/docview/920597285/fulltextPDF?accountid=10612> (Accessed 18 September 2012).

Etowa, J. B. 2012b. Becoming a mother: The meaning of childbirth for African-Canadian women. *Contemporary Nurse* (online), 41(1): 28-40. Available:

<http://web.ebscohost.com.dutlib.dut.ac.za:2048/ehost/pdfviewer/pdfviewer?sid=6aed3418-cc28-4a1f-a62962e4bc4c88ef%40sessionmgr104&vid=7&hid=107> (Accessed 30 December 2012).

Fair, D. C. and Morrison, T. 2011. A qualitative study on techniques used to enhance maternal control during labor and delivery. *International Journal of*

*Childbirth Education* (online), 26 (3): 21-25. Available:  
<http://www.mendeley.com/profiles/cynthia-fair/> (Accessed 30 June 2013).

Ferret, R. 2011. *Spirituality in Nursing Care: Correcting the Imbalance* (online), 1-10. Available: <http://www.inter-disciplinary.net/wp-content/uploads/2011/02/ferretspaper.pdf> (Accessed 21 May 2013).

Fisher, J. A., Bowman, M. and Thomas, T. 2002. Issues for South Asian Indian Patients Surrounding Sexuality, Fertility, and Childbirth in the US Health Care System. *JABFP* (online), 16(2): 151-155. Available: <http://www.jabfm.org/content/16/2/151.full.pdf+html> (Accessed 26 July 2012).

Flick, U. 2009. *Designing Qualitative Research*. London: Sage.

Flick, U. 2014. *An Introduction to Qualitative Research*. 5<sup>th</sup> ed. London: Sage.

Florendo, J. E. 2011. A phenomenological experience of handling childbirth by level 2 students. *Far Eastern University Faculty Research Journal Education* (online), 1(1): 62-80. Available:  
<http://ejournals.ph/index.php?journal=FEUFRJ&page=article&op=viewFile&path%5B%5D=4843&path%5B%5D=5028> (Accessed 14 April 2013).

Fraser, D. M. and Cooper, M. A. 2003. *MYLES textbook for Midwives*. 14<sup>th</sup> ed. London: Elsevier Ltd.

Fraser, D. M., Cooper, M. A. and Nolte, A. G. W. 2010. *MYLES textbook for Midwives: African Edition*. 2<sup>nd</sup> ed. London: Elsevier Ltd.

Fuller, O. A. 2012. Assessing Cultural and Spiritual Practices for the Childbearing Family. *International Journal of Childbirth Education* (online), 27 (1): 43-45. Available:

<http://search.proquest.com.dutlib.dut.ac.za:2048/docview/920597385/fulltextPDF?accountid=10612> (Accessed 24 September 2012).

Gabrysch, S., Lema, C., Bedriñana, E., Bautista, M. A., Malca, R., Campbell, O. M. R. and Miranda, J. J. 2009. Cultural adaptation of birthing services in rural Ayacucho, Peru. *Bull World Health Organ* (online), 87: 724-729.

Available:

<http://search.proquest.com/nursing/docview/229658156/fulltextPDF/13EF4B08200433BD173/8?accountid=10612> (Accessed 29 June 2013).

Gatrad, A. R. and Sheikh, A. 2001. Muslim birth customs. *Arch Dis Child Fetal Neonatal Ed* (online). 84: F6-F8. Available:

<http://fn.bmj.com/content/84/1/F6.full.pdf+html> (Accessed 27 April 2013).

Gatrad, A. R., Ray, M. and Sheikh, A. 2004. Hindu birth customs. *Arch Dis Child* (online), 89: 1094-1097. Available:

<http://adc.bmj.com/content/89/12/1094.full.pdf+html> (Accessed 06 July 2015).

Goldstein, R. 2012. Jonah's Birth. *The Journal of Perinatal Education* (online), 21(3): 138-144. Available: <http://dx.doi.org/10.1891/1058-1243.21.3.138> (Accessed 25 August 2012).

Gray, D. E. 2009. *Doing Research in the Real World*. 2<sup>nd</sup> ed. Great Britain: Sage Publications.

Halldorsdottir, S. and Karlsdottir, S. I. 2011. The primacy of the good midwife in midwifery services: an evolving theory of professionalism in midwifery.

*Scandinavian Journal of Caring Sciences* (online), 25(4): 806-817. Available:

<http://dutlib.dut.ac.za:2062/ehost/pdfviewer/pdfviewer?sid=7e6dcaca-136d-4cee-a1c8-25d9be6fc234%40sessionmgr114&vid=5&hid=126> (Accessed 28 June 2013).

Hallgren, A., Kihlgren, M. and Olsson, P. 2005. Ways of relating during childbirth: An ethical responsibility and challenge for midwives. *Nursing Ethics* (online), 12(6): 606-621.

Available:<http://web.ebscohost.com/ehost/pdfviewer/pdfviewer?sid=9cf87949-ca1d-4673-92ab-359ba7602f44%40sessionmgr198&vid=2&hid=108>

(Accessed 30 June 2013).

Hampton, D. L. and Hampton, G. M. 2000. Professionalism and the nurse-midwife practitioner: An exploratory study. *Journal of the American Academy of Nurse Practitioners* (online), 12(6): 218-225. Available: <http://search.proquest.com/nursing/docview/21878945/fulltextPDF/13EFOE146C12C4BD82E/15?accountid=10612> (Accessed 28 June 2013).

Hanssen, I. and Pedersen, G. 2013. Pain relief, spiritual needs, and family support: Three central areas in intercultural palliative care. *Palliative and Supportive Care* (online), 11: 523-530. Available: <http://search.proquest.com.dutlib.dut.ac.za/docview/1460284085?pq-origsite=summon> (Accessed 04 July 2015).

Hardin, A. M. and Buckner, E. M. 2004. Characteristics of a Positive Experience for Women who have Unmedicated Childbirth. *The Journal of Perinatal Education* (online), Fall: 13 (4): 10-16. Available: <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1595217/pdf/JPE130010.pdf> (Accessed 01 July 2013).

Hartigan, H. 1990. Of woman-with women: The nature of midwifery. *International Journal of Childbirth Education* (online), 5(11). Available: <http://search.proquest.com/docview/212866007?accountid=10612> (Accessed 12 August 2013).

Helman, C. G. 2007. *Culture, Health and Illness*. 5<sup>th</sup> ed, London: Hodder Arnold (an imprint of Hodder Education, and Hachette UK company).

Henderson. C. and Macdonald. S. 2004. *Mayes' Midwifery: A Textbook for Midwives*. 13<sup>th</sup> ed. London: Elsevier Limited.

Henning, E., van Rensburg, W. and Smit, B. 2004. *Finding your way in qualitative research*. South Africa: Van Schaik Publishers.

Hicks, L. R. S., Tovar, D. A., Orav, E. J. and Johnson, P. A. 2008. Experiences with Hospital Care: Perspectives of Black and Hispanic Patients. *Journal Of General Internal Medicine* (online), 1234-1240. Available: <http://web.ebscohost.com/ehost/pdfviewer/pdfviewer?sid=b5abc7a9-07c3-491b-b8e0-f728a4714ed4%40sessionmgr104&vid=2&hid=122> (Accessed 28 June 2013).

Hildingsson, I., Johansson, M., Karlström, A. and Fenwick, J. 2013. Factors Associated With a Positive Birth Experience: An Exploration of Swedish Women's Experiences. *International journal of childbirth* (online), 3(3): 153-164. Available: <http://search.proquest.com.dutlib.dut.ac.za/nursing/docview/1465350527/fulltextPDF/625DBE1D3A104235PQ/15?accountid=10612> (Accessed 09 July 2015).

Hill, N., Hunt, E. and Hyrkäs, K. 2011. Somali Immigrant Women's Health Care Experiences and Beliefs Regarding Pregnancy in the United States. *Journal of Transcultural Nursing* (online), 23(1): 72-81. Available: <http://tcn.sagepub.com/content/23/1/72.full.pdf+html> (Accessed 16 July 2013).

Hodnett, E. D. 2002. Pain and women's satisfaction with the experience of childbirth: A systematic review. *Am J Obstet Gynecol* (online), 186(5): S160 – S172. Available: <http://ac.els-cdn.com/S0002937802701890/1-s2.0->

[S0002937802701890-main.pdf?\\_tid=95c7d310-f077-11e1-b60b-00000aab0f6c&acdnat=1346093401\\_6109555d15f99e6fa2158dd21c1ac6d8](http://S0002937802701890-main.pdf?_tid=95c7d310-f077-11e1-b60b-00000aab0f6c&acdnat=1346093401_6109555d15f99e6fa2158dd21c1ac6d8)  
(Accessed 27 August 2012).

Holloway, M. 2006. Death the great leveller? Towards a transcultural spirituality of dying and bereavement. *Journal of Clinical Nursing* (online), 15: 833-839. Available:  
<http://web.a.ebscohost.com.dutlib.dut.ac.za/ehost/pdfviewer/pdfviewer?vid=2&sid=ec16fdf9-8f0a-49c9-89bdf55043541abe%40sessionmgr4002&hid=4101>  
(Accessed 17 July 2015).

Hrešanová, E. 2014. 'Nobody in a Maternity Hospital Really Talks to You': Socialist Legacies and Consumerism in Czech Women's Childbirth Narratives. *Sociologický časopis/ Czech Sociological Review* (online), 50(6): 961-985. Available:  
<http://search.proquest.com.dutlib.dut.ac.za/docview/1658831250/fulltextPDF/A2F0E1B9938146D4PQ/3?accountid=10612> (Accessed 05 July 2015).

International Confederation of Midwives. 2011. *Global standards for Midwifery Regulation 2011*. Available: [www.internationalmidwives.org](http://www.internationalmidwives.org)  
(Accessed 07 July 2013).

Iravani, M., Zarean, E., Janghorbani, M. and Bahrami, M. 2015. Women's needs and expectations during normal labor and delivery. *Journal of Education and Health Promotion* (online), 4:6: 31-37. Available:  
<http://www.jehp.net/text.asp?2015/4/1/6/151885> (Accessed 02 June 2015).

Jackson, A. K. 2007. Cultural competence in health visiting practice: a baseline survey. *Community Practitioner* (online), 80(2): 17-22. Available:  
<http://search.proquest.com.dutlib.dut.ac.za:2048/docview/213361485/fulltextPDF/1382EB06C7D10E649FF/88?accountid=10612> (Accessed 27 July 2012).

James, J. N., Prakash, K. S. and Ponniah, M. 2012. Awareness and attitudes towards labour pain and labour pain relief of urban women attending a private antenatal clinic in Chennai, India. *Indian Journal of Anaesthesia* (online), 56(2): 195-198.

Available:<http://medind.nic.in/iad/t12/i2/iadt12i2p195.pdf>

(Accessed 19 October 2013).

Jeffreys, M. R. and Zoucha. R. 2001. The Invisible Culture of the Multiracial, Multiethnic Individual: A Transcultural Imperative. *Journal of Cultural Diversity: Fall* (online), 8(3): 79-84. Available:

<http://search.proquest.com.dutlib.dut.ac.za:2048/docview/219311046/fulltextPDF/1382EB06C7D10E649FF/99?accountid=10612> (Accessed 27 July

2012).

Johnson, F. A., Padmadas, S. S. and Matthews, Z. 2013. Are Women Deciding against Home Births in Low and Middle Income Countries? *PLOS ONE* (online), 8(6): 1-10. Available:

<http://search.proquest.com/docview/1368625569/fulltextPDF/13F625173AC3B31D179/56?accountid=10612> (Accessed 20 July 2013).

Jukelevics, N. 1990. The influence of families on labour and birth. *International Journal of Childbirth Education* (online), 5(4): 11-12.

Available:<http://search.proquest.com/nursing/docview/212865799/fulltext/13EFOE146C12C4BD82E/54?ACCOUNTtid=10612> (Accessed 28 June 2013).

Kainz, G., Eliasson, M. and von Post, I. 2010. The Child's Father, an Important Person for the Mother's Well-Being During the Childbirth: A Hermeneutic Study. *Health Care for Women International* (online), 31: 621-635.

Available:  
<http://dutlib.dut.ac.za:2062/ehost/pdfviewer/pdfviewer?vid=4&sid=712db10e->



[9705-4f8e-b4c9-8c107fd2ac31%40sessionmgr114&hid=126](#) (Accessed 28 June 2013).

Kalder, M., Knoblauch, K., Hrgovic, I. and Munstedt K. 2010. Use of complementary and alternative medicine during pregnancy and delivery. *Arch Gynecol Obstet. Springer-Verlag* (online), 283: 475-482. Available: <http://www.springerlink.com.dutlib.dut.ac.za:2048/content/a538676w420u0r64/fulltext.pdf> (Accessed: 16 October 2012).

Kaphle, S., Hancock, H. and Newman, L. A. 2013. Childbirth traditions and cultural perceptions of safety in Nepal: Critical spaces to ensure the survival of mothers and newborns in remote mountain villages. *Midwifery* (online), 29(10): 1173-1181. Available:<http://download.journals.elsevierhealth.com/pdfs/journals/0266-6138/PIIS0266613813001757.pdf> (Accessed 15 October 2013).

Keating, A. and Fleming, V. E. M. 2009. Midwives' experiences of facilitating normal birth in an obstetric-led unit: a feminist perspective. *Midwifery* (online), 25: 518-527. Available: [http://ac.els-cdn.com/S0266613807001131/1-s2.0-S0266613807001131-main.pdf?\\_tid=58e80b2e-f06b-11e1-8237-0000aacb35f&acdnat=1346088144\\_6b1e634bd1a5e32a28211d843d4c458e](http://ac.els-cdn.com/S0266613807001131/1-s2.0-S0266613807001131-main.pdf?_tid=58e80b2e-f06b-11e1-8237-0000aacb35f&acdnat=1346088144_6b1e634bd1a5e32a28211d843d4c458e) (Accessed 25 August 2012).

Kennedy, H. P.2011. Teaching and Learning Birth: "Help All to Know". *The Journal of Perinatal Education* (online), 20(2) (Spring): 76-77. Available: <http://web.ebscohost.com.dutlib.dut.ac.za:2048/ehost/pdfviewer/pdfviewer?vid=4&hid=8&sid=1564b302-3ff6-4307-9e55-383b0d84c909%40sessionmgr4> (Accessed 25 August 2012).

Kinney, M. V., Kerber, K. J., Black, R. E., Cohen, B., Nkrumah, F., Coovadia, H., Nampala, P. M. and Lawn, J. E. 2010. Sub-Saharan Africa's Mothers,

Newborns, and Children: Where and Why Do They Die? *PLOS Med* (online), 7(6): 1-9.

Available: <http://www.plosmedicine.org/article/info%3Adoi%2F10.1371%2Fjournal.pmed.1000294> (Accessed 12 October 2013).

Kitzinger, S. 1978. Pain in Childbirth. *Journal of Medical Ethics* (online), 4(3): 119-121. Available: <http://www.jstor.org/stable/27715718> (Accessed 18 July 2015).

Klabbers, G. A., Wijma, K., Paarlberg, M., Emons, W. H. M. and Vingerhoets, A. J. 2014. Treatment of severe fear of childbirth with haptotherapy: design of a multicenter randomized controlled trial. *Complementary and Alternative Medicine* (online) 14 (385): 1-10. Available: <http://search.proquest.com.dutlib.dut.ac.za/docview/1614555105/fulltextPDF/A2F0E1B9938146D4PQ/1?accountid=10612> (Accessed 05 July 2015).

Koenig, H. G. 2012. Religion, Spirituality, and Health: The Research and Clinical Implications. *International Scholarly Research Network* (online), 2012: 1-33. Available: <http://www.hindawi.com/journals/isrn/2012/278730/> (Accessed 23 July 2015).

Koren, M. E., Czurylo, K., Epsom, R., Gattuso, M., Stark, B., Zastrow, P. and Basu, S. 2009. Nurses' Work Environment and Spirituality: A Descriptive Study. *International Journal of Caring Sciences* (online), 2 (3): 118-125. Available: [www.internationaljournalofcaringsciences.org](http://www.internationaljournalofcaringsciences.org) (Accessed 15 February 2012).

Kumbani, L. C., Chirwa, E., Malata, A., Odland, J. O. and Bjune, G. 2012. Do Malawian women critically assess the quality of care? A qualitative study on women's perceptions of perinatal care at a district hospital in Malawi. *Reproductive Health Journal* (online), 9:30. Available:

<http://www.reproductive-health-journal.com/content/pdf/1742-4755-9-30.pdf>  
(Accessed 24 June 2013).

Lahood, G. 2007. Rumour of angels and heavenly midwives: Anthropology of transpersonal events and childbirth. *Women and birth* (online), 20: 3-10. Available: <http://download.journals.elsevierhealth.com/pdfs/journals/1871-5192/PITS1871519206000928.pdf> (Accessed 20 May 2013).

Larkin, P., Begley, C. M. and Devane, D. 2009. Women's experiences of labour and birth: an evolutionary concept analysis. *Midwifery* (online), 25: e49-e59. Available: <http://www.sciencedirect.com.dutlib.dut.ac.za/science/article/pii/S1031170X02800071> (Accessed 04 July 2015).

Laroya, N. and Sharma, T. 2006. *The Religious and Cultural Bases for Breastfeeding Practices among the Hindus* (online), 1 (2): 94-99. Available: [www.discourseanalysis.com/pages/india/india.html](http://www.discourseanalysis.com/pages/india/india.html) (Accessed: 29 July 2012).

Lasch, K. E. 2000. Culture, Pain, and Culturally Sensitive Pain Care. *Pain Management Nursing* (online), 1(3): 16-22. Available: <http://www.sciencedirect.com.dutlib.dut.ac.za/science/article/pii/S152490420000035> (Accessed 07 June 2015).

Leap, N. 2000. *No Gain without Pain* (online). Available: <https://www.birthinternational.com/articles/childbirth-education/49-no-gain-without-pain> (Accessed 14 October 2013).

Leap, N., Dodwell, M. and Newburn, M. 2007. *Working with pain in labour. An overview of evidence* (online), 22-26. Available: [www.nct.org.uk/.../Research%20overview%20Working%20with%20pai](http://www.nct.org.uk/.../Research%20overview%20Working%20with%20pai) (Accessed 19 October 2013).

Lemon, B. S. 2006. Amish Health Care Beliefs and Practices in an Obstetrical Setting. *Journal of Multicultural Nursing & Health* (online), Fall: 12(3): 54-59. Available:

<http://search.proquest.com/nursing/docview/220297590/fulltextPDF/13EF4B08200433BD173/54?accountid=10612> (Accessed 29 June 2013).

Lewallen, L. P. 2011. The Importance of Culture in Childbearing. *Journal of Obstetric, Gynecologic and Neonatal Nursing* (online), (40) 4-8. Available: <http://jognn.awhonn.org> (Accessed 25 July 2012).

Littlejohn, M. 2010. *Spiritual Birth. Birth in South Africa: Indigenous Traditions* (online). Available: <http://www.spititualbirth.net/birth-in-south-africa-indigenous-traditions> (Accessed 19 May 2013).

Littlejohn, M. 2011. *Spiritual Birth. Sacred Birth Rituals* (online). Available: <http://www.spititualbirth.net/sacred-birth-rituals> (Accessed 19 May 2013).

Lleras, D. 2007. The childbirth experience: An obstetrical nurse's perspective. *International Journal of Childbirth Education* (online), 22(1): 19-21. Available: <http://search.proquest.com/nursing/docview/212865030/fulltextPDF/13EF98CCDCC75B099D0/25?accountid=10612> (Accessed 30 June 2013).

Lliadou, M. 2012. Supporting women in labour. *Health Science Journal* (online), 6(3): 385-391. Available: <http://www.hsj.gr/volume6/issue3/633.pdf> (Accessed 02 July 2013).

Lobo, M. 2006. Cultural Awareness of Nurses in Practice. *Nursing Journal of India* (online), 97(2): 33-35. Available: <http://search.proquest.com.dutlib.dut.ac.za:2048/docview/214382582/fulltextPDF/1382F6D489082713CB/101?accountid=10612> (Accessed 27 July 2012).

Louwagie, M. 2008. Spiritual Support for Native American Indian Patients. *International Journal of Childbirth Education* (online), 23(3): 17-18. Available: <http://web.a.ebscohost.com.dutlib.dut.ac.za/ehost/pdfviewer/pdfviewer?vid=17&sid=ec16fdf9-8f0a-49c9-89bd-f55043541abe%40sessionmgr4002&hid=4101> (Accessed 17 July 2015).

Lowe J. and Struthers, R. 2001. A Conceptual Framework of Nursing in Native American Culture. *Journal of Nursing scholarship* (online), 33(3): 279-283. Available: <http://nursing.ucla.edu/workfiles/CAIRE/articles/conceptual%20frameworkpdf> (Accessed 02 December 2012).

Lubbe, G. 2008. *Simply Ask. A guide to religious sensitivity for healthcare professionals* (online). Available: <http://www.desmondtutudiversitytrust.org.za/simplyask.pdf> (Accessed 27 May 2013).

Lundgren, I. 2002. Releasing and relieving encounters: experiences of pregnancy and childbirth (online), Doctor of Philosophy, Uppsala University Available: <http://www.divaportal.org/smash/get/diva2:161654/FULLTEXT01.pdf> (Accessed 21 August 2012).

Lydon-Lam, J. 2012. Models of Spirituality and Consideration of Spiritual Assessment. *International Journal of Childbirth Education* (online), 27(1): 18-22. Available: <http://www.docstoc.com/docs/112678417/Models-of-spirituality-and-consideration-of-Spiritual-Assessment> (Accessed 22 May 2013).

Machi, A. L. and McEvoy, T. B. 2009. *The Literature Review*. United States of America: SAGE Ltd.

Madsen, L. M. 2011. Editorial: Roles in midwifery. *Journal of Clinical Nursing* (online), 20: 600-601. Available:

<http://dutlib.dut.ac.za:2062/ehost/pdfviewer?vid=4&sid=712db10e9075-4f8e-b4c9-8c107fd2ac31%40sessionmgr114&hid=126> (Accessed 28 June 2013).

Magill-Cuerden, J. 2006. Nurturing and supporting mothers: A hidden skill in midwifery. *British Journal of Midwifery*, 14(6): 374.

Magill-Cuerden, J. 2007a. Showing respect for women: another skill for midwives. *British Journal of Midwifery*, 15(3): 126.

Magill-Cuerden, J. 2007b. Lessons to learn from an emerging maternity service. *British Journal of Midwifery*, 15(6): 326.

Magnusson, J. E. and Fennell, J. A. 2011. Understanding the role of culture in pain: M ori practitioner perspectives relating to the experience of pain. *Journal of the New Zealand Medical Association* (online), 124(1328): 41-51. Available: <http://www.nzma.org.nz/journal/124-1328/4501/> (Accessed 05 July 2015).

Mahlako, K. M. 2008. The perception of a selected group of midwives towards women experiencing labour pain (online). Master of Arts, University of South Africa. Available:

[http://uir.unisa.ac.za/bitstream/handle/10500/2691/dissertation\\_mahlako\\_%20m.pdf?sequence=1](http://uir.unisa.ac.za/bitstream/handle/10500/2691/dissertation_mahlako_%20m.pdf?sequence=1) (Accessed 14 October 2013).

Maimbolwa, M. C., Yamba, B., Diwan, V. and Ransjö-Arvidson, A-B. 2003. Issues and innovations in nursing practice. Cultural childbirth practices and beliefs in Zambia. *Journal of advanced Nursing* (online), 43(3): 263-274. Available:

<http://web.ebscohost.com/ehost/pdfviewer/pdfviewer?sid=f03a995b-d740-4dce-9820faf48162776e%40sessionmgr14&vid=2&hid=25>

(Accessed 19 October 2013).

Malaysia Ministry of Health. Health technology assessment section: Medical development division. 2008. *Natural-Health/ Pure Swietenia Mahogany Seed*. Available:

[https://www.google.co.za/?gfe\\_rd=cr&ei=tIXsvab5Lpe9bN7Lo6AC&gws\\_rd=ssl#q=www.umm.edu/altmed/articles/herbal-medicine-](https://www.google.co.za/?gfe_rd=cr&ei=tIXsvab5Lpe9bN7Lo6AC&gws_rd=ssl#q=www.umm.edu/altmed/articles/herbal-medicine-00351.htm+world+health+organization&start=10)

[00351.htm+world+health+organization&start=10](https://www.google.co.za/?gfe_rd=cr&ei=tIXsvab5Lpe9bN7Lo6AC&gws_rd=ssl#q=www.umm.edu/altmed/articles/herbal-medicine-00351.htm+world+health+organization&start=10) (Accessed 27 September 2015).

Mander, R. 2000. The meanings of labour pain or the layers of an onion? A woman-oriented view. *Journal of reproductive and infant psychology* (online), 18(2): 133-141. Available: <http://dx.doi.org/10.1080/02646830050008378> (Accessed 04 July 2015).

Maputle, S. M. and Nolte, A. 2008. Mother's experiences of labour in a tertiary care hospital. *Health S A Gesondheid* (online), 13(1): 55-62. Available: <http://www.hsag.co.za/index.php/HSAG/article/viewFile/257/247> (Accessed 12 October 2013).

Maputle, S. M. and Hiss, D. S. 2010. Midwives' experiences of managing women in labour in the Limpopo Province of South Africa. *Curationis* (online), 33 (3): 5-14. Available:

[http://web.ebscohost.com/dutlib.dut.ac.za:2048/ehost/pdfviewer/pdfviewer?vid=11&hid=122&sid=7d18ffbd-4bd1-4f66-a903-](http://web.ebscohost.com/dutlib.dut.ac.za:2048/ehost/pdfviewer/pdfviewer?vid=11&hid=122&sid=7d18ffbd-4bd1-4f66-a903-b62f4062cd1b%40sessionmgr14)

[b62f4062cd1b%40sessionmgr14](http://web.ebscohost.com/dutlib.dut.ac.za:2048/ehost/pdfviewer/pdfviewer?vid=11&hid=122&sid=7d18ffbd-4bd1-4f66-a903-b62f4062cd1b%40sessionmgr14) (Accessed 03 June 2012).

Maputle, S. M. and Hiss, D. S. 2013. Criteria to facilitate the implementation of woman-centred care in childbirth units of Limpopo Province, South Africa (Part 2). *Curationis* (online), 36(1): 5-14. Available:

[http://www.labome.org/bin/l.pl?link=puid\\_23718863&cmd=ask&epid=169108](http://www.labome.org/bin/l.pl?link=puid_23718863&cmd=ask&epid=169108)  
1 (Accessed 20 July 2013).

Marks, L. 2006. Religion and family Relational Health: An Overview and Conceptual model. *Journal of religion and Health* (online), 45(4): 603-618. Available: <https://americanfamiliesoffaith.byu.edu/Documents/fulltext%20Family%20Relational%20Health%202006.pdf> (Accessed 30 May 2015).

Maxwell, K. R. 2009. Birth Behind the Veil: African American midwives and mothers in the rural south, 1921-1962. Doctor of Philosophy. The State University of New Jersey. Available: <http://mss3.libraries.rutgers.edu/dlr/showfed.php?pid=rutgers-lib:26364> (Accessed 11 June 2012).

Mbiti, J. S. 1971. *African Religions and Philosophy*. London. Sage Publications.

McGrath, C. K. 2012. The Courage to Birth. *The Journal of Perinatal Education* (online), 21(2): 72-79. Available: <http://dx.doi.org/10.1891/1058-1243.21.2.72> (Accessed 25 August 2012).

McGuinness, F. 2006. Defining normal birth would help midwives and mothers. *British Journal of Midwifery*, 14(6): 328.

McLachlan, H. and Forster, D. 2009. The safety of home birth: Is the evidence good enough? *CMAJ* (online), 181(6-7): 359-360. Available: <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2742151/pdf/1810359.pdf> (Accessed 07 February 2013).

Mellish, J. M. and Paton, F. 2010. *An Introduction to the Ethos of Nursing*. 2<sup>nd</sup> ed. Sandton: Heinemann Higher & Further Education.



Mensah, R. S., Mogale, R. S. and Richter, M. S. 2014. Birthing experiences of Ghanaian women in 37<sup>th</sup> Military Hospital, Accra, Ghana. *International Journal of Africa Nursing Sciences* (online), 1:29-34. Available: <http://www.sciencedirect.com/science/article/pii/S2214139114000067> (Accessed 24 May 2015).

Mercer, J., Green-Jervis, C. and Brannigan, C. 2012. The legacy of a self-reported negative birth experience. *British Journal of Midwifery* (online), 20(10): 717-722. Available: <http://dutlib.dut.ac.za:2062/ehost/pdfviewer/pdfviewer?vid=4&sid=712db10e-9705-4f8e-b4c9-8c107fd2ac31%40sessionmgr114&hid=126> (Accessed 28 June 2013).

Merg, A. L. and Carmoney, P. 2012. Phenomenological Experiences: Homebirth after Hospital Birth. *International Journal of Childbirth Education* (online), 27 (4): 70-75. Available: <http://connection.ebscohost.com.dutlib.dut.ac.za:2048/c/articles/82284677/phenomenological-experiences-homebirth-after-hospital-birth> (Accessed 30 December 2012).

Mitchell, K. 2001. Childbirth: a momentous occasion Muslim women's childbirth experiences. Master of Arts. Victoria University of Wellington. Available: <http://researcharchive.vuw.ac.nz/bitstream/handle/10063/175/thesis.pdf?sequence=2> (Accessed 29 July 2012).

Mitchell, M. 2010. Risk, pregnancy and complementary and alternative medicine, *Complementary Therapies in Clinical Practice* (online), (16) 109-113 Available: [http://ac.els-cdn.com/S174438810900108X/1-s2.0-S174438810900108X-main.pdf?\\_tid=c0b06786-79f7-11e2-95bc-0000aacb35e&acdnat=1361211757\\_af91be0369cabe12c18cf082955db48f](http://ac.els-cdn.com/S174438810900108X/1-s2.0-S174438810900108X-main.pdf?_tid=c0b06786-79f7-11e2-95bc-0000aacb35e&acdnat=1361211757_af91be0369cabe12c18cf082955db48f)

(Accessed 18 February 2013).

Mixer, S. J. 2008. Use of the culture care theory and ethnonursing method to discover how nursing faculty teach culture care. *Contemporary Nurse* (online), 28(1-2): 23-36. Available: <http://search.proquest.com.dutlib.dut.ac.za:2048/docview/203177633/fulltextPDF/1382F6D489082713CB/131?accountid=10612> (Accessed 27 July 2012).

Mobarakabadi, S. S., Najmabadi, K. M. and Tabatabaie. M. G. 2015. Ambivalence towards Childbirth in a Medicalized Context: A Qualitative Inquiry among Iranian mothers. *Iranian Red Crescent Medical Journal* (online), 17(3): 1-6. Available: <http://search.proquest.com.dutlib.dut.ac.za/docview/1677318419/fulltextPDF/A2F0E1B9938146D4PQ/25?accountid=10612> (Accessed 05 July 2015).

Molloy, M. 2008. *Experiencing the world's religions. Tradition, Challenge, and Change*. 4<sup>th</sup> ed. New York: McGraw-Hill.

Montagu, D., Yamey, G., Visconti, A., Harding, A. and Yoong, J. 2011. Where do poor women in developing countries give birth? A multi-country analysis of demographic and health survey data. *PLOS One* (online), 6(2): 1-7. Available: <http://search.proquest.com/nursing/docview/1296323843/fulltextPDF/1411291A77572273399/7?accountid=10612> (Accessed 12 October 2013).

Moore, A. 2009. Pioneering a new model of midwifery care: A phenomenological study of a midwifery group practice. Masters of Midwifery. Australian Catholic University. Available: <http://dlibrary.acv.edu.au/digitalthesis/public/adtacuvp288.11032011/02whole.pdf> (Accessed 16 March 2013).

Morhason-Bello, I. O., Olayemi, O., Ojengbede, O. A., Adedokun, B. O., Okuyemi, O. O. and Orji, B. 2007. Attitude and preferences of Nigerian antenatal women to social support during labour. *Journal of Biosocial Science* (online), 40(4), 553-563. Available:

<http://search.proquest.com/nursing/docview/203950743/fulltextPDF/1411291A77572273399/88?accountid=10612> (Accessed 12 October 2013).

Morson, M. C. 2013. Experiences of women in early labour sent home following hospital assessment. Master of Science in Nursing, Trinity Western University. Available:

[https://www.twu.ca/library/theses/225877\\_pdf\\_19FF8146-DBFA-11E2-99AB-313AEF8616FA\\_morson\\_m.pdf](https://www.twu.ca/library/theses/225877_pdf_19FF8146-DBFA-11E2-99AB-313AEF8616FA_morson_m.pdf) (Accessed 05 July 2014).

Mpantsha, E. N. 2003. The Study to investigate the challenges that face the Trained Midwives in the Workplace during the 21<sup>st</sup> Century in eThekweni Region of KwaZulu-Natal. M. Cur. Nursing, University of Zululand. Available: <http://UZspace.uzulu.ac.za/handle/10530/814> (Accessed 10 June 2013).

M'Soka, N. C. S. 2010. Beliefs in women receiving maternal and child health services at Chawama Clinic in Lusaka, Zambia regarding pregnancy and childbirth. Thesis M. Med. (Family Medicine), University of Limpopo (Medunsa Campus). Available: <http://ul.netd.ac.za/handle/10386/509> (Accessed 19 May 2013).

Mugambe, J. M., Nel, M., Hiemstra, L. A. and Steinberg, W.J. 2007. Knowledge of and attitude towards pain relief during labour of women attending the antenatal clinic of Cecilia Makiwane Hospital, South Africa. *South African Family Practice* (online), 49(4): 16,16a-16d. Available: [www.ajol.info/index.php/safp/article/download/13354/59370](http://www.ajol.info/index.php/safp/article/download/13354/59370) (Accessed 19 October 2013).

Narayanasamy, A. 2002. The ACCESS model: a transcultural nursing practice framework, *British Journal of Nursing* (online), 11(9): 643-650. Available:<http://search.proquest.com.dutlib.dut.ac.za:2048/docview/199462739/fulltextPDF/1382F6D489082713CB/107?accountid=10612> (Accessed 27 July 2012).

Narayanasamy, A. 2003. Transcultural nursing: How do nurses respond to cultural needs? *British Journal of Nursing* (online), 12(3): 185-194. Available: <http://search.proquest.com.dutlib.dut.ac.za:2048/docview/199455134/fulltextPDF/1382F6D489082713CB/109?accountid=10612> (Accessed 27 July 2012).

Nawal, D. and Goli, S. 2013. Birth preparedness and its effect on place of delivery and post-natal check-ups in Nepal. *PLOS One* (online), 8(5): 1-8. Available:<http://search.proquest.com/docview/1036975697/fulltextPDF/13F625173AC3B31D179/9?accountid=10612> (Accessed 20 July 2013).

Ngomane, S. and Mulaudzi, F. M. 2010. Indigenous beliefs and practices that influence the delayed attendance of antenatal clinics by women in the Bohlabelo district in Limpopo, South Africa. *Midwifery* (online), 28(1): 30-38. Available:<http://www.kit.nl/kit/Indigenous-beliefs> (Accessed 19 April 2013).

Noseworthy, A., Phibbs, S. R. and Benn, C. A. 2012. Towards a relational model of decision-making in midwifery care. *Midwifery 2013* (online) 29: e42-e48. Available: [http://ac.els-cdn.com/S0266613812001222/1-s2.0-S0266613812001222-main.pdf?\\_tid=11b58994-e0d8-11e2-bdf7-00000aab0f26&acdnat=1372523120\\_6b7c2d65a7d39654817f83cb5c3096d5](http://ac.els-cdn.com/S0266613812001222/1-s2.0-S0266613812001222-main.pdf?_tid=11b58994-e0d8-11e2-bdf7-00000aab0f26&acdnat=1372523120_6b7c2d65a7d39654817f83cb5c3096d5) (Accessed 29 June 2013).

Nyango, D. D., Mutihir, J. T., Laabes, E. P., Kigbu, J. H. and Buba, M. 2010. Skilled attendance: The key challenges to progress in achieving MDG-5 in North Central Nigeria. *African Journal of Reproductive Health* (online), 14(2):

129-138.

Available:

<http://search.proquest.com/docview/858460797?accountid=10612> (Accessed 20 July 2013).

O'Brien, M. E. 2010. *Spirituality in Nursing: Standing on Holy Ground*. 4<sup>th</sup> ed. (online). Sudbury, Massachusetts: Jones and Bartlett Publishers. Available: <https://books.google.co.za/books?id=1s-PJfEr324C&printsec=frontcover#v=onepage&q&f=false> (Accessed 17 June 2015).

O'Leary, Z. 2010. *The Essential Guide to Doing Your Research Project*. 3<sup>rd</sup> ed. Great Britain: Sage Publications.

Olsson, A. and Adolfsson, A. 2011. Midwife's experiences of using intuition as a motivating element in conveying assurance and care. *Health* (online), 3(7): 453-461. Available: <http://www.scirp.org/journal/HEALTH/> (Accessed 19 June 2012).

Omery, A. 1983. Phenomenology: a method for nursing research. *Advances in Nursing Science* (online), 5 (2): 49-64. Available: [http://journals.lww.com/advancesinnursingscience/Citation/1983/01000/Phenomenology\\_a\\_method\\_for\\_nursing\\_research.10.aspx](http://journals.lww.com/advancesinnursingscience/Citation/1983/01000/Phenomenology_a_method_for_nursing_research.10.aspx) (Accessed 24 April 2013).

Otis, K. E. and Brett, J. A. 2008. Barriers to hospital births: why do many Bolivian women give birth at home? *Rev Panam Salud Publica* (online), 24(1): 46-53. Available: <http://www.scielosp.org/pdf/rpsp/v24n1/v24n1a06.pdf> (Accessed 24 June 2013).

Page, R. L., Ellison, C. G. and Lee, J. 2009. Does Religiosity Affect Health Risk Behaviors in Pregnant and Postpartum Women? *Maternal and Child Health Journal* (online), 13: 621-632. Available:

<http://web.a.ebscohost.com.dutlib.dut.ac.za/ehost/pdfviewer/pdfviewer?vid=13&sid=ec16fdf9-8f0a-49c9-89bd-f55043541abe%40sessionmgr4002&hid=4101> (Accessed 17 July 2015).

Papadopoulos, I. and Omeri, A. 2008. Transcultural nursing theory and models: The challenges of application. *Contemporary Nurse* (online), 28(1-2): 45-47. Available:  
<http://search.proquest.com.dutlib.dut.ac.za:2048/docview/203165688/fulltextPDF/1382F6D489082713CB/118?accountid=10612>(Accessed 27 July 2012).

Parratt, J. 2002. The impact of childbirth experiences on women's sense of self: A review of the literature. *Australian College of Midwives Incorporated* (online), 15(4): 10-16. Available:  
<http://www.sciencedirect.com.dutlib.dut.ac.za/science/article/pii/S1031170X0280001> (Accessed 04 July 2015).

Patterson, A. S. 2014. Religion and the Rise of Africa. *Brown Journal of World Affairs* (online), XX1 (1): 181-196. Available:  
<http://search.proquest.com.dutlib.dut.ac.za/docview/1655719589/fulltextPDF/91DD9BAB9AEE4972PQ/1?accountid=10612> (Accessed 30 May 2015).

Pera, S. and van Tonder, S. 2011. *ETHICS in Healthcare*. 3<sup>rd</sup> edition. Lansdowne: Juta and Co. Ltd.

Polit, D. F. and Beck, C. T. 2008. *Nursing Research: Generating and assessing evidence for nursing practice*. 8<sup>th</sup> ed. Philadelphia: Lippincott Williams and Wilkins.

Polit, D. F. and Beck, C. T. 2012. *Nursing Research: generating and assessing evidence for nursing practice*. 9<sup>th</sup> ed. Philadelphia: Lippincott Williams and Wilkins.

Polit, D. F., Beck, C. T. and Hungler, B. P. 2001. *Essentials of Nursing Research: Methods, Appraisal, and Utilization*. 5<sup>th</sup> ed. United States of America: Lippincott Williams and Wilkins.

Pugh, M. A. 2014. Childbirth Education – Then and Now. *International Journal of Childbirth Education* (online), 29(4): 8-14. Available: <http://search.proquest.com.dutlib.dut.ac.za/docview/1609199204/fulltextPDF/FD6E5F5B4625406DPQ/50?accountid=10612> (Accessed 16 July 2015).

Rabor, F. M., Taghipour, A. and Najmabadi, K. M. 2015. Voices of Mother's Interaction with Midwives in Natural Childbirth: A Qualitative Study. *Health* (online), 7: 153-160. Available: <http://mailer.oalib.net/paper/3137532#.VW3D4NKqqko> (Accessed 02 June 2015).

Ramashwar, S. 2008. Nigerian women would like to receive social support during childbirth. *International Family Planning Perspectives* (online), 34(4): 202-203. Available: <http://search.proquest.com/docview/235866503?accountid=10612> (Accessed 30 June 2013).

Revell, M. A. 2012. Use of Complementary and Alternative Medicine in the African American Culture. *International Journal of Childbirth Education* (online), 27(3): 55-59. Available: <http://search.proquest.com.dutlib.dut.ac.za/docview/1039291532/fulltextPDF/61230A8A049D4C48PQ/4?accountid=10612> (Accessed 05 July 2015).

Robertson, E. and Johansson, S. E. 2010. Use of complementary, non-pharmacological pain reduction methods during childbirth among foreign-born and Swedish-born women. *Midwifery* (online), 26: 442-449. Available:

[http://ac.els-cdn.com/S0266613808000880/1-s2.0-S0266613808000880-main.pdf?\\_tid=6a20c392-f078-11e1-b60b-00000aab0f6c&acdnat=1346093756\\_28737328a6bba1dbae3fd794dc947a11](http://ac.els-cdn.com/S0266613808000880/1-s2.0-S0266613808000880-main.pdf?_tid=6a20c392-f078-11e1-b60b-00000aab0f6c&acdnat=1346093756_28737328a6bba1dbae3fd794dc947a11)  
(Accessed 27 August 2012).

Rooks, J. P. and Ernst, E. K. M. 1999. The future of midwifery. *International Journal of Childbirth Education* (online), 14 (4): 16-21. Available: <http://search.proquest.com/nursing/docview/212858865/fulltextPDF/13EF0E146C12C4BD82E/33?accountid=10612> (Accessed 28 June 2013).

Russel, K. E. 2007. Mad, bad or different? Midwives and normal birth in obstetric led units. *British Journal of Midwifery*, 15(3): 128-130.

Sandelowski, M. 2000. Focus on Research Methods Whatever Happened to Qualitative Description? *Research in Nursing & Health* (online), 23: 334-340. Available: <http://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.461.4974&rep=rep1&type=pdf> (Accessed 27 May 2015).

Sapountzi-Krepia, D., Lavdaniti, M., Raftopoulos, V., Psychogiou, M., Hong-G. H., Tortumluo lu, G. and Vehvilainen-Julkunen, K. 2008. Greek mothers' perceptions of their cooperation with the obstetrician and the midwife in the delivery room. *International Journal of Caring Sciences* (online), 1(3): 124-131. Available: <http://www.internationaljournalofcaringsciences.org>  
(Accessed 28 June 2013).

Sauls, D. J. 2002. Effects of Labor Support on Mothers, Babies, and Birth Outcomes. *Journal of Obstetric, Gynecologic and Neonatal Nursing* (online), 31(6): 733-741. Available: <http://prdupl02.ynet.co.il/ForumFiles/3947233.pdf> (Accessed 12 October 2013).



Schneider, D. A. 2013. Helping Women Cope with Feelings of Failure in Childbirth. *International Journal of Childbirth Education* (online), 28(1): 46-50. Available:

<http://search.proquest.com.dutlib.dut.ac.za/docview/1281834814/FD6E5F5B4625406DPQ/10?accountid=10612> (Accessed 16 July 2015).

Schwartz, J. A. 2014. Childbirth as a profound experience: exploring narrative and image of experiences during birth (online). Doctor of Philosophy. Faculty of the California Institute of Integral Studies San Francisco, CA. Available: <http://media.proquest.com/media/pq/classic/doc/3585760431/fmt/ai/rep/NPDF?s=8sEIVb1gesGkaJTCeyRublwoavA%3D> (Accessed 19 May 2015).

Searle, C. 1988. *Ethos Of Nursing And Midwifery: A general perspective*. Durban: Butterworth Publishers Pty Ltd.

Sellers, P. M. 2012. *Sellers' Midwifery*. 2<sup>nd</sup> ed. Cape Town: Juta & Co. Ltd.

Sessions, M. 2013. Emotional Experiences During Childbirth: Their Association with Birth Practices and Beliefs (online). Doctor of Philosophy, Florida State University College of Social Sciences and Public Policy. Available: <http://diginole.lib.fsu.edu/cgi/viewcontent.cgi?article=7608&context=etd> (Accessed 10 August 2015).

Shidhaye, R.V., Galande, M., Bangal, V. B., Smita, J. and Shidhaye, U. R. 2012. Awareness and attitude of Indian pregnant women towards labour analgesia. *Anaesth pain & Intensive Care* (online), 16(2): 131-136. Available: <http://www.apicareonline.com/?p=1273> (Accessed 19 October 2013).

Shimpuku, Y. 2002. Mothers' Perceptions of Childbirth Experience at the Hospital in Rural Tanzania (online). Doctor of Philosophy, University of Illinois at Chicago, Illinois. Available:

<http://search.proquest.com/nursing/docview/762997195/13EF9F4F1A41E24546D/1?accountid=10612> (Accessed 30 June 2013).

Simkin, P. 2006. What Makes a Good Birth and Why Does it Matter? *International Journal of Childbirth Education*. (online), 21(3): 4-6. Available: <http://search.proquest.com.dutlib.dut.ac.za/docview/212862581/fulltextPDF/CB62AE97CC634084PQ/63?accountid=10612> (Accessed 16 July 2015).

Smith, H. Brown, H. Hofmeyer, G. J. and Garner, P. 2004. Evidence-based obstetric care in South Africa: influencing practice through the 'Better Births Initiative'. *South African Medical Journal* (online), 94(2): 117-120. Available: <http://www.samj.org.za/index.php.spmj/article/download/2513/1772> (Accessed 11 July 2013).

Snyman, L. C. 2007. The Role of the Midwife in Preventing Maternal Mortality. *Professional Nursing today* (online), 11(3): 8-10. Available: <http://www.pntonline.co.za/index.php/PNT/article/view/127/130> (Accessed 16 January 2014).

South African National Department of Health. 2015. *Guidelines for maternity care in South Africa. A manual for clinics, community health centers and district hospitals*. 4<sup>th</sup> ed. (online). Available: <http://healthweb.kznhealth.gov.za/mcwh/Maternal Care Guidelines 2015.pdf> (Accessed 23 July 2015).

South African Statistics SA. 2014. *Statistical release P0302* (online). Available: <http://www.statssa.gov.za/publications/P0302/P03022011.pdf> (Accessed 25 July 2012).

South African Government Information. *Pocket Guide to South Africa 2011/12. Government Communication and Information System* (online).

Available: <http://www.info.gov.za/aboutsa/people.htm#people> (Accessed 08 March 2013).

*South African Nursing Council*. 2005. Government Notice No. R. 2488 (as amended). Regulations Relating to Persons who are Registered or Enrolled under the Nursing Act (online). Available: <http://www.sanc.co.za/regulat/Reg-cmi.htm> (Accessed 25 July 2012).

*South African Nursing Council*. 2005. Nursing Act No.33 of 2005 (online). Available: <http://www.sanc.co.za/publications.htm> (Accessed 25 July 2012).

South African Nursing Council. 2001. Circular 5/2001. *Revision of the scope of practice for nurses*. Available: [www.sanc.co.za/archive/archive2001/newsc105.htm](http://www.sanc.co.za/archive/archive2001/newsc105.htm). (Accessed 25 July 2012).

Speziale, H. S. J. and Carpenter, D. R. 2007. *Qualitative research in nursing: advancing the humanistic imperative*. 4<sup>th</sup> ed. Crawfordville: Lippincott Williams & Wilkins.

Stephenson, R., Baschieri, A., Clements, S., Hennink, M. and Madise, N. 2006. Contextual Influences on the Use of Health Facilities for Childbirth in Africa. *American Journal of Public Health* (online), 96(1): 84-93. Available: <http://search.proquest.com/nursing/docview/215089026/fulltextPDF/13EF98CCDCC75B099D0/17?accountid=10612> (Accessed 30 June 2013).

Straus, L., McEwen, A. and Hussein, F. M. 2007. Somali women's experience of childbirth in the UK: Perspectives from Somali health workers. *Midwifery* (online) 25: 181-186. Available: [http://www.researchgate.net/publication/6236164\\_Somali\\_women's\\_experience\\_of\\_childbirth\\_in\\_the\\_UK\\_Perspectives\\_from\\_Somali\\_health\\_workers/file/3deec51926e8e89563.pdf](http://www.researchgate.net/publication/6236164_Somali_women's_experience_of_childbirth_in_the_UK_Perspectives_from_Somali_health_workers/file/3deec51926e8e89563.pdf) (Accessed 24 June 2013).

Swanepoel, H. and de Beer, F. 2006. *Community Development: Breaking the cycle of poverty*. 4<sup>th</sup> ed. Cape Town: Juta & Co Ltd.

Tebid, R., du Plessi, D., Beukes, S., Van Niekerk, V. and Jooste, K. 2011. Implications for nurse managers arising from immigrant women's experience of midwifery care in a hospital. *Journal of Nursing Management* (online) 19: 967-975. Available: <http://dutlib.dut.ac.za:2062/ehost/pdfviewer/pdfviewer?vid=4&sid=712db10e-9705-4f8e-b4c9-8c107fd2ac31%40sessionmgr114&hid=126> (Accessed 28 June 2013).

*The Holy Bible: New International Version*. 1984. Grand Rapids, Michigan United States of America: Zondervan.

Thornton, R. 2009. The transmission of knowledge in South African Traditional Healing. *Africa* (online), (79) 1: 17-34. Available: <http://search.proquest.com.dutlib.dut.ac.za:2048/docview/213654456/fulltextPDF?accountid=10612> (Accessed 8 August 2012).

Thorstensson, S., Ekström, A., Lundgren, I. and Wahn, E. H. 2012. Exploring Professional Support Offered by Midwives during Labour: An Observation and Interview Study. *Nursing Research and Practice* (online), 2012: 1-10. Available: <http://www.hindawi.com/journals/nrp/2012/648405/> (Accessed 15 October 2013).

Tiran, D. 2008. *Bailliere's Midwives Dictionary*. 11<sup>th</sup> ed. China: Elsevier.

Tjale, A. and de Villiers, L. 2004. *Cultural Issues in Health and Healthcare*. Cape Town: Juta & Co. Ltd.

Truter, I. 2007. African Traditional Healers: Cultural and religious beliefs intertwined in a holistic way. *SA Pharmaceutical Journal – September 2007* (online), 56-60. Available:

<http://www.sapj.co.za/index.php/SAPJ/article/download/239/231> (Accessed 24 July 2012).

United Nations Population Fund (UNPFA). 2011. Midwifery around the world. Part 1 (online), 1-16. Available:

[http://www.unfpa.org/sowmy/resources/docs/main\\_report/en\\_SOWMR\\_Part1.pdf](http://www.unfpa.org/sowmy/resources/docs/main_report/en_SOWMR_Part1.pdf) (Accessed 21 October 2013).

Uys, L. R. and Mulder, M. 1985. *Nursing: Humane, Scientific Health Care*. Pretoria: Sigma Press (Pty) Ltd.

van Butselaar, J. 2014. Religion in Africa: Power for life. *Studies in World Christianity and Interreligious Relations* (online), 48: 219-231. Available: <http://search.proquest.com/docview/1610259189?accountid=10612> (Accessed 30 May 2015).

van der Westhuizen, M. 2011. Trends in South African Labor & Pain Management. *International Journal of Childbirth Education* (online), 26(4): 28-31. Available:

<http://dutlib.dut.ac.za:2062/ehost/pdfviewer/pdfviewer?vid=6&sid=712db10e-9705-4f8e-b4c9-8c107fd2ac31%40sessionmgr114&hid=126> (Accessed 28 June 2013).

Walsh, D. 2006. The ontology of childbirth. *British Journal of Midwifery*. 14(11): 662.

Weatherspoon, D. 2011. Current Practices in Easing Discomfort from Labor and Delivery: Alternative and Medical Practices. *International Journal of Childbirth Education* (online), 26(4): 44-48. Available:

<http://search.proquest.com.dutlib.dut.ac.za/nursing/docview/920753830/fulltextPDF/26D547B177FE4E0EPQ/29?accountid=10612> (Accessed 05 July 2015).

Wehbe-Alamah, H. 2008. Bridging generic and professional care practices for Muslim patients through use of Leininger's culture care modes. *Contemporary Nurse : a Journal for the Australian Nursing Profession* (online), 28 (1-2): 83-97. Available: <http://search.proquest.com.dutlib.dut.ac.za:2048/docview/203169368/fulltextPDF?accountid=10612> (Accessed 26 July 2012).

Westfall, R. E. 2001. Herbal Medicine in Pregnancy and Childbirth. *Advances In Natural Therapy* (online), 18(1): 47-55. Available: <http://www.springerlink.com.dutlib.dut.ac.za:2048/content/x810444072178540/fulltext.pdf> (Accessed 16 October 2012).

White, M. 2007. Listening to Mothers II: Second National U. S. Survey of Women's Childbearing Experiences. *International Journal of Childbirth Education* (online), 22(1): 27-29. Available: <http://search.proquest.com/docview/212843160/fulltextPDF/13EFBC1BF36377354D2/18?accountid=10612> (Accessed 30 June 2013).

Wilde-Larsson, B., Sandin-Bojö, A. K., Starrin, B. and Larsson, G. 2011. Birthgiving women's feelings and perceptions of quality of intrapartal care: a nationwide Swedish cross – sectional study. *Journal of Clinical Nursing*, (online) 20: 1168-1177. Available: <http://dutlib.dut.ac.za:2062/ehost/pdfviewer/pdfviewer?vid=4&sid=712db10e-9705-4f8e-b4c9-8c107fd2ac31%40sessionmgr114&hid=126> (Accessed 25 June 2013).

Williams, D. R. and Sternthal, M. J. 2007. Spirituality, religion and health: evidence and research directions. *Medical Journal of Australia* (online), 186(10): S47-S50.

Available:[https://www.mja.com.au/system/files/issues/186\\_10\\_210507/wil11060\\_fm.pdf](https://www.mja.com.au/system/files/issues/186_10_210507/wil11060_fm.pdf) (Accessed 04 June 2015).

Wilson, L. 2012 Cultural Competence: Implications for Childbearing Practices. *International Journal of Childbirth Education* (online), 27(1): 10-17 Available:  
<http://search.proquest.com.dutlib.dut.ac.za:2048/docview/920597255/fulltextPDF?accountid=10612> (Accessed 24 September 2012).

Worku, A. G., Yalew, A. W. and Afework, M. F. 2013. Maternal complications and women's behavior in seeking care from skilled providers in North Gondar, Ethiopia. *PLoS One* (online), 8(3): 1-8. Available:  
<http://search.proquest.com/nursing/docview/1330908573/fulltextPDF/141112C4BB871B27FE9/73?accountid=10612> (Accessed 12 October 2013).

World Health Organization. 2005a. *The World Health Report. Chapter four. Attending to 136 million births, every year* (online). Available:  
<http://www.who.int/whr/2005/chap4-en.pdf> (Accessed 07 July 2013).

World Health Organization. 2005b. *The World Health Report. Overview. Make every mother and child count* (online). Available:  
[http://www.who.int/whr/2005/overview\\_en.pdf](http://www.who.int/whr/2005/overview_en.pdf) (Accessed 07 July 2013).

Yadgar, Y. 2013. Tradition. *Springer Science+Business Media Dordrecht* (online), 36: 451 - 470. Available:  
<http://search.proquest.com.dutlib.dut.ac.za/docview/1461842519?pq-origsite=summon> (Accessed 30 May 2015).

Zinnbauer, B. J. and Pargament, K. I. 2005. Handbook of the psychology of religion and spirituality: religiousness and spirituality. 20 – 42. Available:  
[http://www.psychology.hku.hk/ftbcstudies/refbase/docs/zinnbauer/2005/33\\_Zinnbauer+Pargament2005.pdf](http://www.psychology.hku.hk/ftbcstudies/refbase/docs/zinnbauer/2005/33_Zinnbauer+Pargament2005.pdf) (Accessed 18 April 2016).

## APPENDICES

### Appendix 1: Permission letter to the KZN Department of Health

The Health Research and Knowledge Management Component  
KwaZulu-Natal Department of Health  
Private Bag X9051  
Pietermaritzburg  
3201

Date.....

Dear Sir/Madam

#### Re: REQUEST FOR PERMISSION TO CONDUCT RESEARCH STUDY

I Mrs A Ramanand am presently registered as a Masters student at the Durban University of Technology in the Department of Nursing. The proposed title of my study is **"The childbirth experience: A phenomenological exploration of its personal and cultural meanings for women from diverse traditions"**. The study will be conducted in the UMgungundlovu district of KwaZulu-Natal.


I hereby request permission to recruit participants that is, mothers from the postnatal wards of the following hospitals which were purposively selected to conduct the study:

1. Edendale Hospital
2. Greys Hospital
3. Northdale Hospital

The study will require participants (mothers) to participate in a one to one interview session which will be conducted at their six weeks check up at their local clinic or the attending hospital. The interview will take place in a private room and will last for approximately one hour. Participation is voluntary, and an informed consent will be obtained from all participants. Confidentiality will be maintained at all times. The participant's identity will remain confidential whereby pseudonyms (different names) will be used for the information, and there will be no risks or discomfort. Please find attached a copy of my research proposal for your perusal.

It would be greatly appreciated if you could forward me your response.

Yours faithfully

  
Mrs A. Ramanand (Researcher)  
Contact Details: Cell: 0844332260  
Email: [anoosha.ramanand@gmail.com](mailto:anoosha.ramanand@gmail.com)

Supervisor: Prof. R Bhagwan  
Telephone: 031-3732197  
Email: [bhagwanr@dur.ac.za](mailto:bhagwanr@dur.ac.za)

Co-supervisor: Ms CN Adams  
Telephone: 0338459016  
Email: [carolinea@dur.ac.za](mailto:carolinea@dur.ac.za)





health

Department:  
Health  
PROVINCE OF KWAZULU-NATAL

Health Research & Knowledge Management sub-component  
10 – 103 Natalia Building, 330 Langalibalele Street  
Private Bag x9051  
Pietermaritzburg  
3200  
Tel: 033 – 3953189  
Fax: 033 – 394 3782  
Email: [hikm@kznhealth.gov.za](mailto:hikm@kznhealth.gov.za)  
[www.kznhealth.gov.za](http://www.kznhealth.gov.za)

Reference : HRKM 187/13  
Enquiries : Mr X Xaba  
Tel : 033 – 395 2805

Dear Mrs A. Ramanand

**Subject: Approval of a Research Proposal**

1. The research proposal titled 'The childbirth experience: A phenomenological exploration of its personal and childbirth meanings for women from diverse traditions' was reviewed by the KwaZulu-Natal Department of Health.

The proposal is hereby **approved** for research to be undertaken at Edendale, Grey's and Northdale hospital and Bangalore, Khan road, East Boom, Central City, Scottsville, Eastwood, Woodlands, Edendale Gateway and Imbalenhle clinics.

2. You are requested to take note of the following:
  - a. Make the necessary arrangement with the identified facility before commencing with your research project.
  - b. Provide an interim progress report and final report (electronic and hard copies) when your research is complete.
3. Your final report must be posted to **HEALTH RESEARCH AND KNOWLEDGE MANAGEMENT, 10-102, PRIVATE BAG X9051, PIETERMARITZBURG, 3200** and e-mail an electronic copy to [hikm@kznhealth.gov.za](mailto:hikm@kznhealth.gov.za)

For any additional information please contact Mr X. Xaba on 033-395 2805.

Yours Sincerely

Dr E Lutge  
Chairperson, Health Research Committee

Date: 15/08/2013

**Appendix 2: Permission letter to the District Manager**

Ms M Zuma-Mkhonza  
The District Manager  
UMgungundlovu Health District  
Pietermaritzburg  
3201

**Date**.....

Dear Madam

**Re: REQUEST FOR PERMISSION TO CONDUCT RESEARCH STUDY**

I, Mrs A Ramanand am presently registered as a Masters student at the Durban University of Technology in the Department of Nursing. The proposed title of my study is **"The childbirth experience: A phenomenological exploration of its personal and cultural meanings for women from diverse traditions"**. The study will be conducted in the UMgungundlovu district of KwaZulu-Natal.


I hereby request permission to recruit participants that is, mothers from the postnatal wards of the following hospitals which were purposively selected to conduct the study:

1. Edendale Hospital
2. Grey's Hospital
3. Northdale Hospital

The study will require participants (mothers) to participate in a one to one interview session which will be conducted at their six weeks check up at their local clinic or the attending hospital. The interview will take place in a private room and will last for approximately one hour. Participation is voluntary, and an informed consent will be obtained from all participants. Confidentiality will be maintained at all times. The participant's identity will remain confidential whereby pseudonyms (different names) will be used for the information, and there will be no risks or discomfort. Please find attached a copy of my research proposal for your perusal.

It would be greatly appreciated if you could forward me your response.

Yours faithfully

  
Mrs A. Ramanand (Researcher)  
Contact Details: Cell: 0844332260  
Email: [anoosha.ramanand@gmail.com](mailto:anoosha.ramanand@gmail.com)

Supervisor: Prof. R Bhagwan  
Email: [bhagwanr@dut.ac.za](mailto:bhagwanr@dut.ac.za)

Co-supervisor: Ms CN Adams  
Email: [carolinea@dut.ac.za](mailto:carolinea@dut.ac.za)  
.....



health

Department:  
Health  
PROVINCE OF KWAZULU-NATAL

UMGUNGUNDLOVU HEALTH DISTRICT OFFICE  
OFFICE OF THE DISTRICT MANAGER  
Private Bag X9124, Pietermaritzburg,  
3200  
Brasfort House, 262 Langalibalele Street,  
Pietermaritzburg, 3201  
Tel.: 033-8971000,  
Fax: 033-897 1078  
Email: [thule.kunene@kznhealth.gov.za](mailto:thule.kunene@kznhealth.gov.za)  
[www.kznhealth.gov.za](http://www.kznhealth.gov.za)

Enquiries: Mrs. N.M. Zuma - Mkhonza

Ref No: 15/16

Date: 30 JULY 2013

MRS A RAMANAND  
103 BRIXHAM ROAD  
ORIENT HEIGHTS  
PIETERMARITZBURG  
3201

DEAR MRS RAMANAND,


**RE: THE CHILDBIRTH EXPERIENCE: A PHENOMENOLOGICAL  
EXPLORATION OF ITS PERSONAL AND CULTURAL MEANINGS FOR  
WOMEN FROM DIVERSE TRADITIONS.**

I have the pleasure in informing you that permission has been granted to you by the District to conduct research on *"The childbirth experience: a phenomenological exploration of its personal and cultural meanings for women from diverse traditions"*

Please note the following:

1. Please ensure that you adhere to all the policies, procedures, protocols and guidelines of the Department of Health with regards to this research.
2. This research will only commence once this office has received confirmation from the Provincial Health Research Office Committee in the Department of Health.
3. Please ensure this office is informed before you commence your research.
4. The District Office / Facility will not provide any financial resources for this research.
5. You will be expected to provide feedback on your findings to the District Office/Facility

Thank you

  
MRS N.M. ZUMA - MKHONZA  
DISTRICT MANAGER  
UMGUNGUNDLOVU HEALTH DISTRICT

Hospital (1)

**Appendix 3(a): Letter of Permission**

Anoosha Ramanand  
103 Brixham Road  
Orient Heights  
Pietermaritzburg,  
3201,  
23 May 2013

The Hospital Manager  
Mrs. Z.S.I. Ndwandwe  
Edendale Hospital  
Private bag x 509  
Plessislaer  
3216.

Dear Madam

**RE: REQUEST FOR PERMISSION TO CONDUCT A RESEARCH STUDY**

I am currently registered as a Masters student at the Durban University of Technology in the Department of Nursing. The proposed title of my research study is: **The childbirth experience: a phenomenological exploration of its personal and cultural meanings for women from diverse traditions.**

I hereby request your permission to recruit participants (mothers) from the postnatal ward at Edendale Hospital to participate in the study. My research proposal will follow for your perusal.

The study will require participants (mothers) to participate in a one to one interview session which will be conducted at their six weeks check up at their local clinic or the attending hospital. The interview will take place in a private room and will last for approximately one hour. Participation is voluntary, and a written informed consent will be obtained from all participants. Confidentiality will be maintained at all times. The participant's identity will remain confidential whereby pseudonyms (different names) will be used for the information collected, and there will be no risks or discomfort. Please find attached a copy of my research proposal for your perusal.

Yours faithfully

...  
Mrs A. Ramanand (Researcher)  
Contact Details: Cell: 0844332260  
Email: [anoosha.ramanand@gmail.com](mailto:anoosha.ramanand@gmail.com)

Supervisor: Prof. R Bhagwan  
Telephone: 031-3732197  
Email: [phagwan@dut.ac.za](mailto:phagwan@dut.ac.za)

Co-supervisor: Ms GN Adams  
Telephone: 0338459016  
Email: [carolinea@dut.ac.za](mailto:carolinea@dut.ac.za)



**health**  
Department:  
Health  
PROVINCE OF KWAZULU-NATAL

**Edenburg Hospital**  
Private Bag X 500, Edenburg, 3218  
Tel: 033 355 4040, Fax: 033 355 4087  
email: thers@edenburg.kzn.gov.za  
www.edenburg.gov.za

**OFFICE OF THE CHIEF EXECUTIVE OFFICER**

Reference No: 3006/1  
Enquiries: Mrs. T.J. Ndlovu  
Tel: 033-355-4040  
Date: 24 May 2013

Mrs. A. Ramanand  
103 Brixham Road  
Orient Heights  
Pietermaritzburg  
5201

Dear Mrs. Ramanand

**RE: Request to conduct a research: "The childbirth experience: A phenomenological exploration of its personal and cultural meanings for women from diverse traditions"**

Your letter dated 22 May 2013 refers.

Your request to conduct the above-mentioned surveillance is supported by Edenburg Hospital Management, subject to approval by Biomedical Research Ethics Committee and Department of Health Research Committee.

Yours Sincerely,

  
Mrs. Z.M. Mwanjwe  
CHIEF EXECUTIVE OFFICER  
EDENBURG HOSPITAL

## Hospital (2)

### Appendix3(b): Letter of Permission

Anoosha Ramanand  
103 Brixham Road  
Orient Heights  
Pietermaritzburg,  
3201.  
23 May 2013

The Hospital Manager  
Dr. K. Belinge  
Greys Hospital  
Private bag 9001  
Pietermaritzburg  
3200

Dear Sir

#### **RE: REQUEST FOR PERMISSION TO CONDUCT A RESEARCH STUDY**

I am currently registered as a Masters student at the Durban University of Technology in the Department of Nursing. The proposed title of my research study is: **The childbirth experience: a phenomenological exploration of its personal and cultural meanings for women from diverse traditions.**

I hereby request your permission to recruit participants (mothers) from the postnatal ward at Greys Hospital to participate in the study. My research proposal will follow for your perusal.

The study will require participants (mothers) to participate in a one to one interview session which will be conducted at their six weeks check up at their local clinic or the attending hospital. The interview will take place in a private room and will last for approximately one hour. Participation is voluntary, and a written informed consent will be obtained from all participants. Confidentiality will be maintained at all times. The

**Reference: Research**  
**Enquiries : Dr K B Bilenge**  
**Telephone : (033) 897 3321**  
7 June 2013

Mrs A Ramanand  
103 Brixham Road  
Orient Heights  
**Pietermaritzburg**  
3201

Dear Mrs Ramanand,

**RE : PERMISSION TO CONDUCT RESEARCH STUDY-**


**The childbirth experience: a phenomenological exploration of its personal and cultural meanings for women from diverse traditions.**

I have pleasure in informing you that permission has been granted to you by the Hospital CEO to conduct the above research Study.

Please note the following:

1. Please ensure that you adhere to all the policies, procedures, protocols and guidelines of the Department of Health with regards to this research.
2. **This research will only commence once this office has received confirmation from the Provincial Health Research Committee in the KZN Department of Health.**
3. Please ensure this office is informed before you commence your research.
4. The Hospital will not provide any resources for this research.
5. You will be expected to provide feedback on your findings to the Hospital CEO.

Regards,



---

**DR K. B. BILENGE**  
**CHIEF EXECUTIVE OFFICER**  
**GREYS HOSPITAL**

## Hospital (3)

### Appendix 3(c): Letter of Permission

Anoosha Ramanand  
103 Brixham Road  
Orient Heights  
Pietermaritzburg,  
3201.  
23 May 2013

The Hospital Manager  
Mrs F. M. Du Preez  
Northdale Hospital  
Private bag X 9006  
Pietermaritzburg,  
3200.

Dear Madam

#### RE: REQUEST FOR PERMISSION TO CONDUCT A STUDY

I am currently registered as a Masters student at the Durban University of Technology in the Department of Nursing. The proposed title of my research study is: **The childbirth experience: a phenomenological exploration of its personal and cultural meanings for women from diverse traditions.**

I hereby request your permission to recruit participants (mothers) from the postnatal ward at Northdale Hospital to participate in the study. My research proposal will follow for your perusal.

The study will require participants (mothers) to participate in a one to one interview session which will be conducted at their six weeks check up at their local clinic or the attending hospital. The interview will take place in a private room and will last for approximately one hour. Participation is voluntary, and an informed consent will be obtained from all participants. Confidentiality will be maintained at all times. The participant's identity will remain confidential whereby pseudonyms (different names) will be used for the information, and there will be no risks or discomfort. Please find attached a copy of my research proposal for your perusal.

Your cooperation will be greatly appreciated.

Yours faithfully

...  
Mrs A. Ramanand (Researcher)  
Contact Details: Cell: 0844332260  
Email: [anoosha.ramanand@gmail.com](mailto:anoosha.ramanand@gmail.com)

Supervisor: Prof. R Bhagwan  
Telephone: 031-3732197  
Email: [bhagwanr@dut.ac.za](mailto:bhagwanr@dut.ac.za)

Co-supervisor: Ms CN Adams  
Telephone: 0338459016  
Email: [carolinea@dut.ac.za](mailto:carolinea@dut.ac.za)





health

Department:  
Health  
PROVINCE OF KWAZULU-NATAL

**NORTHDALE HOSPITAL**  
Private bag x 9006, Pietermaritzburg, 3200  
1389 Dr Chota Motale Road, Pietermaritzburg, 3200  
Tel.033-3679000., Fax.: 033-3871990  
Email: Hlengiwe.grace@kznhealth.gov.za  
www.kznhealth.gov.za

---

Date: 29 May 2013  
Enquiries: Mrs F.M Du Preez  
Ref: Institutional Support

Mrs A. Ramanand

Dear Madam

**RE: PERMISSION TO CONDUCT RESEARCH AT NORTHDALE HOSPITAL**

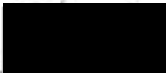
I have pleasure in informing you that permission has been granted to you by Northdale Hospital to conduct research on "The childbirth experience: A phenomenological exploration of its personal and cultural meanings for women from diverse traditions".

Please note the following:

1. Please ensure that you adhere to all the policies, procedures, protocols and guidelines of the Department of Health with regards to this research.
2. This research will only commence once this office has received confirmation from the Provincial Health Research Committee in the KZN Department of Health.
3. Please ensure this office is informed before you commence your research.
4. The Hospital will not provide any resources for this research.
5. You will be expected to provide feedback on your findings to Northdale Hospital.

Thanking you,

Sincerely

  
Mrs F.M Du Preez  
Chief Executive Officer  
Northdale Hospital

---

uMnyango Wezempilo . Departement van Gesondheid

*Fighting Disease, Fighting Poverty, Giving Hope*

## Appendix 4a



### LETTER OF INFORMATION

#### Dear Participant

Warm greetings to you. You are invited to kindly participate in my research study. The details are enclosed below.

**Title of the Research Study:** The childbirth experience: A phenomenological exploration of its personal and cultural meanings for women from diverse traditions.

**Principal Investigator/s/researcher:** Anoosha Ramanand

**Co-Investigator/s/supervisor/s:** Professor R. Bhagwan (Supervisor) and Mrs. C.N Adams (Co- Supervisor)

**Brief Introduction and Purpose of the Study:** The birthing experience is a significant, unique and exciting experience for every woman. All women experience childbirth differently. For some women it is a celebration and surprise, others may experience joy and happiness, others experience sadness and some find it to be a discovery. The purpose of this study is to explore the experience of childbirth and the unique personal and cultural meaning it has for women from different traditional backgrounds. It also endeavours to explore how this can be further enhanced towards a more positive and satisfying experience for women in the context of South African midwifery practice.

#### **Outline of the Procedures:**

Your hospital was selected to choose mothers from the postnatal ward to be part of the study. At least twelve mothers will be chosen over a period of time. You are kindly requested to take part in an interview session which will last for about one hour. You will receive light snacks for participating in the study.

Written permission has been granted from the Kwazulu Natal Department of Health, the District manager and the hospital manager to conduct the research study. This research study has been reviewed by the Faculty of Health Sciences and Higher Degrees Research Committee, and has received ethical clearance from the

Institutional Research Ethics Committee at the Durban University of Technology (DUT).

**Risks or Discomforts to the Participant:** There will be no harm, discomfort or victimization caused at any given time.

**Benefits:** This study will identify the significance and meaning of childbirth in women from different traditional backgrounds towards making recommendations for culturally sensitive midwifery education and practice. Nurses, midwives and doctors will become more aware and will have an understanding of different traditional practices of our society. The study will be utilized to promote more effective transcultural and midwifery care in the future.

**Reason/s why the Participant May Be Withdrawn from the Study:** Participation is voluntary. You have the right to withdraw from the study at any time and there will be no penalty.

**Remuneration:** Participants will receive light snacks with no remuneration.

**Costs of the Study:** None

**Confidentiality:** All information collected will be strictly private and confidential and will only be used for research purposes. A different name will be used for the information given so that your identity will remain confidential. A password protected file to safeguard the information for 15 years will be used and thereafter deleted. Any hard copies will also be stored in a safe place for 15 years and then shredded according to the DUT policy.

**Research-related Injury:** We are not expecting any form of injury or adverse events.

**Persons to Contact in the Event of Any Problems or Queries:**

**Supervisor:** Professor R Bhagwan, 031 373 2197 email bhagwanr@dut.ac.za

**Co-Supervisor:** Mrs. N. Adams, 0338459016 email carolinea@dut.ac.za

**Researcher:** Mrs. A Ramanand, 0844332260

email: anoosha.ramanand@gmail.com or you may contact the Institutional Research Ethics administrator on 031 373 2900.

**IREC Administrator:** Ms L Deonarain, 031 3732900, email lavishad@dut.ac.za



## CONSENT

### Statement of Agreement to Participate in the Research Study:

- I hereby confirm that I have been informed by the researcher, \_\_\_\_\_ (name of researcher), about the nature, conduct, benefits and risks of this study - Research Ethics Clearance Number: \_\_\_\_\_,
- I have also received, read and understood the above written information (Participant Letter of Information) regarding the study.
- I am aware that the results of the study, including personal details regarding my sex, age, date of birth, initials and diagnosis will be anonymously processed into a study report.
- In view of the requirements of research, I agree that the data collected during this study can be processed in a computerised system by the researcher.
- I may, at any stage, without prejudice, withdraw my consent and participation in the study.
- I have had sufficient opportunity to ask questions and (of my own free will) declare myself prepared to participate in the study.
- I understand that significant new findings developed during the course of this research which may relate to my participation will be made available to me.

---

**Full Name of Participant**

**Date**

**Time**

**Signature/Right Thumbprint**

I, \_\_\_\_\_ (name of researcher) herewith confirm that the above participant has been fully informed about the nature, conduct and risks of the above study.

Anoosha Ramanand \_\_\_\_\_

\_\_\_\_\_

**Full Name of Researcher** **Date** **Signature**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Full Name of Witness (If applicable)** **Date** **Signature**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Full Name of Legal Guardian (If applicable)** **Date** **Signature**

## Appendix 4b



### INCWADI YOKWAZISA

#### MBAMBI- QHAZA

Uyemukeleka ngezandla zombili. Ukubamba iqhaza ezifundweni zocwaningo lwami. Imininingwano yilawo alandelayo.

#### ISIHLOKO SESIFUNDO SOCWANINGO

Isipiliyoni sokubelethwa kimtwana. Inqgayizivele ngocwaningo oluyincazelo ngesiko – mpilo ngabesifazane ngikwehlukahlukana kwamasiko.

#### **INHLOKO YOCWANINGO / UMCUBUNGULI ANOOSHA RAMANAND ONGUMCUNGULI / NONGUSUPHAVAYISI. PROFESSOR R. BHAGWAN Usuphavayisi kanye no Mrs C.N. ADAMS UNGUMSIZI KA SUPHAVAYISI.**

Isiqalo esifingqiwe, kanye nenhloso ngqangi yesifundo: ubungoti obuyingqayizivele ekubeletheni, ubungoti obunobuchule ngolwazi lwabesifazane abanalo. Bonke abesifazane baba nolwazi oluhlukahlukene ngokubelethwa kwengane. Kwabanye besifazane bake bakuhalalise kuphinde kube yinto eyisehlakalo, kwabanye kube injabulo nento ejabulisayo, kwabanye kube wusizi nezinyembezi, futhi kube ukufunda okusha. Inhloso yalesisifundo ukucubungula ubungcweti bokuzalwa bengane nobuchwepheshe kanye nokuchazeleka ngesiko elinakho ngabesifazane ngokwehluka-hlukana kwamasiko. Kuwukuzama ukucubungula kabanzi ngocwaningo ngendlela egculisayo ngokuqukethwe yinhlangano yezokubelethisa yase Mzansi – Africa. (South African Midwifrey Practice)

#### **UKUHLELEKA KWENQUBO – MGOMO**

Sikhethiwe isibhedlela sakho ukuqoka omama kwi Post Natal Ward ukubamba iqhaza kulezizifundo. Kulesisikhathi samanye kuqokwe oMama abangu 12. Ngokuthobeka uyanxuswa ukubamba iqhaza kwizivivinyo ezizothatha 1hora (one hour) ngokubamba iqhaza kulezifundo kukhona

nezibiliboco eziyotholakala. Imvumo eshicilelwe isinikeziwe ngokusemthethweni umnyango wezempilo (Kwazulu Natal Department of Health)

Sikhethiwe isibhedlela sakho ukuqoka omama kwi Post Natal Ward ukubamba iqhaza kulezifundo. Kulesisikhathi samanye kuqokwe oMama abangu 12. Ngokuthobeka uyanxuswa ukubamba iqhaza kwizivivinyo ezizothatha I hora (one hour) ngokubamba iqhaza kulezifundo kukhona nezibiliboco eziyotholakala. Imvumo eshicilwe isinikeziwe ngokusemthethweni umnyango wezempilo (Kwazulu Natal Department of Health), umphathi wesifunda kanye nomphathi wesibhedlela ukuqhuba lolu cwaningo. Lolu cwaningo ngalesi sifundo lubuyekeziwe yi Faculty of Health Sciences kanye ne degrees Research Committee, yase Yamukela Impumelelo Enohlonze kwi Degrees Research Committee e Durban University of Technology (DUT)

#### UNGAZIZWA KAHLE NOBUNGOZI KOBAMBE IQHAZA

Abukho ubungozi, ukuhlukumezeka nokungazizwa kahle okungenzeka.

Inzuzo: lesifundo sizoqhakambisa ukubaluleka nencazelo ngokubelethiswa komuntu wesifazane ngokwehlukahlukana ngokwamasiko kanye nenkuliso maqondana nokwenza ukubelethisa. Abahlengikazi, Ababelethisi kanye noDokotela bazoqwasha kabanzi baqonde ngokwahlukahlukana nokwenziwa kwamasiko emphakathini.

Lesifundo siyosetshenziswa ukufafaza ngikuyikho kumasiko ezizwe ezehluka hlukene kanye nokunakekelwa koku belethiswa nango muso.

#### ISIZATHU UKUBA YINI NDABA ABUYE AKHISHWE UMBAMBI-QHAZA KULESIFUNDO

Ukubamba iqhaza kumele ovolontiye unelungelo lokuphuma, noma lokuyeka noma yinini lezifundo. Ngeke kube kube khona inhlawulo kumahala

## **IMALI EKHOKHWAYO: AYIKHO**

### **OKUYIMFIHLO:**

Lonke ulwazi oluqoqiwe luyo gconwa luyimfihlo, luyo setshenziswa ngesikhathi kwenziwa ucwaningo. Kuyosetshenziswa igama elehlukile kwelakho ukuze kungabonakali ukuthi nguweni ukuze sihlale sikugcine njenge mfihlo. Ifayela le password evikelekile ukuvikela okuyimfihlo iminyaka engu 15 isagciniwe futhi ivikelekile ngokuhamba kwesikhathi ibuye icishwe. Ezinye izinqwembe zamaphepha ziyogcinwa endaweni ephephile iminyaka engu 15. Ibuye isetshenziswe ngokwenqubo ka DUT.

### **Ucwaningo oluncikene nokulimala**

Usibhekile ukuba kube khona ubungozi noma ukulimala.

OKUMELE UTHINTANE NABO UMA KUKHONA INKINGA NOMA IMIBUZO.

- Isekela Lomphathi : Professor R. Bhagwan  
Ucingo: 031 373 2197  
Email: [bhagwanr@dut.ac.za](mailto:bhagwanr@dut.ac.za)
- Osiza isekela Mphathi : Mrs C. N. Adams  
Tel: 033 854 9016  
Email: [carolinea@dut.ac.za](mailto:carolinea@dut.ac.za)
- Umcwangingi : Mrs A. Ramanand  
Cell: 0844332260  
Email: [anoosha.ramanand@gmail.com](mailto:anoosha.ramanand@gmail.com) noma
- Uthinte I- Institute Research Ethics Administrator ku :031 373 2900  
IREC: umphathi: Ms L. Deonarain  
TEL: 031 373 2900 Email: [lavishad@dut.ac.za](mailto:lavishad@dut.ac.za)





## UKUVUMA

### ISITATIMENDE SESIVUMELWANO SOKUBAMBA IQHAZA EZIFUNDWENI ZACWANINGO

- Ngियाqinisekisa ukuthi ngaziwe ngumcwaningi .....  
(igama lomcwaningi)
- Uhlobo ukuziphatha inzuzo nobucayi bezifundo – Research Ethics Clearance number.
- Futhi ngiyitholile, ngayifunda ngase ngiyiqonda imininingwane, engena engenhla. (Incwadi yobambe iqhaza eneminingwane maqondana nezifundo.)
- Ngियाqonda ukuthi imiphumela yezifundo kanye nemininingwane yami maqondana nobulili, iminyaka yokukhula kwami, usuku lwami lokuzalwa, iziqalo zamagama ami ngeke kwaziwe. Kuyo Proseswa kube ngumphumela wezifundo.
- Okudingekayo ngalolucwaningo, ngiyavuma ukuthi I DATA ethathiwe ngesikhathi salezifundo siyo proseswa ngendlela ethize yomcwaningi.
- Nginegunya elisemthethweni ukushintsha noma, ukuvuma noma sengiziphophezele ekubambeni iqhaza kulezizifundo.
- Ngibe nethuba elanele lokubuza imibuzo ngokwami (ngalena kwenkinga) ngibe futhi ngizimisele ukubamba iqhaza kulezizifundo.
- Ngियाqonda ukuthi uma kukhona okusha osekitholakele ngesikhathi salolu cwano maqondana nokubamba kwami iqhaza kuyomele kuhlale kutholakala ngaso sonke isikhathi uma ngikudinga.

Amagama aphelele ombambi qhaza

usuku

sikhathi

---

Ukusayina /Ukebeka isithupa sokudla

Mina Anoosha Ramanand igama lomcwaningi ngiyaqinisekisa ukuthi lombambi qhaza ongenhla uchazelwe ngokwanele mayalana nohlobo, nobungozi ngalezizifundo ezingenhla

---

Amagama aphelele omcubunguli (uma kudingeka)

Usuku

---

Ukusayina / ukubeka isithupa sokudla

---

Amagama aphelele kafakazi (uma kudingeka)

Usuku

---

Ukusayina / ukubeka isithupa sokudla

---

kudingeka) Amagama aphelele ka mbheki (uma Usuku

---

Ukusayina / ukubeka isithupa sokudla

## Appendix 5

### Research Title:

**The childbirth experience: a phenomenological exploration of its personal and cultural meanings for women from diverse traditions.**

### INTERVIEW GUIDE FOR MOTHERS

1. Can you share with me your experience of childbirth?

**Probe:** When that happened, explain how you felt?

2. How would you describe this event personally? - - - - (and in relation to family)

3. What would you say were the pleasant things about your experience?

**Probe:** You mentioned- - - - can you tell me more?

4. Can you describe how your faith tradition views childbirth?

**Probe:** Can you please elaborate?

5. Were your traditional views and beliefs respected during and after the delivery of your baby?

**Probes:** Tell me more - - - -?

How do you think- - - -?

6. What were some of the traditional practices and alternate and complementary medicines you used before and after birth?

**Probe:** You mentioned- - - - can you tell me more?

7. Can you indicate possible ways that the hospital can provide a more culturally sensitive birth experience?

8. Is there anything else you would like to tell me?

9. Would you mind being contacted again if the need arises?

**THANK YOU FOR YOUR COOPERATION!**

## Appendix 6



### INSTITUTIONAL RESEARCH ETHICS COMMITTEE (IREC)

1 August 2013

IREC Reference Number: REC 28/13

Mrs A Ramanand  
103 Brixham Road  
Orient heights  
Pietermaritzburg  
3201

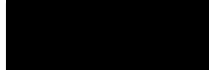
Dear Mrs Ramanand

**The childbirth experience: A phenomenological exploration of its personal and cultural meanings for women from diverse traditions**

The Institutional Research Ethics Committee acknowledges receipt of your final data collection tool for review.

We are pleased to inform you that the questionnaire has been APPROVED; you may now proceed with data collection on the proposed project.

Yours Sincerely



Prof J. K. Adam  
Chairperson: IREC