

**ZIMBABWEAN NDEBELE PERSPECTIVES ON ALTERNATIVE MODES OF
CHILD BIRTH**

by

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Dedication

*In memory of my beloved father,
Enoch Foster Mnaphi who made selfless
sacrifices for me to be educated and be a
health professional.*

STUDENT NUMBER: 3661-147-6

DECLARATION

I declare that **ZIMBABWEAN NDEBELE PERSPECTIVES ON ALTERNATIVE MODES OF CHILDBIRTH** is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references and that this work has not been submitted before for any other degree at any other institution.

Judith Audrey Chamisa.....

5th February 2011.....

Full names

Date

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ABSTRACT

The study explored cultural perspectives of the Zimbabwean Ndebele on alternative modes of childbirth. A qualitative generic, exploratory and descriptive design guided the study. The problem is that alternative modes of birthing are not acceptable to the Zimbabwean Ndebele. Women who give birth through alternative modes of birthing, which include caesarean section (CS) instrumental deliveries (ID) and any other unnatural modes are stigmatised. Data were collected from purposively selected samples of women who had given birth through alternative modes of birthing, spouses, mothers-in-law, community elders, *sangomas* (traditional healers) and traditional birth attendants (TBAs) using individual unstructured in-depth interviews, structured interviews and focus group interviews (FGIs). Data were analysed through use of qualitative content analysis which involved verbatim transcripts. Interpretations of narrations of data and script reviewing were done while simultaneously listening to audio-tapes which were transcribed in the IsiNdebele the language that was used to collect data. Data were then translated into English to accommodate all readers.

Accounts of all the informants that were interviewed point to effects of supernatural ancestral powers, infidelity and use of traditional and herbal medicines as cause for “tiedness” (labour complications), a concept that showed a strong thread throughout the study. Study findings illuminated that traditional practices are culture-bound and the desire is to perpetuate the valued culture.

Recommendations made from the study are; cultural orientation of local and foreign health workers, cultural consultation and collaboration with *sangomas* (traditional

healers) and particular recognition of the significance of the study as a cultural heritage of the Zimbabwean Ndebele society. Further research on how women and their spouses cope with the grieving process after experiencing the crisis and grief following CS is recommended. With all the recommended areas addressed, Zimbabwean Ndebele would find alternative modes of birthing acceptable.

KEY CONCEPTS

Alternative modes of childbirth; caesarean section; birthing; tradition; culture; religion; beliefs; practices; experience; perspectives.

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List of abbreviations

The following abbreviations will be used in the proposed study:

ANC	Antenatal care
AIDS	Acquired Immunodeficiency Syndrome
BEmOC	Basic Emergency Obstetric care
BEmONC	Basic Emergency Obstetric and Neonatal Care
CS	Caesarean section
FGD	Focus group discussions
HIV	Human Immune Virus
ID	Instrumental delivery
MNH	Maternal and Neonatal Health
NHS	National Health Strategy
PHC	Primary Health Care
PSI	Population Services International
STI	Sexually Transmitted Infection
TBA	Traditional Birth Attendant
UNISA	University of South Africa
WHO	World Health Organization
WRA	White Ribbon Alliance
ZDHSR	Zimbabwe Demographic Health Survey Report
ZMDG	Zimbabwe Millennium Developmental Goal

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CHAPTER 1

INTRODUCTION AND OVERVIEW OF THE STUDY

1.1 INTRODUCTION

For a majority of women around the world pregnancy and childbirth are normal, healthy and often happy and fulfilling experiences where various customs express celebration (Phumaphi 2005:48; Babaniyi 2006:41; Millender 2006:331; Johnson, Callister, Freeborn, Beckstand & Huender 2007:174). However, according to Laureate and Kendall (2009:1), discussing 'how to attain population sustainability' at the United Nations International Conference on Population and Development in Cairo, millions of mothers die each year from preventable complications during childbirth. Alternative (unnatural) modes of childbirth are accommodating in saving the lives of the mothers and the babies in some of these cases.

Although studies have been conducted on perceptions of childbirth through alternative modes of birthing; it is not recorded how the Zimbabwean Ndebele society views alternative modes of birthing. The study therefore set out to explore and describe cultural perspectives of Zimbabwean Ndebele society on alternative modes of birthing. In doing so, a vast treasure of cultural norms, values and rituals have been discovered. The intention is to, on completion of the study, formulate culturally accepted guidelines for the care of women who give birth through alternative modes of birthing and for their newborns as suggested by Saravanan, Turrell, Johnson and Fraser (2010:94).

1.2 SOURCE AND BACKGROUND OF THE RESEARCH PROBLEM

Globally, 200 million women become pregnant every year. Fifteen percent of these women are likely to develop complications that will require skilled obstetric care to prevent mortality and morbidity related to pregnancy and childbirth. In developing countries, Zimbabwe included, maternal mortality is the leading cause of death

among women of reproductive age (Reproductive Health Service Delivery Guidelines (RHSDG) 2001:23). According to the Zimbabwe Demographic Health Survey (ZDHS) (2005-2006:239), statistics show an alarming maternal mortality (MMR) rate of 555 per 100 000; the highest in the African continent. The ZDHS (2010-2011:278) states a maternal mortality ratio of 960 (expressed per 100 000 live births). According to the National Health strategy for Zimbabwe 2009-2013 “Maternal mortality levels are at an unacceptably high level of 725 deaths per 100,000 births (Zimbabwe Maternal and Perinatal Mortality Study 2007) with skilled attendance at birth declining from 73% in 1999 to 60% in 2009, and institutional delivery declining from 72% to 60% (MIMS) over the same period” (NHS 2009-2013:3). Although these figures vary, they do indicate an unacceptably high maternal mortality rate in Zimbabwe over a number of years.

In 2002, Zimbabwe was among the 189 Member States who attended the Millennium Summit that adopted the Millennium Declaration with eight interlinked goals to improve people’s lives by 2015. These include the reduction of the maternal mortality ratio by three quarters and the mortality rate of children under five years by two thirds. In a bid to achieve the targeted goals, the Ministry of Health and Child Welfare (MOHCW) in Zimbabwe recommended that all reproductive health clients, including pregnant women, should receive quality care at public health institutions. These are central hospitals, urban clinics, private hospitals, provincial and district hospitals to the lowest level possible, close to where women live in order to ensure safe assisted deliveries. However, the national statistical picture shows that since the 1990s, ante natal care (ANC) attendance and deliveries in institutions has been dropping because women still deliver at home; and yet 85% of the population in Zimbabwe lives within eight kilometres of a health facility (National Health Strategy (NHS) for Zimbabwe 1997-2007:xi, 26; RHSDG 2001:xx, 23).

Despite the high ANC coverage (94% of women going for at least one ANC visit), a significant number (32%) of women are still opting to deliver at home. In 2005/6 only 68% of pregnant women delivered their babies in the presence of a skilled attendant in Zimbabwe. This happened in spite of the fact that most primary level facilities with qualified nurses are able to offer Basic Emergency Obstetric and Neonatal Care (BEmONC). The majority of secondary as well as tertiary and quaternary level

facilities have the capacity to offer Comprehensive Emergency Obstetric and Neonatal Care (CEmONC); though operating times may not always meet the 24/7 criteria set by the World Health Organization (WHO) (Zimbabwe Maternal and Neonatal Health (ZMNH) Road Map 2007-2015:20).

The MOCHCW has also made joint efforts with the midwifery association in Zimbabwe, and with the Zimbabwe Confederation of Midwives (ZICOM), to emphasise (through the media) the importance of utilising ANC services and of delivering their babies at public health institutions. This attempt aimed to identify and treat or prevent risk factors during pregnancy and childbirth (ZTV 1, 2008. The news at eight. 29 July 2008, 20:00; Zimbabwe Television 1, 2008).

There is a direct correlation between the percentage of births assisted by a skilled attendant and maternal and neonatal survival (ZMNH Roadmap 2007-2015:20). Since 25% of obstetrical complications and deaths occur during delivery, and 60% immediately thereafter, it is critical to have skilled and equipped attendants present at the time of birth to attend to both mother and the baby (ZMNH Roadmap 2007-2015:20).

Pregnant women who do not access health care services miss the opportunity of being assessed and monitored for risk factors on time so that they can avert the consequences of the following three delays:

- delay in making a decision to seek care
- delay in the reaching the appropriate health care centre
- delay in receiving appropriate care at a health care centre

These delays aggravate infant and maternal morbidity and mortality (Saravanan, Turrell, Johnson & Frazer 2010:111).

Throughout the world, women who are giving birth are sometimes inevitably subjected to alternative modes of birthing, which might not have been an initial option to them. The mode of birthing varies depending on the reason for the

woman's inability to give birth normally. Operative deliveries, including instrument or assisted deliveries as alternative modes of birthing, are influenced by foetal presentation, maternal distress, foetal distress, cord presentation or any situation that might be threatening the life of the woman or her baby (McKinney, Ashwill, Murray, James, Gorrie & Drooske 2000:270). However, in the developed countries such as the Netherlands, the United Kingdom and the United States of America, women will sometimes opt to give birth by caesarean section (CS). Their reasons include avoiding intense birth pain in labour and reducing any risk that the baby might be subjected to. Another reason for opting for CS is that some women believe they are "too posh to push" (Weaver & Statham 2005:370-372).

It would appear that the decisions that women make in the above mentioned countries have no cultural implications. The women can choose to give birth through alternative modes of birthing, where there is no life threat from labour complications, with no socio-cultural implications and sanctioning.

1.2.1 The geographical location of Zimbabwe

Zimbabwe lies just north of the Tropic of Capricorn between the Limpopo and the Zambezi rivers. The country is landlocked, bordered by Mozambique on the east, South Africa, on the south, Botswana on the west and Zambia on the north and North West. It is part of a great plateau, which constitutes the major feature of the geology of Southern Africa. Almost the entire surface area of Zimbabwe is more than 300 meters above sea level, with nearly 80% of the land lying more than 900 meters above sea level and about 5% lying more than 1,500 meters above sea level (Zimbabwe Demographic Survey (ZDHS) 2005-2006:1; Population Services International ... 2007).



Figure 1.1: Map of Zimbabwe
(Map of Zimbabwe ... 2012)

1.2.2 Demographic data

In 2003, the United Nations estimated the population of Zimbabwe at 12 891 000. In 2008, five years later, Zimbabwe's population stood at 12 million (ZDHS 2005-2006:1). The drop in the population growth is attributed to the loss of lives due to the human immune virus (HIV) and the acquired immunodeficiency syndrome (AIDS), political unrest and migration which has caused migration to neighbouring countries and abroad to either seek employment or refugee status (Population Services International ... 2007). The Ndebele people are concentrated in the South-western Zimbabwe and North-eastern South Africa. In Zimbabwe, (where they are also known as Matebele), they constitute the largest ethnic minority after the Shona majority (71%) accounting for about 16% of the total population, and the rest (13%)

are mixed tribes. Surprisingly the ZDHS (2010-2011:2) still reflects the 2002 Central Statistics Office's (CSO's) population estimate of 11 632 000.

1.2.2.1 Household population and characteristics

According to the ZDHS (2005-2006:9), 52% of the population are female and 48% are male. The ZDHS (2010-2011:18) states 55.4% are males and 44.6% females of the total Zimbabwean population. There are larger numbers of the population in the younger age groups than in the older age groups of each gender, particularly in rural areas. The number of children under five was less than the number aged 5-9, and the population of children under 15 years of age was around 44% in 2005-2006 and 42.8% in 2010-2011 while that of persons aged 65 and older was about 5% for the period 2005-2006 and 4.5% during 201-2011 (ZDHS 2005-2006:9; 2010-2011:17). According to these statistics the larger numbers of younger age groups in both genders is an indication that there is a need for midwives to equip these groups with reproductive health information to enable them to appreciate alternative modes of birthing at this early age.

1.2.2.2 Education attainment

Education is an important factor that influences an individual's attitude and outlook on various aspects that have a significant impact on life. Generally, education attainment in Zimbabwe is higher in men than in women; 71% of men and 63% of women attended secondary school or higher education. Rural people are less educated than their urban counterparts; 49% versus 85% and these statistics are similar across the ten provinces of Zimbabwe (ZDHS 2005-2006:47). It should be noted that literacy assessment in Zimbabwe is associated with positive health outcomes. However, even with the high literacy rate of 95% among men 95% and 91% among women, the Zimbabwean society remains predominantly traditional; particularly men (ZDHS 2005-2006:25). This may be indicative of a need to conduct research into the acceptance of alternative and thus, unnatural ways, of giving birth; ways that are for the larger part stemming from a Western medical and scientific culture. These tendencies are also evident from the ZDHS (2010-2011:22) with an

overall of 94% male aged 6 and above and 91% females aged 6 and above having attended some school education.

1.2.2.3 Fertility

Zimbabwe experienced a decline in fertility of almost 2% over the past two decades with the fertility rate falling from 5.4 births per woman at the time of the 1988 ZDHS to 3.8 births at the time of the 2005-2006 ZDHS survey (ZDHS 2005-2006:xix). The total fertility rate for Zimbabwe 2006 was 3.8 children per woman during 2005-2006. Peak childbearing occurs during ages 20-29 years dropping sharply after 34 years. Fertility among urban women is substantially lower (2.6 children per woman) than among rural women (4.6 children per woman) (ZDHS 2005-2006:48). It should be noted that educational attainment is closely linked to women's fertility. Seemingly, education affects health seeking behaviours, which in the case of the current study includes choices of the place of birth and mode of delivery. These decisions might be influenced by tradition, as discussed in the preceding paragraph. The ZDHS (2010-2011:69) indicates a total wanted fertility rate of 3.4 children, compared with the actual fertility rate of 4.1 children.

1.2.3 General structure of the health services in Zimbabwe

In 2002 the MOHCW reaffirmed its commitment by developing the Health Sector Reforms Strategy to improve the quality of health care services by increasing access of quality care to disadvantaged groups, including all the women in the childbearing age group. All women are expected to utilise the health care services available to them, regardless of their socio-cultural standing, views and beliefs.

Some of the government's commitments included improvements in the distribution of resources to priority activities, and the management and use of the resources that have been allocated (Health sector reforms, Ministry of Health and Child Welfare 2000:1; National Health Strategy (NHS) for Zimbabwe 1997–2007:30). The point of emphasis in the implementation of the decentralisation of health services is that it ensures that women with complicated labour can be assisted in time to save their lives and that of their newborn babies through use of alternative modes of birthing.

Despite the noble commitment by the Zimbabwe government, many women continue to deliver their babies at home. These women might not understand that sometimes medical interventions during childbirth are inevitable, as some labour complications might be unpredictable; hence the current study.

1.2.3.1 Decentralisation

The reorganisation of Zimbabwe's Health System strengthened the services' operations, although in essence the authority and control over resources remained with the Ministry's headquarters (NHS 1997-2007:30). The establishment of Provincial Medical Directors in each of the provinces and the seven provincial hospitals assumed tertiary care in provinces. This revised structure saw the introduction of selected specialist services. Maternal and child health (MCH) services are also included in the specialist services, and these comprise ANC, delivery, postnatal care and family planning services, available at health care centres. The inclusion of MCH services in provincial hospitals was to enhance the hospitals' role in the referral process within each province. Pregnant women who do not seek these services risk incurring unforeseen complications during the antenatal, intrapartum, and postnatal periods and sometimes throughout their reproductive years.

Training of staff members about reproductive health is also an important aspect of reproductive health care services. The training component is in accordance with the Reproductive Health Policy developed in 2003. This policy forms the framework for providing integrated maternal health, family planning, HIV and AIDS and Sexually Transmitted Infection (STI) services in Zimbabwe. Training of staff members about BEmOC and BEmONC was cascaded to all provinces in order to reduce maternal and neonatal mortality rates as well as to equip staff members with skills to avert labour complications early enough to be able to save women's lives by instituting alternative modes of childbirth (Zimbabwe Millennium Development Goals (ZMDG) 2004 progress report 2004:35, 41; Zimbabwe Maternal and Neonatal Health (ZMNH) Roadmap 2007–2015:iv).

Below the provincial level, the district level was established through the integration of all district activities. These were under the control and supervision of district health executives. From an organisational and managerial point of view, the district is the

basic planning unit in the public health sector in Zimbabwe. The 34 government district hospitals dotted throughout the country offer secondary level care (first line referral) (NHS for Zimbabwe 1997-2007:30). Some of the districts which have no government hospitals are supported by designated mission hospitals in these districts.

According to the NHS for Zimbabwe (1997-2007:31), Zimbabwe Millennium Development Goals (ZMDGs) 2004 progress report (2004:41), the major function of the district level hospital is to support and supervise a network of 7 000 village community workers, community and public health personnel and 1 276 facilities operating at community or 'primary care' level. At this level, 17.6% of births are attended by a traditional birth attendant (TBA), and 6.3% by a relative or other person who might unexpectedly find herself faced with an unpredictable situation of a woman giving birth. Data worldwide confirms this statement that by choice or out of necessity, 47% of births in the developing world are assisted by TBAs and/or family members. For this reason, the MOHCW saw it fit to include a training programme for TBAs to equip them with basic skills and knowledge of when to refer their clients to a health care centre in the event of a complicated delivery (Saravanan, Turrel, Johnson & Fraser 2010:93).

As part of the district health system, the primary level plays an important role in the primary health care approach by offering preventive, promotive, and curative as well as rehabilitation services. Four central hospitals in the country serve as major referral centres. In principle, the clients are required to present at the primary level first and then be progressively referred to the secondary level, then the tertiary level right through to the quaternary level, depending on the complexity of the complications or illness. The referral system is a strategy which is in line with the Maternal and Neonatal Health Roadmap of Zimbabwe (MNH Roadmap 2007-2015:3).

1.2.3.2 *Maternal health care services in Zimbabwe*

The health care services in Zimbabwe generally reflect decentralisation with a focus on primary health care (PHC).

1.2.3.2.1 *Background to antenatal care*

Mathole, Lindmark, Majoko and Ahlberg (2003:123) note that the antenatal care (ANC) programme in Zimbabwe was initially designed in Europe during the first decades of the 20th century. The programme was first directed at women in socially difficult living conditions, with the definite objective of improving maternal and prenatal outcomes for the least privileged groups who included Zimbabwean Ndebele women.

Currently the health care system in Zimbabwe is characterised as pluralistic because of the co-existence and the concurrent use of traditional and biomedical practitioners. *Sangomas* (traditional healers) as well as TBAs play an important role in the provision of health care. The health care provided by sangomas and TBAs is popular as it is believed, culturally, to have better health outcomes than care provided in facilities offering Western medical care (Saravanan, Turrel, Johnson & Fraser 2010:94; Mukumbura 2000 cited in Mathole 2006:17). Due to the poor economic situation in Zimbabwe, which has led to the exodus of highly skilled health personnel and high hospital costs as well as shortage of essential drugs, people are forced to turn to traditional care (Matua 2004:34; Ncube 2003 cited in Mathole 2006:19; Nyazema 1992, Mukumbura 2000 cited in Mathole 2006:17).

Socio-economic issues, cultural beliefs and views about pregnancy and childbirth seem to influence women's utilisation of ANC series and also their choices of services during labour. Matua (2004:35) confirms this assertion; which is one of the reasons that led the researcher to the decision to conduct this study.

In the ANC model of care, pregnant women with probability of high risk are identified and referred to a health care centre for specialised monitoring (Mathole 2006:6). It is important therefore, to note that ANC is a widely used strategy for improving maternal health by preventing and treating pregnancy-related conditions as well as detecting risk factors that could lead to complications during delivery. Caesarean section, or any other non-natural or assisted means of childbirth, is necessary where there are risks or complications in pregnancy and childbirth in order to reduce

maternal morbidity and mortality – an important MDG which most countries aim to achieve, Zimbabwe included.

In Bulawayo, maternity health care services are provided by government referral maternity hospitals, primary health care centres (PHC), private hospitals, doctors' surgeries and nursing homes. Statistics of ANC coverage show that 14 326 pregnant women attended ANC at Bulawayo's 18 urban PHCs in 2005 compared to 11 693 in 2004. The attendance translates to an ANC coverage of 52% (City of Bulawayo Annual Report 2005:21).

Delivery registers reviewed at Bulawayo's two major maternity hospitals reveal that; out of a total of 4 550 women who delivered over a period of six months (January to June 2008), only 464 (10.2%) attended ANC. The low percentage of ANC attendance at the major referral hospitals is due to the fact that as referral centres, the hospitals only receive referred clients "booked" at the referring clinics or PHC. However, the hospitals do attend to those who present at the last minute for delivery or emergencies in an effort to reduce maternal mortality and morbidity rates.

The common practise is that health care providers at lower levels of the health care system refer clients to the two major central hospitals for delivery when there are life threatening complications. At this point, the number of women who did not attend ANC would not be reflected as all clients will be "booked" at the time of referral. Clients are only referred for complicated deliveries to avert maternal and neonatal mortality.

The Zimbabwe Ndebele society needs to understand that one of the main reasons for conducting non-natural deliveries is to reduce maternal mortality and this objective of reducing maternal mortality should override cultural beliefs and taboos. All ANC providers utilise the new goal-oriented ANC package, introduced to change the ANC routine, using the ANC goal-oriented approach adapted and adopted from the WHO goal-oriented guidelines (Ministry of Health and Child Welfare RHSDG 2001:25, Ministry of Health and Child Welfare delivery registers January-June 2008).

ANC in Zimbabwe, reached a coverage of 96% in 1988, but has been declining since the 1990s. According to the ZNHS (1997-2007), ANC coverage had dropped to 75% by 1997 and 70% by 2000. The drop in ANC coverage could be a result of multi-focal issues which may include cultural beliefs, rises in costs for maternity services and seeking services from TBAs.

Despite the above mentioned available services, it is not clear whether the Zimbabwean Ndebele community understands what the benefits of utilising available health care facilities are. Their views and beliefs about non-natural births might be so strong that they might be unable to consider other views, whatever the obstetric outcome, which is what this study attempted to explore.

1.2.3.2.2 Goal oriented antenatal care (GOANC)

GOANC is a service package based on the evidence based practice model adapted from the WHO goal oriented guidelines. The ANC model focuses on objective oriented activities with emphasis on essential elements of ANC that have been shown to improve pregnancy outcomes. The WHO model recommends four to five goal oriented ANC visits during the course of pregnancy where there are no risk factors as compared to 12-14 routine ANC visits that were prescribed in the traditional ANC model (MOHCW RHSDG 2001:25) .

During the first visit, the pregnant woman's history is taken and risk factors are assessed, these include assessment whether the woman will be able to give birth normally or would require a CS if abnormal or obstructed labour is anticipated or as determined by the size of the baby in relation to the maternal pelvis. However, it would appear that tradition and culture do not consider or rationalise the above mentioned physical challenges a woman might be facing during labour; hence this study.

At subsequent visits, routine procedures, including blood pressure measurements, abdominal palpations together with foetal heart auscultations, and examinations for oedema, height measurements and urine analyses are performed. Those women at risk can be identified and screened since even if a woman has received optimum

ANC and is correctly identified as being at risk; she might not receive appropriate care during delivery, and this might necessitate an alternate mode of delivery (Zimbabwe MNH Roadmap 2007-2015).

ANC is more beneficial in preventing adverse pregnancy outcomes when it is sought early in pregnancy and is continued through to delivery. According to Mathole (2006:23), in rural Zimbabwe, women are expected to report to the nearest ANC clinic (often a rural health care centre) early in pregnancy preferably before the 12th week of gestation. Those with risk factors are referred to the district hospital for further expert management. This management might include alternative modes of birthing in the event of obstructed labour or any other labour complication that warrants non-natural birthing.

According to the ZDHS (2005-2006:121), 94% of the women who had a live birth during the five years preceding the survey, had at least one ANC visit. Seventy one percent had four ANC visits or more and 21% had two to three visits; bringing the ratio between those who attended ANC and those who never attended to 1:16. Women in urban areas were more likely to have four or more visits than those living in rural areas; 76% and 69% respectively (ZDHS 2005-2006:121). The survey also revealed that 96% of the women with one child, and 87% of women with six or more children, received health care from a health professional who is a doctor or a nurse. ANC coverage from a provider who is a doctor, a nurse or midwife is slightly higher in urban areas than in rural areas at 96% and 93% respectively. ANC is lowest in Manicaland province with 88% of women receiving ANC from a doctor, a nurse or midwife and 10% of the women receiving no ANC at all.

According to Eugillion (2004), the reason for low coverage in the Manicaland province in Zimbabwe is that 60% of the 60,000 annual deliveries in the Manicaland Province of Zimbabwe occur at home (Training TBAs in Manicaland, Zimbabwe ... 2008). Non-utilisation of health facilities for delivery purposes may be influenced by cultural beliefs, fear of forced CS and sometimes the health care provider's attitudes and the high costs for maternity services (Finger 2003:13; Awfung 2004:27; Matua 2004:34; Nyazema 1992, Mukumbura 2000 cited in Mathole 2006:17, Ncube 2003 cited in Mathole 2006:19).

In all other provinces (excluding Manicaland), including Matebeleland, where the Zimbabwean Ndebele population is concentrated, ANC from a doctor, a nurse or midwife ranges between 93% and 97% of women. It is not clear whether the objectives of the women to attend ANC were focused on the prevention of adverse pregnancy outcomes. Other reasons for women attending ANC are to obtain a birth certificate for the child (ZDHS 2005-2006:239).

ANC services in Zimbabwe are provided at gazetted maternity fees according to level of care. The charges, however, varies depending on the level of care and type of delivery and also increase frequently because of the inflationary situation in Zimbabwe. The different levels of care include government hospitals, urban PHC and rural council clinics. Charges for urban PHC are similar to government hospitals whilst the rural council clinics have a lower charge with private surgeries charging much more than government to cover ANC and delivery. These charges might make ANC services inaccessible to some women and might be a deterrent for delivering their babies at health care institutions. Women, who are unable to access ANC services miss the opportunity of being assessed and monitored for at risk factors on time.

They are also more likely to suffer complications during delivery compromising their chances of experiencing safe motherhood (see Appendix L). In addition, Finger (2003:13), Awfung (2004:27), and McCallum (2005:218) conclude that unfriendly attitudes, and sometimes abusive language of health professionals, including midwives in most developing countries, have been responsible for the decline in the general use of hospital based care.

The above assertions are indications that cultural views of the population of Zimbabwe might influence women's decisions about alternative modes of birthing. This could impact negatively on the government's principle of providing quality and equitable health care services meeting the expectations of the WHO ANC goal-oriented model. Women who do not attend ANC might encounter obstetric complications necessitating unnatural birthing processes. These women might prefer delivering their babies in their own environments and in the process could be

exposed to a high risk of maternal and neonatal mortality and morbidity, negating the reproductive health objective and the MGDs of “Achieving universal access to reproductive health by 2015 ...” (World Summit Outcome 2005) to which Zimbabwe subscribes.

Other studies suggest that women’s decisions to seek maternity health care are influenced by a variety of factors such as the need to be assured of access to care during labour. This might influence women’s type of delivery opted for; operative or instrument delivery being the most appropriate in some emergencies. Cultural perspectives on alternative modes of birthing would also influence the woman’s delivery options (ZDHS 2005-2006:127). According to van der Hulst, van Teijlingen, Gouke, Bonsel, Eskes and Bleker (2004:29) and Johnson et al (2007:171), women who choose to give birth at home have fewer obstetric interventions and referrals to secondary care. In Zimbabwe, 32% of women are still giving birth at home (Zimbabwe MNH Roadmap 2007-2015:20). The fear of medical/surgical interventions in the event of labour complications is that there would be stigmatisation following unnatural birthing which could compromise their womanhood and status in society (McMallum 2005:224).

1.3 STATEMENT OF THE RESEARCH PROBLEM

In 2002, Zimbabwe was among the 189 member states that attended the Millennium Summit that adopted the Millennium Declaration with eight interlinked goals to improve people’s lives by 2015. These include the reduction of the maternal mortality ratio by three quarters and the mortality rate of children under five years by two thirds.

In a bid to achieve the targeted goals, the Ministry of Health and Child Welfare (MOHCW) of Zimbabwe recommends that all reproductive health clients who include pregnant women should receive quality care at public health institutions. Despite the high ANC coverage of 94% of women going for at least one ANC visit, 32% of women are still opting to deliver at home and in the process are exposed to a higher risk of maternal mortality and morbidity which negates the reproductive health objective and the MGDs of “Achieving universal access to reproductive health by

2015 ...” (World Summit Outcome 2005) to which Zimbabwe subscribes. However, the current economic situation in Zimbabwe has led to total collapse of the health care system resulting in the exodus of highly skilled health personnel, high hospital costs as well as shortage of essential drugs.

This forces pregnant women not to attend ANC and to deliver at home with the possibility of risk factors not being identified in time, resulting in either emergency caesarian section (CS) or even mother and infant mortality.

It is against this background that it became imperative for this study to be undertaken in order to answer the central research question: “What are the Zimbabwean Ndebele perspectives on alternative modes of giving birth/birthing?”.

1.4 RESEARCH PURPOSE

This qualitative study of Zimbabwean Ndebele society aimed at generating an understanding of the perspectives and meanings attached to alternative modes of birthing.

1.4.1 The research question

The following research question stems directly from the problem statement:

What are the Zimbabwean Ndebele perspectives on alternative modes of child bearing or birthing; to non-natural and non-traditional birthing?

This question was adapted so that it became pertinent to the participants from the different stakeholders (populations) involved in the current study.

1.4.2 Research objectives

The main objectives of the study were to:

- Explore and describe women’s perceptions on alternative modes of childbirth.

- Establish different stakeholders from the Zimbabwean Ndebele's perspectives on alternative modes of birthing.
- Determine the cultural factors that influence societal views towards unnatural modes of birthing.

1.5 SIGNIFICANCE OF THE STUDY

The conclusion and recommendation of the study (chapter 5) illustrate the significance of the current study. However, the envisioned significance of the study that also partially prompted the researcher to embark on the research, include the assumption that the results of the study could be utilised to:

- Develop culturally acceptable guidelines for specialised care for women and their neonates according to mode of birthing – guidelines that will advance:
 - Alternative modes of birthing without people feeling stigmatised for infidelity (as is the current cultural perspective in Zimbabwe) or being viewed as inferior to those women who delivered their babies naturally.
 - Women's self-image even after having given birth through alternative modes.
 - Visiting and giving birth at health centres without fear of medical interventions in the event of labour complications. This should promote the achievement of the MGDs four and five.
- Develop education programmes that will inform the Zimbabwean Ndebele community on the necessity and need for the use of unnatural or alternative modes of child bearing and birthing to ensure survival of women and their newborn babies regardless of their traditional perceptions on these modes of birthing.

1.6 DEFINITION OF KEY CONCEPTS

The following are terms used in the study:

1.6.1 Alternative birthing

This refers to any mode of birthing other than natural or normal birthing including instrument delivery and breach delivery. Also referred to as unnatural birthing

1.6.2 Childbirth/delivery of the baby/birthing

It is the moment when the foetus, followed by the placenta, exits the mother's body. The process is also called labour and is defined as the culmination of a human pregnancy or gestation period with the delivery of one or more newborn infants (Pregnancy and childbirth ... 2007; Childbirth/delivery of the baby ... 2008; The American Heritage Dictionary of the English language ... 2008). In the current study, the word childbirth was used in place of delivery, although in some instances delivery is used where the word childbirth is not easy to apply. The Oxford English Dictionary's acknowledgement of the word "birthing" also applies. This word is also often used depending on the syntax demand and allowance.

1.6.3 Natural birth/normal delivery/vaginal delivery

Natural birth refers to the idea that women are able to give birth without medical intervention where the physician only assists the foetus's head out of the vagina when it becomes visible (McCallum 2005:224; McCandlish 2006:333; Normal delivery ... 2007). McCallum (2005:225) further classifies natural birth as normal birth and refers to a normal birth as a vaginal delivery.

The International Confederation of Midwives defines a normal birth as "A unique dynamic process in which foetal and maternal physiologies and psychosocial contexts interact ... the woman commences, continues and completes labour with the infant being born spontaneously at term ... without surgical, medical or pharmaceutical intervention, but with the possibility of referral when needed" (Duff 2009:280).

Considering the above definition, the understanding is that there is fluidity between the three terms being defined: natural birth, normal birth and vaginal delivery, and these are used interchangeably in the current study.

The World Health Organization (WHO) [Sa] states that a normal delivery is spontaneous in onset, low risk at the start of labour, and remaining so throughout labour and delivery. In addition the baby is born spontaneously in the vertex position (head first) between 37 and 42 completed weeks of gestation and mother and baby are in good condition.

1.6.4 Instrument delivery (ID)

According to McKinney et al (2006:461), the term refers to both forceps and vacuum extraction. These are techniques that assist the descent and rotation of the foetal head to be born as normal vaginal delivery (Klein et al 2004:435). In the current study, ID is considered as an unnatural mode of birthing and an alternative mode of birthing.

1.6.5 Breech delivery

It is the most common alternate delivery position in which the baby's buttocks are the presenting part, as happens in 4% of all births. This is a longitudinal lie with the baby's bottom, feet or knees entering the pelvis first (Tiran 2003 cited in Pairman et al 2006:689; Breech births and other positions ... 2007). During the current study, participants considered this alternative delivery position also to be "unnatural" and an "alternative mode" of birthing.

1.6.6 Caesarean delivery/section

This is when a woman is unable to deliver the foetus vaginally and the foetus is delivered surgically through an abdominal incision and uterine incision where the amniotic sac is opened and the baby is delivered through the opening. It is usually performed when a vaginal delivery would put the baby's or mother's life/health at risk; although in recent times it has been performed on request for births that would otherwise have been normal (McKinney et al 2006: 27; NHS Direct 2007 cited in Gould 2007:57; Pregnancy and childbirth ... 2007; Bennington ... 2008). During the

current study participants mostly had caesarian sections in mind, and deliberated this, when talking about alternative modes of birthing and unnatural birthing.

1.6.7 Culture

The term refers to the perspectives, practices and products of a social group, comprising the repertoire of learned ideas, values, knowledge, aesthetic preferences, rules and customs, ceremonies and ways of life characteristic of a given group (Cohen & Kennedy 2007:47; A definition of culture ... 2008; Culture ... 2008). “The culture of a society is the way of life of its members; the collection of ideas and habits which they learn, share and transmit from generation to generation” (Giddens 2001:22). Such “habits” and “ideas” are, as this thesis attests, plentiful with regard to pregnancy, child birth and associated issues.

1.6.8 Experience

Experience is defined as “to live through” (Thesaurus ... 2008). However, experience as a general concept comprises knowledge or skill in, or observation of, something or some event gained through involvement in the event (Merriam-Webster ... 2008). In the current study the term experience refers to those self-expressions that reveal perceived emotional, physical and psychological feelings evolving around labour, birth and infant caring. It includes personal inner feelings about the environment as well as individuals’ attitude. Experience means those self-expressions that reveal perceptual emotional feelings of women evolving around labour and alternative modes of birthing including the post delivery exposure to community and the socio-cultural interactions, as well as those of spouses, TBAs, community elders and sangomas.

1.6.9 Perception

Perception is defined as an organised process in which an individual interprets situations from an environment; draws subjective or personal inferences and conclusions from these in order to take certain actions or perform certain behaviours. It is a representation of what is perceived; the formation of a basic component, idea

or image. It is an interpretive process involved in forming an impression of a person or thing (Kimberly, Quinn, Macrae & Bodenhouse 2008:68; Perception definition ... 2008). With regards to the current study *perception* implies how the participants viewed and interpreted alternative modes of delivery in relation to culture.

1.6.10 Traditional midwife/birth attendant

Traditional birth attendants (TBAs), also known as traditional midwives, are primary pregnancy and childbirth providers who usually learn their trade through apprenticeship, although some might be self-taught. According to Mathole et al (2005:943), TBAs are a diverse group, including ordinary women who acquired their skills through learning from others and may only provide antenatal care but have knowledge of special herbs known to be important for cervical dilatation.

The second group described by Mathole et al (2005: 943), comprises those TBAs who are traditional healers/diviners who say they have supernatural powers to protect pregnant women against witchcraft, especially during the early period of pregnancy, because during that time pregnant women are believed to be most vulnerable. This category of TBAs can prescribe herbs known to be effective in stabilising early pregnancy. The third group comprises of TBAs known as prophets. This group is associated with the church and uses faith healing through prayer and holy water.

Truter (2007:58) and Saravanan et al (2010:95) concur that TBAs (*isiNdebele: ababelethisi*) are generally older illiterate woman who might be “community TBAs” or “family TBAs” who have learnt their midwifery skills through apprenticeship and have been midwives for many years and are highly respected for their midwifery and ritual expertise.

1.7 ASSUMPTIONS

Assumptions are statements that are taken for granted or considered to be true without proof or verification, often embedded in thinking and behaviour. Assumptions are basic principles on which research is based (Holloway 2004:289; Polit & Beck 2004:13; Burns & Grove 2005:39; Grove, Burns & Gray 2013:41). To this end ontological epistemological, axiological and methodological assumptions were posited.

1.7.1 Ontological assumptions

Ontology is “a branch of philosophy concerning the nature of being. It is related to assumptions about the nature of reality” (Holloway& Wheeler 2010:340). Ontology is concerned with social reality and the very nature of existence in people’s world in relation to their lived experiences; the way they tell their life stories and express their opinions of the phenomenon under study as was the situation the current study of the Zimbabwean Ndebele perspectives on alternative modes of childbirth. (Holloway & Wheeler 2010:21).

With regards to ontological assumptions, the only reality is that constructed by the individuals involved in the research. Reality is thus multiple, subjective and mentally constructed by the individuals. Subjectivity and values are inevitable and desirable (Polit & Beck 2006:15). In this regard it is assumed that:

- The Ndebele culture creates unique perceptions - collectively one of many realities also with regard to child birth.
- In the same vein the research creates a certain reality via interpretation and restructuring of the data as does the reader when reading these interpretations and presentations.

1.7.2 Epistemological assumptions

The term “epistemology” is made up of the Greek-derived term *episteme*, knowledge or science and logos, “knowledge”, information. Epistemology is concerned with the analysis of propositional knowledge “knowing that” without asking the “how” question and as such, qualitative research focuses on the process that is occurring as well as product outcome.

In this regard it is assumed that:

- The Ndebele culture provides “know that” propositional knowing, knowing that through the research intervention derives a “how” and a “why” element; an element of scientific knowledge.
- Linguistic and narrative knowledge (epistemology) derived through a controlled and systematic process of qualitative data gathering and analysis produces knowledge as “scientific” as statistical knowledge.
- Culture (tradition and customs) provides sufficient and efficient sources of accepted truth.
- Tradition and culture are efficient as a source of information as they provide a common foundation of accepted truth (Polit & Beck 2004:11).

1.7.3 Methodological assumptions

Methodological assumptions have to do with how knowledge is obtained during an inquiry. In qualitative research, the linguistic epistemology underlying the research paradigm, requires methods that will elicit exactly this. Different types of interviews, in the context of the current research, are indicated. The emphasis is on narrative information and qualitative analysis (Polit & Beck 2004:14).

During the current study, the researcher ensured that participants were interviewed in the local isiNdebele language so that they could express themselves using words that best expressed what their experiences and their meanings.

For the purpose of this study it was assumed that:

- In depth one-on-one interviews and focus group interviews would elicit the required information from participants about their lived situations.
- Axiomatic or ethical issues could be clarified through the data gathering methods utilised to enhance quality of the data through a process of dialogue and justification (Chinn & Kramer 2008:14).
- Personal knowing, and thus ontological issues, could be clarified through response and reflection (Chinn & Kramer 2008:14).
- Empirical (experiential and perceptual) knowledge could be clarified and elicited through qualitative confirmation and validation (adapted from Chinn & Kramer 2008:14).

1.7.4 Axiological assumptions

Axiology answers the question “what is the role of values in the inquiry?” Axiology relates to the axiom or assumption that subjectivity and value are inevitable (Polit & Beck 2004:14). In the current study, subjectivity is relied on as participants, relating their own experiences about cultural values and traditions, provided the information on which this study relied because traditions consist of “truths” or beliefs that are based on customs and past trends (Burns & Grove 2009:8)

With regard to the current research it is assumed that:

- Values are culturally founded and as such permeate all aspects of the research.
- Culture provides a frame of ethics relative to that of the researcher.
- Axiology is provided for by the data gathering methods as these allow for access to one’s (researcher’s and participants’) feelings, life-understanding convictions, commitments and beliefs.

1.7.5 Rhetoric assumptions

Rhetoric assumptions refer to the legitimacy of language within the research undertaking – that which is most fundamental about the language usage in a study (Assumptions ... 2012)

For the purpose of the current research it is assumed that:

- Personal voices of participants, their knowing, can be conveyed through their colloquial expression of their experiences relating to the research topic.
- The researcher translates colloquially expressed knowing into a more formally expressed academic style forming knowledge and a formal knowledge system within existing such systems.
- Qualitative rhetoric is different to that of quantitative rhetoric.
- Paradigmatic rhetoric exactness serves to illuminate the research project as a whole.
- Certain words from the Ndebele language might be so specific that they could not be translated into another language (such as English). These words can only be circumscribed in a foreign language and the actual terminology retained in data presentation (*in vivo*).

1.8 RESEARCH METHODOLOGY

Polit and Beck (2004:14) describe research methodology as a “plan or blue print of how you intend conducting the research”; while Burns and Grove (2005:211) refer to methodology as the entire strategy from problem identification to the final plans for data collection. The current research adhered to these definitions.

1.8.1 Research paradigm

According to Chinn and Kramer (2008:301), the term paradigm refers to: “A world view or overarching frame of reference. A paradigm implies standards or criteria for assigning value or worth to both the processes and the products of a discipline, as

well as for the methods of knowledge development”. A paradigm is a world view, a general perspective, a way of breaking down the complexity of the real world (Polit & Beck 2006:13). “Paradigms are also normative, telling the practitioner what to do without the necessity of long existential or epistemological consideration ...” (Pato 1978:203 cited in Lincoln & Guba 1985:15). The two major research paradigms currently adhered to in health research are the quantitative and qualitative paradigms. Table 1.1 summarises characteristics of qualitative research.

Focus of research	Quality (nature, essence)
Goal of investigation	Understanding, description, discovery, hypothesis generating
Design characteristics	Flexible, evolving, emerging
Setting	Natural, familiar
Sample	Small, nonrandom, theoretical
Data collection	Researcher as primary instrument, interviews, observation
Mode of analysis	Inductive (by researcher)
Findings	Comprehensive, holistic, expansive
Focus of research	Quality (nature, essence)

The current research was conducted within the qualitative paradigm. The researcher adhered to the outline in table 1.1. Qualitative research is a systematic, subjective approach used to describe life experiences and give them significant meaning. The qualitative research was chosen, in order to conduct an in-depth study into the everyday experiences of the Zimbabwean Ndebele society on alternative modes of birthing (Polit & Beck 2004:16; Burns & Grove 2009:51; Grove, Burns & Gray 2013:70). Qualitative research is a means of exploring in-depth richness and complexity inherent in phenomena (Schwartz-Barcott & Kim 1986 cited in Burns & Grove 2005:52; Burns & Grove 2009:51).

1.8.2 Research design

Mouton (2001:55 cited in De Vos, Strydom, Fouche & Delport 2005:132) defines a research design as “a plan or blue print for conducting a study” (Burns & Grove 2009:218; Grove, Burns & Gray 2013:692). The research design guides the researcher in planning and implementing the study giving an overall picture of what spells out the basic strategies and efficient methods that are used to obtain data

which helps in drawing inferences about a scientific phenomenon in order to answer the research question (Polit & Beck 2004:14; Burns & Grove 2005:211; Burns & Grove 2009:218; Grove, Burns & Gray 2013:692). However; strong advocates of the qualitative school, Denzin and Lincoln (1994:202 quoted in De Vos et al 2005:268) define methodologies such as ethnography, phenomenology and the biographical method as “strategies of enquiry or tools that can be used to design qualitative research”. Streubert Speziale and Carpenter (2011) also maintain this point of view. The current research design was a qualitative exploratory, descriptive and contextual design.

1.8.3 Research methods

The following section briefly discusses the methods and techniques that were adopted with regard to sampling and data collection. A complete discussion and substantiation follows in chapter 3.

Table 1.2 summarises the population and sampling of participants as well as the data gathering methods used for each sample from different populations all of whom hold either a culturally based perception of alternative (unnatural) child birth or actually having experiencing giving birth to a child “unnaturally”. The stakeholders in this research at the population level involved: mothers, spouses, community elders, TBAs and sangomas.

1.8.3.1 Sample selection

1.8.3.1.1 Participant sampling

Non-probability sampling was used in the current study to sample participants from different populations or stakeholders pertaining to the research topic. Table 1.2 summarises the selection of participants for the current research.

TABLE 1.2: SUMMARY OF PARTICIPANT SAMPLING FROM DIFFERENT POPULATIONS	
POPULATION/SAMPLE	SAMPLING TECHNIQUES
Women (mothers) who gave birth by unnatural mode of delivery within two months prior to the time of the study	Non-probability purposive
Spouses/fathers to babies born through non-natural modes of delivery	Non-probability purposive
Women who delivered unnaturally and who declined having their interviews being tape-recorded	Non-probability purposive
Traditional healers (Sangomas) with knowledge of Zimbabwean Ndebele cultural issues relating to child birth Had administered herbs at some stage to facilitate natural birth in case of a complicated delivery	Purposive snow-balling technique
Community elders looked upon by society as guides on cultural issues on birth to perpetuate the Zimbabwean Ndebele culture of <i>ubuntu</i> (humanness)	Purposive snow-balling
Traditional birth attendants who assist women in the community when giving birth	Non-probability purposive

1.8.3.1.2 Site sampling

The study was conducted in Bulawayo, the second largest city in Zimbabwe. Records were utilised from two purposively selected government referral maternity hospitals to follow up purposively identified participants in the community. One centre is located in the high density areas and the other in the low density areas. The two government maternity hospitals offer consultant specialist services which include alternative modes of birthing.

1.8.3.2 Data collection

In order to ascertain the perspectives and experiences of the participants, personal interviews and focus group interviews (FGIs) were conducted with the researcher being the main data collection instrument. In the current study, the researcher personally conducted both the unstructured in-depth face-to-face interviews and the semi structured interviews to elicit accurate first hand information. FGIs were also guided by the researcher. The interviews were tape-recorded, transcribed, interpreted and later translated from isiNdebele (the local language that was used to collect data during interviews) into English to allow the readers and other

researchers to read and understand what the participants were asked during interviews.

Population/Sample	Data collection method	Motivation	Research question
Women two months after giving birth unnaturally	Unstructured in-depth, face-to-face interviews	To gather information on individual lived experiences and views on alternative modes of birthing	What is your experience of giving birth through alternative mode of delivery and the community's reaction to this?
Women who delivered unnaturally and declined having their interviews being tape-recorded	Semi structured face-to-face interviews	To gather information on individual lived experiences and views on alternative modes of child birth	Specific questions Based on themes and categories that emerged from the analysis of interview data from those who were prepared to have an interview conducted and tape recorded
Men/spouses who would have fathered a baby born of an alternative mode of <i>delivery</i>	Unstructured in-depth, face-to-face interviews	To obtain information on individuals' experiences and views on alternative modes of birthing after fathering a child born through an alternative mode of delivery	What is your experience of fathering a child born through an unnatural mode of delivery? How do you view your wife following the unnatural birthing
Sangomas Traditional healers	Unstructured in-depth, face-to-face interviews	Sangomas were expected to share experiences of encounters with women as they manage and intervene during pregnancy and complicated labour	What are your views on woman opting for unnatural birthing from a cultural point of view? What can you do for women relating to unnatural child birthing?
Community elders	Unstructured in-depth, face-to-face interviews	Exploration of day-to-day experiences, perceptions, cultural views and opinions through listening to discussions and narrations	What are your views on woman opting for unnatural birthing from a cultural point of view
Traditional birth attendants (TBAs)	Focus group interview	Exploration of day-to-day experiences, perceptions, cultural views and collective opinions through listening to discussions and narrations	What are your views on woman opting for unnatural birthing from a cultural point of view

Table 1.4 provides detail on the number of interviews conducted.

Population groups interviewed	Initial interviews conducted	First return interviews	Second Return interviews	Third return interviews	Total number of interviews per group
Women	6	4	1	1	12
Men (spouses/fathers)	2	1			3
Community elders	4	2	1		7
<i>Sangomas</i> (Traditional healers)	3	2	1	1	7
TBAs	1(FGI)	1 (FGI)			2
Grand Totals	16	10	3	2	31

1.8.3.3 Data analysis

Data collection goes hand in hand with data analysis (De Vos et al 2005:335). The tape-recorded interviews were transcribed verbatim after which a language expert reviewed and verified translations of tape recorded interviews from IsiNdebele into English prior to data analysis. Data from notes of the semi-structured interviews were also interpreted and translated prior analysis.

Thematic analysis, according to Ezzy (Ezzy 2002 cited in Saldana 2009:Loc2775) allows categories to emerge from the data. Analysis entailed check of fit of codes and categories across the whole data set and related categories were combined. This was done to establish emergent themes (Research in brief 2003:233; Field & Morse 1985 cited in Burns & Grove 2005:57; Grove, Burns & Gray 2013:46). In addition, once the researcher acquainted herself well with the data via thematic analysis, the findings were further discussed in terms of Parse's Theory of Human Becoming to emphasize the paradoxical position in which pregnant women in the Ndebele culture find themselves should they not give birth in natural manner.

Information was subjected to credibility verification as indicated in table 1.5.

TABLE 1.5: STRATEGIES TO ENSURE TRUSTWORTHINESS	
STRATEGY	Measures taken
Credibility	Prolonged engagement with and persistent observation of different populations Using different data collection methods to fit the requirements of samples from different populations Reflective critique by members of the different populations Providing dense description of themes and categories that emerged from the data via data displays containing all data units pertaining to a category instead of making an anecdotal selection of single "outstanding" units
Dependability	Inquiry audit Using different data collection methods to suit the requirements of samples from different populations
Confirmability	An audit trail was left. Data units are all numbered and an audit can easily be conducted by tracing the unit by number and reading it in context should the need arise Peer examination of all data units and their relation and applicability with regard to the theme and category they are assigned to
Transferability	The dense description provided should assist in deciding on transferring the findings of this study

1.8.4 Ethical considerations related to data collection

Table 1.6 provides a brief summary of how the researcher attended to the ethical concerns relating to the current study. A complete discussion follows in chapter 3. The main points the researcher attended to are the basic ethical principles of autonomy, justice, beneficence and non-maleficance as these pertain to the participants, the "institutions" where the research was conducted, researcher's scientific integrity and domain specific issues.

TABLE 1.6: ETHICAL GRID/Framework

	AUTONOMY	JUSTICE	BENEFICENCE	NON-MALEFICENCE
DEFINITION	Holloway (2004:18) defines autonomy as all independent decision making of autonomous (informed and competent) participants	Right to fair treatment (Burns & Grove 2005:189; Grove, Burns & Gray 2013:164).	Doing good (Thesaurus ... 2008)	Doing no harm (Definition: non-maleficence ... 2008)
PARTICIPANTS	Participants should make informed decisions to consent to voluntary to participate Right to self-determination, respect and protection (Burns & Grove 2005:181; Grove, Burns & Gray 2013:171 & 302-3)	Protected by the Ethics Committee at UNISA and the Medical Research Council of Zimbabwe. See Appendices E, F & K respectively	Protection of participants, rights. Doing good and creating good rapport and comfort Maintaining anonymity, veracity, privacy and the like Afford participants equal opportunities. Possible benefits of the research were communicated to all participants	As for beneficence taking into consideration the more pertinent definitions of the two concepts of beneficence and non-maleficence
"INSTITUTIONS"	Hospitals were informed about the reason the names of former patients were needed "Elders" from different communities were involved in the research	Openness regarding research (proposal was presented to the institutions) undertaking to treat institutions fairly in terms of anonymity of participants treated by these institutions	Most of the beneficence probably relate to the improvement of communication between traditional and formal health knowledge systems The possibility of promoting both indigenous culture and western medicine	Accepting what informants offered as the truth. Not to be shocked or amazed at what they believe in and what they do culturally
MY SCIENTIFIC INTEGRITY AS RESEARCHER	Must be knowledgeable on ethical issues and include ethical considerations in order to make methodological decisions about rigor (Polit & Beck 2004:157) Protect the integrity of scientific knowledge by preventing fraudulent publications and fabricated research results (Burns & Grove 2005:207; Grove, Burns & Gray 2013:188)	The researcher should be just to self, data and participants Reflexivity assisted me in this regard	Acknowledge that the primary purpose of the research is of academic nature however the findings could also benefit the specific and even broader populations	To refrain from being inquisitive by keeping pertinently to the aim of the research

	Moral obligation to research. No plagiarism (Babbie & Mouton 2002:531; Van der Wal 2005:147) Should observe professional code of conduct			
ETHICS PERTINENT TO THE RESEARCH TOPIC	Respect for differing cultures. Allowing for colloquial language usage Respect the cultural norm and values	Respect to the traditional values of the society. Non-judgmental respect sacred issues.	Inform or disseminate findings should not be to the broader academic community only but also to health care institutions and the community	Confidentiality on cultural issues. Focus on the topic under study and not diversity avoid causing emotional and psychological trauma

1.9 LIMITATIONS OF THE STUDY

Interviews were conducted with women in the community two months after the unnatural delivery of their babies. During that period the women who had delivered unnaturally would have interacted with the community and would have been subjected to possible unfavourable treatment from their communities regarding alternative modes of birthing (Donkor 2008:22). However, during that period some women were not at their registered residences because women who delivered at referral centres were mostly referred from PHC and private surgeries some of which are outside the city and the women had left for their original homes.

Some women were not willing to have their interviews tape-recorded for fear of being reported to the health institutions where their babies were born as they still owed money. However, semi-structured interviews were then compiled with specific questions from the emergent themes from interviews that were held with the women who had consented to their interviews being tape-recorded.

It would be difficult to transfer the finding of the current research to other cultures, especially since the Zimbabwean Ndebele is a rather isolated group.

1.10 STRUCTURE OF THE THESIS

The study consisted of five chapters.

CHAPTER 1:	Introduction to, and overview of, the study
CHAPTER 2:	Literature reviewed
CHAPTER 3:	Methodology
CHAPTER 4:	Presentation of data
CHAPTER 5:	Interpretation of data in terms of the Theory of Human Becoming
CHAPTER 6:	Summary, conclusion and recommendations

1.11 CONCLUSION

This chapter serves as an overview and summary of the research report (thesis). The background to the research problem, the problem statement and ensuing research question and objective were linked and the research paradigm, design and methods (sampling, data collection and analysis) highlighted. Ethical issues were tabulated and perceived significance and limitations of the study alluded to. The rest of the report follows according to the layout presented in this chapter.

CHAPTER 2

LITERATURE REVIEW

2.1 INTRODUCTION

In all scientific research endeavours, the literature review should be the first step that a researcher undertakes. The literature review makes the problem clearer and therefore contributes towards interpreting data leading to a better understanding of the research topic under study. In this chapter, the researcher presents a review of literature on previous studies that relate to views, perceptions and different perspectives of societies on alternative modes of birthing outside of, and with regard to the Zimbabwean Ndebele.

In an attempt to investigate the phenomenon under study, the researcher utilised literature from both primary and secondary sources. These included journals, textbooks written by various authorities and research findings from previous research reports from articles as well as from the internet. Media archives were also utilised in order to access newspaper articles.

2.1.1 Exploring literature on qualitative research studies

Burns and Grove (2009:92) and Grove, Burns and Grey (2014:97) define literature review as an organised written presentation of what has been published on a topic by scholars. A review of literature is the way we learn what is known and not known about a certain topic. The literature review should be organised around the key concepts one wishes to study in order to have a clear understanding of the phenomenon of interest. Babbie (2007:489) and Holloway (2005:150) thus say the purpose of the literature review is to convey to the reader what is currently known regarding the topic under study.

Qualitative researchers have differing opinions about the extent to which the literature review should be used to guide the research study. Qualitative researchers do not all agree about the value of doing an upfront literature review. Some believe that the literature should not be consulted prior to collecting new data. According to Straus and Corbin (1998 cited in Holloway 2005:150), and Babbie (2007:489), their main argument is that reviewing literature prior undertaking studies might unduly influence their conceptualisation of the phenomenon under study. Researchers subscribing to this position, therefore, attempt to enter the setting unformed so that the phenomenon is elucidated based on the participants' viewpoints rather than on prior information, thus minimising the risk of working deductively (Polit & Beck 2006:68). Punch (2005:41), states that qualitative researchers should be able to make accurate and free decisions in the research settings. However, others believe that researchers should conduct at least a brief literature review at the beginning of the study.

Having explored the different view points on literature review in qualitative inquiry, in the current study, the researcher reviewed literature as an on-going process in order to use it as a guide. This also ensured that the researcher did not study an area which has been researched many times before so that her study adds new knowledge (Holloway 2005:150; Holloway 2010:Loc1146). Literature also informed the researcher of the global, regional and the Southern African people's views on alternative modes of birthing. This included views of other Zimbabwean societies who do not belong to the Ndebele people.

In this chapter, literature related to the study was reviewed focusing on the key concepts of the research problem. It should be noted, however, that most of the literature reviewed in the current study, mainly contains historical and original excerpts of cultural practices that have been perpetuated over decades and have not been polluted or changed; hence the use of not so recent references in some instances, because of its historical permanence. The reader's attention is pertinently drawn to the source by Krige (1937).

2.2 THEORETICAL CONSIDERATIONS OF BIRTHING

Birthing is a universal natural process, defined as the culmination of a human pregnancy or gestation period with the delivery of one or more newborn infants (Pregnancy and childbirth ... 2007; Childbirth/delivery of the baby ... 2008; The American Heritage of the English language ... 2008). It should be noted that in all African cultures, the Zimbabwe Ndebele culture included, the belief is that the purpose of having sex with a woman in marriage is procreation (Mariano 2004:262; Dube 2008; Comment on "breath of life" ZTV 1, The news at five.1 4 December 2008, 17:00; Donkor 2008:22). According to Mariano (2004:261) the evident accomplishment of sexuality is the birth of a child which awakens and renews the lineage and attests a man's potency. On the other hand, birthing gives the woman a new social status as well as identity. In the African culture in general, and in the Zimbabwean Ndebele in particular; until the woman bears a child, she is regarded as an incomplete person because she has not fulfilled all the life stages from infancy to motherhood as prescribed by culture (Mariano 2004:262).

2.2.1 Possible negative effects of natural birthing

The process of birthing has evolved over millennia to ensure the survival of the human species (Pairman et al 2006:102). Traditional birth attendants (TBA), also known as traditional midwives are a primary pregnancy and childbirth provider who usually learn their trade through apprenticeship, although some may be self-taught. According to Mathole et al (2005:943), TBAs are a diverse group, which includes ordinary women who acquired their skills through learning from others and may only provide antenatal care but have knowledge of special herbs known to be important for cervical dilatation.

Sometimes injuries to the pelvic structures occur during delivery as the baby negotiates passage through the birth canal, particularly in young adolescent mothers whose pelvic bones and physical structures are still immature (Ajayi, Garba & Ojo 2004:35). It is therefore important to note that in such instances alternative modes of birthing become inevitable as they are often performed in an emergency, giving no time for cultural consideration or medical intervention.

According to Ajayi et al (2004:35), the incidence of birthing related injury to pelvic structures could be quite high following a complicated natural delivery or can be infrequent but debilitating with such damage as the vesico-vaginal fistula (VVF); a linkage that develops between the vagina and the urinary bladder, results in girls and women, some as young as twelve years of age leaking urine uncontrollably through the vagina (Safe Motherhood Newsletter of World Activity 1999-2003). In Gambia, for example the prevalence of birthing injury as a result of complicated labour is 46%. In Sierra Leone, thousands of women suffer VVF; a common complication from obstructed labour which occurs in places where women do not have access to hospital services or emergency CS (Seibure & Glenwright ... 2007).

Studies done by the WHO in the Sub-Saharan Africa, in countries which include Zimbabwe, reveal that a vast majority of VVFs are due to obstructed labour. In Zimbabwe alone 2 million women have VVF as a result of obstructed labour (UNFPA cited in Ersodal, Verkuyl, Bjorklund and Bergstrom ... 2008). Other studies done in Nigeria (Murphy ... 1981) reveal that in Nigeria ninety percent (90%) of the long-term patients in the fistula ward at a University Teaching Hospital were childless. In a review of the literature, 82% of the patients with VVFs were from West Africa. In this situation where a woman has a VVF, she is left with constant leakage of urine from the vagina as a result of non-intervention in prolonged obstructed labour. To the woman this can be very embarrassing and psychologically traumatic as well as dehumanising and destructive to the self-concept. For this reason, she is often abandoned by her family and community because of the smell which is sometimes linked to superstitious beliefs (Seibure & Glenwright ... 2007).

In the researcher's experience, victims of VVF only surface from the community when they come to hospital seeking repair of the physical damage which could have been avoided through alternative modes of birthing. It is important to note that VVF is directly linked to maternal mortality. VVF involves a complex network of social issues (Wall, Arrowsmith, Briggs, Browning & Lassey ... 2000). Furthermore; distribution and availability of health care resources, perceptions about the nature and importance of health problems and socio-economic and political infrastructures also have a bearing on health seeking behaviours.

In a study done by Ajayi et al (2004:35) on obstetric complications of early marriages among women in Samaru and Zaria in Nigeria; findings reveal that complicated pregnancy and delivery were higher among those below the age of 15 years. In this study, a total of 70 (49.9%) of the respondents had one complication or the other during delivery which inevitably required medical intervention. The prevalence of common obstetric complications which also include VVF was higher among mothers who were less than 17 years of age. In the researcher's view point this could relate to the young girls who are subjected to early arranged or forced marriages in the culture of most African tribes which include the Zimbabwean Ndebele.

The risk of obstructed labour is among the more serious consequences in young age pregnancies because at that age a woman's pelvis may be too narrow for birthing. In most instances obstructed labour can also increase a woman's risk of VVF.

Obstructed labour is further complicated for women who undergo female genital mutilation (FGM), which doubles the risk of maternal deaths. According to Blum (2003 cited in Danda, Mudokwenyu-Rawdon & Mapanga 2009:74), psychological consequences such as postnatal depression occur in 10% to 15% in all deliveries and in 26% to 32% of adolescent deliveries.

Nearly 600 000 women in the world die from complications of pregnancy each year. For every woman of the 600 000 who dies about 300 more suffer injuries, infection and disability during pregnancy or child birth (The White Ribbon for Safe Motherhood 1999-2003; Gould 2007:57). Filippi et al (2006:60) point out that in Southern Africa, one in every 16 women dies in pregnancy or during birthing. This risk is 175 times higher than that in developed countries. Filippi et al (2006:60) further point out that this is but the tip of the iceberg as more women are estimated to suffer pregnancy related illnesses (9.5 million), near miss events where a woman nearly dies during delivery from birthing complications (1.4 million) and other potentially devastating consequences after birth. The consequences of maternal deaths on women and their families can be substantial, and recovery can be slow with lasting consequences.

In the researcher's view point; it would appear that although using alternative modes of delivery to save the life of the mother and that of the newborn by skilled personnel prevents most of the devastating complications, the Zimbabwean Ndebele society neither understand the reasons for complicated pregnancy nor the reasons for resorting to alternative modes of birthing. (This aspect also came out in the interviews and the analysis of the data). For this reason then, the research question: "What are the Zimbabwean Ndebele perspectives on alternative modes of birthing?"

In instances where the natural process is not possible or cannot be completed; assisted medical deliveries are resorted to as in alternative modes of birthing. Alternative modes of deliveries include operative deliveries; caesarean section (CS) and instrument deliveries (forceps and vacuum extraction). (NHS Direct 2007 cited in Gould 2007:57).

2.3 NON-NATURAL MODES OF CHILD BIRTH

Non-natural or "unnatural" and alternative modes of birthing are sometimes inevitable and may occur as an emergency such that there may be no time to consider cultural merits and demerits when the life of the mother or the neonate is at risk due to complications of labour.

2.3.1 Caesarean section

McKinney et al (2006:27; NHS Direct 2007 cited in Gould 2007:57) define caesarean section (CS) as surgical birth of the infant through an incision in the abdominal wall and uterus. This type of delivery provides a reasonable birth option where there is a need to improve the survival of very small preterm infants and after the mother is diagnosed with a condition that puts her life at risk should the pregnancy be left to go to term (for example: eclampsia or severe pre-eclampsia, obstructed labour and prolonged labour and cord presentation in the case of a foetus). Examples of such situations include: foetal distress (where the foetus suffers lack of oxygen), placenta *prevea* (afterbirth lying low and blocking the baby's exit) and *cephalo-pelvic disproportion* (baby's head too big for the maternal pelvis) (McKinney et al 2006:461; NHS Direct 2007 cited in Gould 2007:57). In some instances, CS may also be

performed as an elective procedure on the basis of the mother's personal choice rather than as a result of medical risk (Gould 2007:57).

This is crucial information that the Zimbabwean Ndebele society needs to be exposed to so that they understand and appreciate the purpose of alternative modes of birthing. In the examples given above medical intervention is not a choice, but becomes inevitable in order to save both the mother and the baby's lives. The Zimbabwean Ndebele society may not be aware of the consequences of the resultant outcomes of non-medical interventions where there is good indication for such intervention.

2.3.1.1 *Caesarean section birth rates globally*

Globally, there is a general increase in the CS birth rates. In the United Kingdom, women are four times more likely to have a CS today than thirty years ago (Birth Choice UK 2007 cited in Gould 2007:58). In the 1950s approximately 3% of births in the United Kingdom were by CS and by 2004, the rate of CS births had reached 23%. This increase in CS is reflected in many other countries, including the United States and many European countries as well as in Australia and New Zealand (Chaim et al 2000 cited in Gould 2007:58). However, rates are lower in some countries, most notably the Netherlands, where considerable emphasis is placed on natural approaches to maternity care with approximately one third of births happening in the woman's home and the caesarean rate probably the lowest for a western country at the end of the twentieth century, at 11.2% (Churchill et al 2006 cited in Gould 2007:58; Declercq & Viisainen 2001 cited in Mander 2007:71).

A review of global statistics on caesarean birth rates shows that in the United States of America (USA), CS birth rates are high and make around 30% of all births. In Germany this rate is 25%. The Netherlands, Mali, Niger and Nigeria are recorded to make 2%. CS birth rates have sky rocked over the last fifteen years in East Asia as the region became more and more developed and urbanised. Departmental statistics in a Bangkok private hospital show that in 2005, 59% of all babies came into the world through (CS) compared to 31% two decades earlier. In 2007 St Paul's hospital in Hong Kong had 70% of the babies delivered by CS. The reasons for the high CS

rates include a variety of non-medical reasons such as fear of natural labour pain, convenience for the doctor as these are easier to handle than natural births and the fact that CSs are lucrative business for the private practitioners (Klein, Miller & Thomson 2004:436; Asia's rise in caesarean section ... 2007).

In Australia, 29% of women gave birth by CS in 2004, a substantial increase from 18% in 1991. Eleven percent (11%) mothers had an assisted vaginal delivery with forceps or vacuum extraction representing a decrease from the previous 13% in 1991 (Australian social trends ... 2008; Pairman et al 2006:738). In both Australia and New Zealand there is evidence that CS delivery is increasingly chosen by health care professionals and women, however, the rise in the proportion of the deliveries by CS does not seem to be explained by a change or increase in the obstetric complications (Black et al 2001 cited in Pairman et al 2006:738). According to Pairman et al (2006:738), in 2002 in Australia less than 2% of all women had risk markers for a medical condition during pregnancy. Less than 10% had a previous obstetric complication such as diabetes mellitus or gestational hypertension. This means that less than 12% of Australian childbearing women have risk markers that suggest that an intervention such as CS may be required. The explanations for health professionals opting to deliver women by CS delivery include a lower tolerance for taking risks, fear of malpractice litigation, and increased use of anaesthesia and early diagnosis of foetal hypoxia. The other explanation is that it may be quicker to do a CS than a vaginal delivery in a difficult labour (Pairman et al 2006:739).

It appears that unlike in most African countries there are no cultural implications that interfere with medical interventions in Australia and New Zealand. Both health care professionals and the women aim at a good outcome for the baby even if the result is morbidity for a large number of otherwise healthy and strong women (Pairman et al 2006:738).

2.3.1.2 *Caesarean birth rates in the African Region*

In 2000 at the World Summit, the Zimbabwe head of state was among the 190 world leaders and Heads of Governments who committed themselves to achieving

universal access to reproductive health by 2015 as set out at the International Conference on Population and development. Millennium development goal 5 (MDG5), one of eight global development goals internationally agreed upon, calls for reduction of maternal mortality by 75% by 2015 (MacDonagh 2005:4; World Summit Outcome 2005). Maternal mortality is defined as the death of a woman while pregnant or within 42 days of termination of pregnancy (MacDonagh 2005:4; Krul, Glea, Prescott & Freedman 2008:142; Maternal mortality ... 2008).

The lifetime risk of dying in pregnancy or shortly after delivery stands at 1:300 000 in Sweden and 1:16 in sub-Saharan Africa, perhaps the largest differential between the rich and poor countries of any statistics (Wall, Arrowsmith, Briggs, Browning & Lassey ... 2000; MacDonagh 2005:4; Krul 2005:4; Krul, et al 2008:142). However, considering the above statistics on the risk of dying in pregnancy, it appears that reduction of maternal mortality by seventy 75% by 2015 as intended by MDG5 in the highest burdened regions such as Sub-Saharan Africa, Zimbabwe included, requires a rapid massive scale up of health systems. The scale up should include the provision of universal skilled birth attendance (doctors, nurses or midwives), referral for complications of pregnancy and wide spread availability of emergency obstetric care (EmOC), such as CS and instrument deliveries which include vacuum extraction and forceps deliveries (MacDonagh 2005:9). This necessitates that indigenous communities should be informed about these alternative methods of birthing as well as formal healthcare institutions and professionals having an understanding of the cultural perceptions to such interventions. It is therefore also important to know what the perceptions of the Zimbabwean Ndebele on unnatural birthing are considering that in some instances the situation can be an emergency and such deliveries carried out to save both the mother and the infant may have long lasting socio-psychological effect. Hence, the current study.

Buekens (1993) recommends that CS rates should not be higher than 15%. Many countries from East Southern and Southern Africa had CS rates higher than 5% in urban areas. However, West Africa has a different situation. Ghana alone has a rate of higher than 5% in urban areas.

In several African countries there is no indication of a rapid epidemic of CS, except for a very slight increase in Niger, Madagascar and Tanzania (Buekens ... 1993). Other studies indicate that there is a world-wide epidemic of CS going on. Literature reviewed confirms that the sub-Saharan region has the lowest CS rates of below 5% (Collin, Marshall & Filippi ... 2006). In the researcher's view point, the low CS rates in the African region could be a confirmation of the fact that CS is not acceptable in most African societies for socio-cultural reasons as indicated in the discussion earlier on (Olabisi et al 2009:965).

Findings of a study by Krul et al (2008:142) in 34 of the 46 low income and low-middle-class income countries in the World Health Organisation African countries to determine association between government versus private financing of health services and the utilisation of antenatal care (ANC), reveal that skilled birth attendants versus CS rates in only six countries in the sample had CS rates of over 15%. The findings also indicate that government health expenditure and the percentage of total health expenditure is significantly associated with utilisation of skilled birth attendants. Total expenditure is also significantly associated with utilisation of skilled birth attendants. The findings show that the government is only able to spend on services that are being utilised. Findings of 15% CSs performed in 34 countries indicate low rate in health seeking behaviour standards.

Generally, the CS rates in the African region and those of Zimbabwe have been decreasing as they are affected by a variety of factors which include tradition and culture as well as dwindling economy and non-availability of more advanced health care. It is therefore necessary to reduce cultural, financial and physical obstacles to reproductive health in order to improve maternity health and most important to achieve the MGDs related to reproductive health (Global maternal health in crisis, despite progress ... 2009).

2.3.1.3 Caesarean births in Zimbabwe

According to the Zimbabwe Demographic Health Survey (ZDHS) (2005-2006:128) 5% of babies were born through CS. In Zimbabwe, CS births are most common among first births (6%), followed by urban births (9%). The most noticeable

difference in CS coverage is reflected in the mother's education. Women with higher than secondary education are fourteen times more likely to have a CS than women with no education' seven times more likely than women with a primary education and more than twice as likely as women with a secondary education (ZDHS 2005-2006:128). In this instance the relationship of CS births and education could be attributed to the fact that educated women are usually high-income women in urban areas who understand the concept of safe motherhood and can also afford the costs. It also appears that these women have twice as many CSs as their rural and low-income compatriots (Janowitz et al 1985; Barros et al 1991 cited in McCallum 2005:216)..

The Mpilo Maternity Hospital Obstetric Report (2004-2006) points out that, out of a total of 30 476 deliveries, 8 112 deliveries (26.6%) were through alternative modes of birthing. At the same hospital, the delivery register (January-June 2009) shows that fifteen percent (15%) of the total births were through non-natural modes of birthing (see table 5). A review of delivery registers of two other maternity hospitals in Zimbabwe within the same period indicates a similar picture with a percentage range of between 2% and 4% (Ministry of Health and Child Welfare (MOHCW) ANC and delivery register 2008-2009). It appears that globally, the developed countries have much higher rates of non-natural modes of delivery as compared to countries in the African region. Zimbabwe belongs where the rates are low because of poor health seeking behaviours which could be attributed to reasons alluded to by Van Roosmalen and Van der Does (1995:22), Mathole, Lindmark, Majoko & Ahlberg (2004:129) and Matua (2004:35); that non-natural birthing is not acceptable in most African cultures as it results in societal rejection and stigmatisation which may lead to psychological trauma.

TABLE 2.1: MPILO MATERNITY DELIVERIES JANUARY - JUNE 2009							
TYPE OF DELIVERY	JANUARY	FEBRUARY	MARCH	APRIL	MAY	JUNE	TOTAL
Normal vertex delivery	752	507	481	454	495	548	3237
Face to Pubis	0	0	0	4	9	7	20
Breech delivery	16	7	14	6	12	9	64
Vacuum Extraction	1	2	9	0	5	2	19
Caesarean Section	140	53	55	85	65	102	482
Total	891	569	559	5	586	668	3822

Figure 2.1 provides a graphic representation of the contents of table 2.1

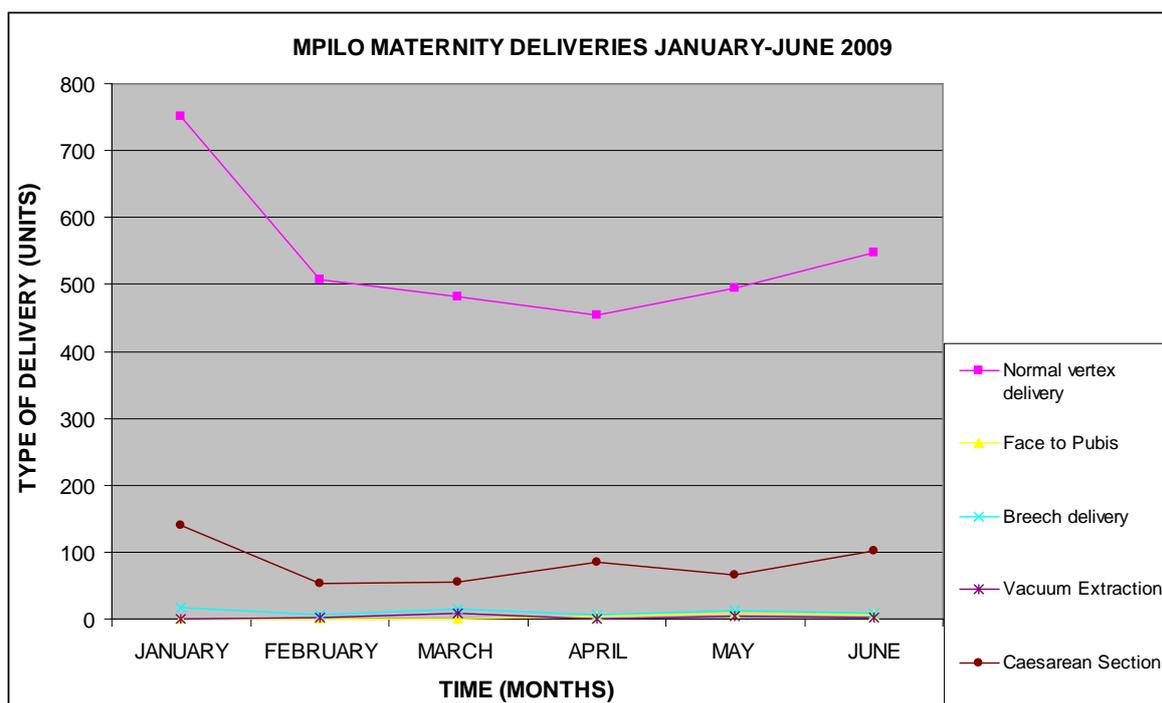


Figure 2.1: Type of deliveries at Mpilo maternity hospital

The figure above indicates that there is a trend in the types of deliveries conducted at Mpilo maternity Hospital which depicts the situation in the four major hospitals in Zimbabwe. The pattern that comes out from the preceding table is that out of a total

of 3 822 deliveries, 20.5%, were delivered as face to pubis; 1.8% were breech deliveries; nineteen point five percent (19.5%), were vacuum extraction/instrument deliveries and 13% were delivered by CS. This brings the total percentage of non-natural deliveries to 16%. Eighty four percent (84%) of the total deliveries were normal natural births.

The above information is an indication that the health care facility has the capacity and the skilled personnel to handle large numbers of deliveries without using medical interventions. This also counters women's fears which were alluded to by Matua (2004:35) in that when women deliver at a health care centre they fear that they may be forced to deliver by CS. Although the 0.5% and 1.8% were born as face-to-pubis (face towards the pubic area) and breech deliveries (baby bottom coming first) respectively; were not operative; they would still be considered non-natural in the Zimbabwean culture as the baby would not be presenting with the normal vertex (head first position).

2.3.2 Instrument deliver

Instrumental deliveries or operative deliveries discussed in this section include forceps and vacuum extraction.

2.3.2.1 *Forceps and vacuum extraction*

McKinney et al (2006:461) and Pairman et al (2006:710-712) explain that use of forceps or vacuum extraction applies traction to the foetal head during birth, aiding the woman's expulsive efforts to expedite the birth of the baby. Both techniques assist descent only or descent and rotation of the foetal head from an occipito-posterior or occipito-transverse position to the occipito-anterior position which is the natural position of how the foetal head is born. Although these discussed medical interventions result in the normal vaginal delivery, they are used as alternative modes of birthing. It is however not clear as to whether the Zimbabwean Ndebele accepts this as natural birthing.

The above-mentioned authors explain obstetric forceps as metal instruments having two curved blades that can be locked or opened and are shaped to grasp the foetal head. Disposable foam blades are usually made available to cushion the foetal head from injury by blades.

McKinney et al (2006:461) and Pairman et al (2006:710-712) further explain that a vacuum extractor has a cup which uses suction to grasp the foetal head while traction is applied and can only be used to deliver the foetus in a cephalic, vertex presentation. However, instrument deliveries can also be used on a face presentation; and the after-coming head of a breech presentation as well as to protect the foetal head in a preterm baby.

2.3.2.2 *Indications for instrument delivery (ID)*

According to McKinney et al (2006:462), ID is considered if the second stage of labour should be shortened for the well-being of the woman, foetus or both and if a vaginal delivery should be accomplished quickly without undue trauma. Maternal indications for instrument delivery include exhaustion, inability of the mother to push effectively, cardiac or pulmonary disease to prevent the woman straining the heart at delivery. Interestingly, Nyathi (2005:4) discusses a similar procedure that is performed by the TBA where the midwife pushes her fingers into the birth canal and gets hold of the baby's head to assist it to come out during a difficult delivery. While this type of delivery goes unquestioned by the Zimbabwean Ndebele society as part of measures taken to assist a difficult delivery; it is not clear what the perspectives of the Zimbabwean Ndebele are on equivalent medical alternative modes of delivery.

2.3.3 Implications of alternative modes of childbirth

It should be acknowledged that whatever mode of birth, there is always some implication. These could be physiological, psychological and socio-cultural; more so if unnatural modes of birthing are employed.

2.3.3.1 Physiological

McKinney et al (2006:462) point out that much as the instrument delivery may be certain to save both the mother's life and the foetal life; it has its own risks to both. Instrument delivery may cause trauma to the foetal tissue. The infant may suffer facial and scalp injury or intracranial haemorrhages, with resultant neurological deficits leading to mental damage or even physical disability if brain functional areas are affected (Pairman et al 2006:712; Huband et al 2006:309).

It is not known whether such effects of alternative modes of birthing on the infant could be what discourages the Zimbabwe Ndebele society's utilisation of health institutions as they believe that cultural interventions of complicated labour by TBAs have better outcomes (Mukumbura 2000 cited in Mathole 2006:17). However; what should be considered is that both mother and child would be alive; working towards achieving MDGs 4 and 5 of reducing maternal mortality by three quarters and infant mortality by two thirds by 2015.

A vacuum extractor may create scalp oedema at the application area. Sometimes hypothermia, facial asymmetry (most obvious when the infant cries) may suggest facial nerve injury. The mother may have lacerations, vaginal tissue may be caught by the cup and haematoma of the vagina may develop causing pain and greater chances of infection (Klein 1995:421; McKinney et al 2006:462; Pairman et al 2006:713). In addition, the outcome of a difficult labour resulting in an instrument delivery may have a life-long impact on the mother who may have to look after a mentally retarded child resulting from trauma from ID.

2.3.3.2 Psychological

The literature review highlights caesarean section as a surgical procedure with negative physical and psychological consequences for the mother, the father and the infant. The mother's psychological responses to CS may include loss of control during delivery and loss of self esteem. They may be fearful, traumatised, guilty and grief-stricken and angry from failing to achieve goals of a vaginal delivery as well as the length of separation and poor interaction with the baby due to physical pain from

the scar. Women may worry about the process and outcome of the normality and well being of the infant, which may cause psychological challenges and result in maternal stress influenced by psycho-socio-cultural factors of being shameful and stigmatised (Mutryn 1993:1274; Donko 2008:22; Fenwick, Gamble & Mawson 2003:13).

While it is appreciated that women who give birth through unnatural modes of delivery go through a grieving process for failure to have normal birth leading to feelings of inadequacy as a woman and the “loss of womanhood”. Women grieve for body distortion from the CS scar which may influence resumption of sexual interactions with their spouse (Fenwick et al 2003:130). There is little that is known about the grief that is experienced. Women’s lived experiences of grieving for a natural birth have not been explored. Unfortunately, such grief cannot be anticipated by the care givers for them to afford the woman the opportunity for anticipatory grief and counselling that they would need. The grieving process for women who deliver through unnatural modes of childbirth was not discussed as it is beyond the scope of this study. However, based on the data gathered and analysed, it was possible to make certain recommendations in this regard.

Outcomes of the different modes of delivery may also affect mother-to-child interaction. Mothers may have difficulty in breastfeeding, psychological trauma and physical trauma related to the mode of delivery. These occur to both women who have had babies before and the first time mothers who could also be dealing with transition from girlhood to motherhood. This usually brings confusion and has a negative effect on the self-concept (Reproductive Health Services Guidelines 2001:67).

2.3.3.3 Socio-cultural

In the Zimbabwe Ndebele culture, and in some other cultures as well, the child may be given a name relating to the events surrounding the manner the child was born (Nyathi 2005:4). The examples given by this author are that of "Gundwane", a word which means a rat in the local isiNdebele language to emphasise the size of the baby if it was born prematurely. Incidentally, one of the Ndebele chiefs was named

"Gundwane" for the same reason. Another example is that of King Lobengula's mother whose name was Fulatha. Normally, baby delivery is head first. In a few rare occasions the baby is delivered feet first and this rare phenomenon is worth recording in the form of a name Fulatha. "Foto", is a name given to a baby if the head has a depression from pressure from a forceps delivery or "Mtshotsho" if the baby has a chignon (an elongation of the head) from a vacuum extraction pull (Nyathi 2005:4). Such names may be permanent reminders that the child was born in an unnatural manner, which may even have a stigmatising effect.

2.4 PAIN DURING CHILDBIRTH

2.4.1 Definition of pain

"... in sorrow thou shalt bring forth children ..." (The Holy Bible King James 1999:3). According to this Biblical saying in the book of Genesis chapter 3 verse 16, birth experience was a curse from God after Eve had eaten of the forbidden fruit and had also given it to her husband Adam. The above statement is referring to the pain that women endure during labour. Thus the definition of pain that was understood by Christian philosophers in the Middle Ages - one that influenced health care practices well into the 20th century is that "pain-is-suffering for sins" (King & McCool 2004:471). These authors give a widely accepted definition of pain namely that "pain is an unpleasant sensory and emotional experience associated with actual or potential tissue damage or described in terms of such damage". They continue by pointing out that: "Pain is always subjective. Each individual learns the application of the word through experiences related to injury early in life" and that the "inability to communicate verbally does not negate the possibility that an individual is experiencing pain and is in need of appropriate pain relieving treatment" (King & McCool 2004:471).

Pillitteri (2003:1112) concurs with the above definition and states that the sensation of pain is whatever the person who is experiencing it says it is, and exists whenever they say it does. Pain is universally encountered, but personally experienced as unpleasant and subjective (Kanner 2003:1; Leifer 2005:109). According Kanner (2003:10-15), pain is a multi-dimensional experience with physiological,

psychological and socio-cultural components. King and McCool (2004:471) state that suffering is a result of how pain is perceived and interpreted. Suffering can be both the product of pain and simultaneously a source of it. On the other hand, interpretation of pain depends on how it is perceived (King & McCool 2004:471). Smeltzer and Bare (2003:223-225) explain that perception of pain is a complex experience influenced by a multiplicity of factors which include age, gender, cultural background, individual's previous experience of pain, anticipation of pain, the context in which pain occurs as well as the emotional and cognitive responses and pain threshold.

Individuals have different pain thresholds. Kanner (2003:32), Smeltzer and Bare (2004:226) define threshold as the point at which a pressure or temperature stimulus activates pain receptors and produces pain sensation. According to Pillitteri (2003:1114) individuals who have a low pain threshold experience pain much quicker than those with a higher pain threshold. This means that individuals' perception and tolerance of a painful stimulus varies greatly depending on their psychological and physical state at the time they experience the pain stimulus. A low pain threshold is when an individual reports pain when subjected to a very light pain stimuli while a high pain threshold is when an individual only reports pain when they perceive a stronger amount of pain stimulus.

2.4.2 Labour pain, ethnicity and socio-cultural expectations

Research has found that labour pain is influenced by a number of factors which include the environment within which the woman is giving birth, the woman's coping strategies and expectations, culture, nationality and religion (Fraser, Cooper & Nolte 2006:641; Helman 2007:185). Kitzinger (1999 cited in Pairman et al 2006:423) has argued that the environment and relationships of those present at birth have a profound effect on the way a woman perceives and interprets pain. Other studies have concluded that women perceive home birth as less painful than hospital birth (Chamberlain et al 1997 cited in Pairman et al 2006:423). It is not known whether it is with the same belief that the Zimbabwean Ndebele women prefer to give birth at home rather than in public institutions.

An individual's culture determines attitude, beliefs and behaviour towards pain. Different cultures socialise women on how to respond to labour pain particularly during initiation ceremonies in the African culture. In some cultures, women have a tendency to scream, verbalise and/or dramatise when they are in labour with some cultures allowing such behaviour (Kanner 2003:36; Pillitteri; 2003:58; Smeltzer & Bare 2004:224; Gruenberg 2006:64). Examples include Malawi women and the Shona women from the Eastern part of Zimbabwe. Studies did in Latin America report the same behaviour among Latin American women. Some Muslim and Hindu sects advocate pain acceptance and stoic behaviour during labour as do many other cultures (Perry & Lawdermilk 2006:339). These authors single out Japanese and Hispanic women as well as women from South East Asia as stoic although they do sometimes request medication during labour. Native American women also exhibit stoicism, but use medication from indigenous plants as do Zimbabwean Ndebele women (Nyathi 2004:4). African-American women verbalise pain without restraint and use medication variedly depending on pain severity (Perry & Lawdermilk 2006:339).

According to Nyathi (2004:4), in the Zimbabwean Ndebele culture, mothers react differently to pain during birthing. Some are courageous and will withstand the pain associated with birthing. They endure pain stoically. This could be a result of the training they get during the transitional period at puberty. However, this is not the case with all the mothers; some lack the necessary stoicism despite the training. During labour, they go wild, cry and, in uncontrollable fits, may cause injury to the baby. In the Zimbabwean Ndebele culture, such women would be restrained by men using cowhide.

Nyathi (2004:4) describes the process of restraining a woman who “is wild during delivery”. Two holes are made in the hut where the woman is delivering. Her left leg and left arm are tied together using a strip of cowhide. The strip is then pulled through one of the holes in the hut. The same is done to the other arm and leg. Two teams of men then pull in different directions in such a manner that the woman's legs remain apart. The belief is that with legs remaining apart, the birth canal will remain open and also prevent the woman from injuring the baby. However, these are extreme cases; otherwise the majority of women endure the pain with stoic acceptance. The researcher would like to believe that even in the then days tradition

and culture did make provisions for pain relieving agents or herbs, but because culture was set on stoicism, pain relief was not an issue. In the researcher's view, another issue in the situation of restraining an uncooperative woman when giving birth is that the whole process is dehumanising. The position of giving birth and the psychological implication involved are far beyond what the women can take at that point in time (Matua 2004:35).

According to Nyathi (2005:4), in the Zimbabwean Ndebele culture, women deliver in a squatting position (*uyaqotshama*) which is both comfortable and culturally more dignified as compared to the positions practised in maternity hospitals. As has been alluded to earlier in the study, women perceive home births as less painful than hospital births, because the environment and relationships of those present at the birth have a profound effect on the way a woman perceives and interprets pain (Morse & Park 1988; Chamberlain et al 1993; Chamberlain et al 1997; Sandall et al 2001 cited in Pairman et al 2006:423). Although pain relief is an important factor to consider during birthing, it is not clear whether there is provision for that in the home environment as is the case in hospital settings.

Pairman et al (2006:420) observe that some cultures such as Polynesian women also appear to value *stoicism*. The authors also say that Samoan women of New Zealand may appear very calm during labour with little outward show of their pain. As indicated previously the valuing of *stoicism* in labour is also very true of women of the Sub-Saharan region. Like the Samoan women of New Zealand, Zimbabwean Ndebele women are also known to display a brave outward look when they are in labour without a murmur.

Rehnstrom (2006:47) suggests that in Chile, medical professionals, midwives and others should be sensitised to the effects of the current overly-interventionist model of care for delivery and that natural birth should be promoted as medical custom. Although pain relief in labour is one of the important tasks of the skilled attendant, in many cultures, women believe that natural birth is part of the proof of their womanhood and that they are women enough to stand labour pain and be able to deliver normally as this satisfies their ego. Women believe that giving birth normally is valued in the cultural institutions within which they live.

The belief that *stoicism* is associated with perfect womanhood sometimes leads to women refusing any kind of intervention that would artificially terminate labour pains regardless of whatever complications may occur following a difficult vaginal delivery. Pairman et al (2006:422) suggest that it may be important to allow women to have the experience of conquering an overwhelming personal crisis, to promote confidence in the new mother bearing in mind that: "Submission to all consuming and overwhelming nature of birth and the weathering of the inherent pain of labour is an empowering process for a woman, and one that should not be denied unless critical for her own well-being or that of her own baby" (Robertson 1994:88 cited in Pairman et al 2006:422). This statement emphasises the value that women place on natural birth despite the labour pain they may have to endure. It also appears that the above quote is in support of the cultural perspectives of pain and the subsequent outcome of normal delivery, but condemns any interference with the normal birth process unless absolutely inevitable which is usually an operative delivery or an instrument delivery. There is need for the Zimbabwean Ndebele society to understand the above situation as much as there is a need for people outside of the Ndebele society to understand the Ndebele's view point of view on stoicism.

Historically, women have been told how they should feel about labour pain from the classic victimisation of "Eve's curse" to the "ecstatic" fulfilment of the natural birth movement (Pairman et al, 2006:422). Rubuzzi (1994 cited in Pairman et al 2006:422) claims that in order for women to reframe the deeply acculturated belief that birthing is painful and dangerous they need to see pain as something to conquer rather than something causing a threat to conquer them. They should be prepared to undergo whatever mode of delivery for the best outcome without cultural prejudice.

2.5 AFRICAN CULTURE

Before people can effectively communicate with other people; there is need to understand their culture and their ways of thinking so that they are able to communicate as understandably as possible. This applies to different cultures; Zimbabwean Ndebele culture included (General Conference Office of Adventist mission ... 2008). This statement is appropriate for the current study; hence literature

pertaining to the people of Southern Africa and that of the Zimbabwean Ndebele culture was reviewed in order to put the reader in perspective.

2.5.1 Historical background of the African people in relation to childbirth

African societies throughout the continent live by tradition and they value culture. King (2003:189) asserts that even if traditional cultures of the sub-Saharan Africa incorporated influences from other nations, they maintained their distinctive cultural identity. The Zimbabwean Ndebele society is no exception to this.

In African society where the status of a man is measured largely by the size of his kraal, and that of a woman by the number of children she has borne, the birth of a child is hailed with great joy as an event of importance to the whole village (Krige in Schapera 1937:37; Mariano 2006:261; Donkor 2008:22). In all the Southern African tribes which include Shangana-Tonga, Ndebele and Swazi, no marriage is complete without children and "without children they will forget you when you die." In Shangana, a woman who dies childless is characterised as "never having known the penis" (Runganga et al 2001 cited in Mariano 2004:262). In the author's view, besides being essential for the prestige and social position of both men and women, children in African society are of considerable importance in the tribal economy. At certain periods children's cooperation is essential for the general welfare of the tribe as they take up some important societal responsibilities.

King (2003:192) impresses how important and valued children are in the African zone and indeed in other cultures; because "culturally without children you are naked" (King 2003:192). Children have specific roles assign to them. At an early age they relieve their elders of simple subsistence tasks and later in life they provide aging parents proper burial and memorial rituals as well as continuing sacrifices that ancestral souls need. To confirm this statement, Donkor (2008:22) in a study on socio-cultural perceptions of infertility; states that most men and women in Ghana want to have children for various reasons, such as status and identity and economic security in old age. Thus, motherhood is considered a major societal role of women and a respected female identity to such an extent that inability to meet this expectation could be expected to cause displeasure and unfavourable attitudes from

society. African society is fundamentally opposed to childlessness. To be barren (*inyumba*), in the African culture particularly in the Zimbabwean Ndebele culture, is the worst of evils to befall a woman (Krige 1977:61 cited in Nyathi 2001:89).

Studies done on experiences of childbirth placed emphasis on the cultural view on procreation as the major role and objective of a married woman, however, cultural perspectives on alternative modes of birthing have been neglected. Cross-cultural studies on the anthropology of birthing also attend to the socio-cultural as well as the biological dimensions of birthing around the world, and not to alternative modes of birthing (Van Hollen 1994:501). Jordan (1992 cited in Van Hollen 1994:501) states that globally, beliefs and practices associated with birthing reflect a large area of unopposed cultural patterns; which is currently the situation with the Zimbabwean Ndebele culture as has been observed by the researcher. The author also views birthing as an arena within which culture is produced, reproduced and revisited in order to perpetuate traditional values. The conclusion drawn by Jordan is that there is very little difference in beliefs and practices that are associated with birthing within a given culture.

2.5.1.1 The Zimbabwean Ndebele culture

The Ndebele culture in Zimbabwe is akin to the Zulu culture of South Africa. This is the cultural practice of the *zansi*, the original Ndebele who left Zululand with Mzilikazi in 1872 (Schapera 1946:413; Ndebele Zimbabwe culture and beliefs ... 2008). Yakan (1999: 552-556) gives a vivid account that the Ndebele people, known as the "AmaNdebele" who are a West South African people. The languages they speak include isiNdebele, Nguni, Sotho and Sepedi; a Northern Sotho language. In Southern Africa "AmaNdebele comprise virtually the total population of the former *KwaNdebele* homeland. Considering the preceding background information of the "AmaNdebele" it is not surprising that Zimbabwean Ndebele tradition and culture are a distillation of the Zulu, Xhosa and Ndebele in South Africa.

The Ndebele people are concentrated in South-western Zimbabwe and North-eastern South Africa. In Zimbabwe, (where they are also known as Matebele), they constitute the second largest ethnic minority after the Shona (71%) accounting for

about 16% of the total population, and the rest (13%) are mixed tribes.

The word Ndebele means "stranger" in the Sotho tongue. It originated when in the 1820s, Mzilikazi and a few of his followers ran away from Shaka the Zulu leader after refusing to handover seized cattle from a military raid. Mzilikazi and his followers had to seek refuge in North-eastern South Africa (the then Transvaal). Later fights with the Zulu and the Boer trekkers resulted in the flight further north into Western Zimbabwe (Yakan 1999:553). In 1868, Lobengula succeeded his father Mzilikazi as King of the Ndebele and later concluded the Grobblers Treaty which provided special privileges for Boers travelling and trading with Matebeleland effectively placing Matebeleland under Transvaal's protection. The Grobblers Treaty was later offset by the Moffat Treaty which bound Lobengula to consult the British South African Commissioner prior to entering into arrangements with external parties entailing territorial commitments (Yakan 1999:554).

Within the Republics of South Africa and Zimbabwe, the Ndebele continue to maintain the basic features of their tradition with strict hierarchy made up of original Zulu descendants and conquered peoples. In the researcher's experience of the Ndebele society, men have most influence in the family including any decision taken for birthing. For example, consent to deliver in a public health institution. A man can have many wives and adultery on his part risks only a mild retribution; while adultery on the part of the woman leads to the confiscation of her children and divorce (Schapera 1946:413).

2.6 PREFERRED PLACE OF BIRTHING

Johnson et al (2007:171) believe that most African societies, including the Zimbabwean Ndebele support normal birth and home births conducted by professional midwives, traditional birth attendants (TBAs) and relatives.

In order to explore Zimbabwe Ndebele perspectives on alternative modes of birthing, the social background and culturally preferred place of birth which neither threatens nor causes fear to Zimbabwean Ndebele women during birthing is discussed.

In the whole of Africa and Zimbabwe in particular; women prefer to deliver with the assistance of traditional birth attendants (TBAs) (*ababelethisi*) in the community. This is done to avoid hospital delivery in fear of operative delivery or any other *unnatural* way of child birthing in the event of an obstructed labour or some other eventuality (Mathole 2004:129). African culture in general opposes any "unnaturalness" surrounding pregnancy and birthing and links it with adultery and witchcraft (van Roosmalen and van der Does 1995:22).

In some cultures, women will not give birth in a public place including public health facilities, because the women believe that it is an abomination to deliver in a hospital where they will expose their nakedness and if they do so, the consequence is community rejection. There is also fear that their babies would either be stolen or exchanged for unwanted ones. In addition, many women prefer giving birth at home because of the familiar surroundings while others prefer it in order to perform customary rituals (Matua 2004:34-35).

According to Mathole (2004:129) and Matua (2004:35), women in Zimbabwe and Uganda do not choose health care centres as places for delivery in fear of forced CS and other non-natural measures, Health care providers' attitudes also prevent clients from visiting health care facilities. Other reasons could be related to mythical and customary rituals that they cannot perform in public health institutions. In addition, in the African culture women avoid exposing their sacred bodies to the public. In a nutshell, preference of service provided by TBAs also has some cultural implications besides the many other reasons such as low costs and the fact that their services are believed to have better outcomes as compared to those provided at public health institutions (Finger 2003:13; Awfung 2004:27; Matua 2004:35).

Kornelsen and Grzybowski (2006:260) confirm the Zimbabwean cultural belief that giving birth in a familiar environment with familiar faces around gives the woman confidence and assurance to deliver normally without interference from medical labour management. Matua (2004:34) discusses a similar practice in Uganda.

Cultural beliefs and ideas about pregnancy and childbirth seem to have great influence on women's utilisation of antenatal care services and decision making

during labour. Any abnormality or complication in pregnancy or childbirth is believed to be caused by supernatural powers (van Roosmalen and van der Does 1995:21). Studies done in Kenya, Botswana, Mozambique and India reveal similar findings and the use of TBAs is common in these countries (Mathole et al 2004:130; Matua 2004:36; Jude and Grzybowski 2006:260).

A study carried out in Zimbabwe by Mathole et al (2004:129) revealed that the reason for health-care options by pregnant women other than the referral hospital is to avoid CS. This is so because in Zimbabwe, the Ministry of Health and Child Welfare policy states that one reason for a woman to visit the clinic early in pregnancy is to have risk factors assessed, including whether she would need a CS when giving birth or not. Matua (2004:35) confirms that some mothers fear surgery and believe that if they were to give birth in a health facility they would be subjected to a forced CS.

Culturally, in Zimbabwe, the Ndebele society has always had their traditional midwives (*ababelethisi*), who are usually elderly women referred to as traditional birth attendants (TBAs). The TBAs attend to women during pregnancy and childbirth and are rewarded with something like a goat or chicken. However, money is slowly replacing all other forms of rewards. Nyazema et al (1992 cited in Mathole 2006:18) confirms that payment to traditional healers can be in cash or kind paid over a period of time.

The Zimbabwe Demographic and Health Survey Report (ZDHSR 2005-2006:127) shows that nine percent (9%) of births were assisted by doctors, 60% by nurses or midwives, 11% by trained traditional attendants (TBA), 16% by untrained TBAs, 2% by relatives and two percent (2%) of births had no assistance at all. Overall, more births were attended by TBAs during the ZDHS 2005-2006 than in the 1999 ZDHS with the respective percentage standing at 7%)compared to 18% (ZDHS Report 2005-2006:127).

Preceding information suggests that a substantial percentage of women in the African culture which include the Zimbabwean Ndebele society prefer to give birth in

their natural traditional settings (Matua 2004:34). In Zimbabwe, the reasons may be related to the poor economy currently aggravated by the rather unstable political situation where the women cannot afford transport fares to the health care centre and payment for health care services.

Much as the TBAs have been formally recognised in the Zimbabwe's health care system their training has not equipped them with adequate skills for reduction of maternal mortality and morbidity. The focus is largely on making home deliveries clean and safer by offering basic skills (MOHCW 1997 cited in Mathole 2006:16). A case-referent study by Mbizvo, Fawcuss, Lindmark and Nystrom (1993:369-378) reveals a maternal mortality rate for rural setting of 168 per 100 000 live births and that of urban setting as 85 per 100 000 live births. A ratio of almost 1:2 in terms of urban/rural maternal mortality ratios. Haemorrhage and abortion sepsis were the leading direct causes in rural areas while malaria was the leading indirect cause. In urban areas the leading causes were eclampsia, haemorrhage and complications of abortion. It can be assumed that most of the women in rural areas deliver under the care of TBAs and medical care is not readily available. There has been little formal investigation or evaluation on the programme is still under way, hence there has been no direct statistical evidence on number of referrals and those who die while under the care of TBAs as well as the necessary CSs on those referred to health institutions. The other factor is that when women present at a PHC with complications of pregnancy or labour, they do not disclose the fact that they were under the care of TBAs, but pose as "unbooked" clients (Caude ... 2008).

It would appear that the Zimbabwean Ndebele society prefers that women deliver at home with TBAs who are part of the community and mostly understand their culture; despite the fact that the number of women dying during delivery in rural area is noticeably high as alluded to in the preceding paragraphs where ratios of 1:2 have been documented; a situation which the women may get to know about.

A study by Du Plessis (2005:23-25) with regards to women's experiences of birthing in hospital under the care of a medical practitioner revealed that women were dissatisfied with their birthing experience and felt disempowered. The women felt loss of control during the labour process, experienced a sense of abandonment and

lack of involvement. Robertson (1988:2 in Du Plessis 2005:350) professes that the different approaches to childbirth that have been developed all over the world are essential to the progressive medicalisation of birth with an increase in the number of home deliveries by a midwife. For example in South Africa, there seems to be an increase in the demand by mothers for a less technological medical birth experience. However, Du Plessis (2005:23-35) states that the experiences of the mothers who deliver with a private midwife is an area in South Africa where very little documented research has been carried out and as such minimal documented research is available. This is a situation similar to that of Zimbabwe. As it is not clear whether the reasons for the increase in home deliveries by TBAs in Zimbabwe are associated with cultural beliefs this study which explored the Zimbabwean Ndebele perspectives of alternative modes of birthing was undertaken.

2.7 PROCESS OF CHILDBIRTH IN THE ZIMBABWEAN NDEBELE CULTURE

In the African culture and indeed in the Zimbabwean society, birthing is expected to take a natural course when women do experience problems during child birth, it is regarded as failure to meet the expectations of womanhood.

In some parts of Africa and in the Mashona laws and custom in Zimbabwe, there is a belief that if a woman has obstructed labour during birthing, it is regarded as a sign that she was unfaithful to her husband or it is a result of witchcraft. In such instances, TBAs urge the women to confess her sin and divulge the name of the man she cheated with. If the woman insists on denying having committed adultery, which is very rare considering the physiological, psychological and emotional torture that is done, torturous acts such as pinching of the labial area and asking the woman over and over to force her to admit guilt are used. Once the woman names her lover, it is considered that the danger of death is past and the baby can then be safely delivered (Bullock 1913:11; Van Roosmalen & Van der Does 1995:22; King 2003:125).

The above assertion is confirmed in practice as the researcher witnessed a number of situations where a woman with complicated labour would not give consent for CS and opt for confession to the health care giver for infidelity or holding a grudge

against her husband or anyone for that matter. In some cases the mother or mother-in-law would request for permission to administer some herbs obtained from some *sangoma* (traditional healer) to reverse the complicated labour. This also confirms research findings of a study conducted in Zimbabwe and Tanzania (van Roosmalen & Van der Does 1995:22). The same practice prevails in the Zimbabwean Ndebele custom and in a few other Zimbabwean cultures for that matter. Peru, Bolivia and Chile also have a more or less similar practice where a pregnant woman confesses her sins to the priest who then prays for successful birth (King 2003:125).

In the preceding discussion it is important to note that, it appears as though the woman even if she has not committed the adultery would end up admitting that they did because of the torture that they are subjected to over and above the labour pains that they would be enduring. They may also make a false confession if they believe that by so doing they may have a safe delivery and survive the delivery. It is the responsibility of the midwife to inform the Zimbabwean Ndebele society that labour complications have different causes in the scientific world as well as in the medical fraternity which cannot be averted through performance of rituals during birthing.

Other rituals associated with birthing include fumigation (*ukuthunqisela*) of newborn babies which is done soon after birth. The ritual is usually the smoke from animal skin which is burnt on hot coal. Fumigation of newborn babies is usually administered by the paternal grandmother. Fumigation is part of a broad African/Ndebele belief in the causes of diseases and their prevention, because the Ndebele believe all animals, including humans, have some "air" (*umoya*) around them which can harm the newborn baby (De Villiers & Ledwaba 2003:664; Nyathi 2007:2). The above information may be reasons for the non-utilisation of public health institutions for birthing by the Zimbabwean Ndebele society so as to perform customary rituals as protection for newborn babies against evil spirits.

2.7.1 Traditional measures taken during complicated childbirth

During childbirth, the TBAs perform some intervention procedures and administration of herbs to transfer certain abilities to the woman (Nyathi 2004:4). The author discloses a situation where women often, take some herbs prior to the day of

delivery, to facilitate easy uncomplicated delivery. These herbs, it is believed, loosen up muscles to enlarge the delivery canal to facilitate easy passage of the baby.

A few rituals designed to prevent difficult birth are still practiced; for example when the time for a woman to deliver draws near they should not have any knots around their persons; while their husbands discontinue wearing any collar or neck-tie or knotting their shoelaces. Any tying of items is believed to be transferred, such that their babies would be "tied" (by the umbilical cord). That would mean difficulty in birthing. In addition the women often observe numerous cultural dietary taboos, all calculated at facilitating easy delivery. For example, when eating meat, the woman should avoid tearing it with her hands as this is believed that it could be transferred to the birthing process resulting in the birth canal being torn (Schapera 1946:413; Yakan 1999:552-556; Donner 2003:306; Ndebele Zimbabwe culture and beliefs ... 2008).

When a baby gets stuck during delivery, certain cultural measures are resorted to. The first attempt is to shake (*ukukhuhluzza*) the body of the delivering woman. Sometimes this works and the baby would become free. If this does not work, the traditional midwife often resorts to assisting the baby by pushing her fingers into the birth canal. She then grabs the baby's head and pulls it down to assist delivery. The procedure described is akin to a forceps delivery. In the researcher's view point, the procedure would be an alternative mode of birthing which is non-natural although not recognised as such by the Zimbabwean Ndebele society. In such a case, there would be no stigma or societal rejection attached to the woman and her status as is the case when medical alternative modes of birthing are employed (Matua 2004:34, Nyathi 2005:4). This procedure according to Nyathi (2005:4) evidence the Ndebele culture's appreciation of the physical and mechanical side of labour besides the spiritual aspect that is often attributed to complications of labour.

According to Nyathi (Sunday News Magazine 2005:4), a plant called *isibunu senkonyane* (buttock of a calf) or one called *idolo lenkonyane* (knee of a calf) are often used to promote the labour process. Just before delivery, traditional medicines are delivered through the anal canal. The aim is to clean the rectum in preparation for the delivery. The delivering woman then sits on a stone of suitable size in such a

way that it plugs the anal orifice. This is done to prevent faecal matter being discharged during delivery (Nyathi, Sunday News Magazine 2005:4; Informal discussion with Mtshayi, M 2008, 19 December. Bulawayo). In the researcher's experience, this procedure is also practiced in public health institutions as it is believed to facilitate descent of the foetal head during delivery.

Donkor (2008:22) explains that societal expectations are that the major role of women is procreation. The Ndebele people believe that they are very close to nature and that they should be well all the time. Anything that interferes with their well-being is believed to be caused by people with supernatural powers and that only those people have the powers to reverse those illnesses or happenings. In case of complicated labour, traditional healers use traditional medicines such as *ingqwatshi ka babhemi* (donkey's placenta) in order to intervene in, or reverse, labour complications. The philosophy in using the donkey's placenta is that the donkey has been observed to have very short and precipitate labour and the foal is very active as it jumps around within minutes after birth. It is then believed that, if the labouring woman has cuttings on the abdomen and the dried donkey's placenta is rubbed onto the abdomen with some of it taken as a drink the strength of the donkey's contractions will be transferred to the labouring woman to undo the labour complications. Another herbal medicine that is used is *inkunzane* (a slimy herb) also taken as a drink to augment contractions and to speed up labour (Informal discussion with Mtshayi, M. 2008. (TBA) 19 December. Bulawayo).

2.8 THE ROLE OF RELIGION IN AFRICAN CULTURE

It appears that the Ndebele are a very spiritually oriented people in everything they do including the process of birthing. Ndebele culture is centred on religious rituals and most Ndebele still adhere to their traditional religion that centres on the worship of their high God *Nkulunkulu* and their ancestral spirits. Spiritual rituals guide the day-to-day life of the African people; which includes the Zimbabwean Ndebele society. *Sangomas* are regarded as the spiritual mediums. Mutwa (cited in Hund 2003:161) describes *Sangomas* as the so called "witch doctors" which according to Hund (2003:13), is not exact. The term "witch", however, has several meanings (Chabvunduka cited in Hund 2003:136) such as a bad person who is envious of

others; or a person who goes his own way despite objections of other people, a trouble maker who commits antisocial acts, a deviant. Chabvunduka believes that witchcraft does exist and is not a myth as western missionaries believe.

Mutwa further explains that *Sangomas* are also diviners and diagnosers of illness and further claims that *Sangomas* play the same role as psychiatrists and priests of various religions and have the ability to foresee future events. Mutwa further impresses that these people who are called *Sangomas* or traditional healers have a tremendous store of knowledge hidden in their minds which is what the Zimbabwe Ndebele society has tapped for use during childbirth. Mutwa (cited in Hund 2003:167) refers to a *Sangoma* as the "guardian of his people and his culture"; thus whatever the Zimbabwean Ndebele society does refers to traditional healers as cultural guides.

Traditional medicine is also still popular due to active *nganga* or medicine men (Yakan 1999:556). In central Africa, the term *nganga/nyanga* is used to mean *sangoma*. Geschiere 1998 (cited in Hund 2003:12) writes that the *nganga* is a kind of "super witch" who can heal people who have been bewitched or cursed with misfortune and protection against witchcraft. It is generally believed that the supernatural powers of witches in Zimbabwe are at the heart of almost everything that brings sorrow, pain, shame, death, illness, insanity, impotence, barrenness, unemployment, failure in exams among other things (Mathema 2009:4). Considering the spirituality surrounding pregnancy and childbirth, and the *sangomas*' role in this, *sangomas* were included in the current research.

According to Hund (2003:13), in the Zulu culture, which extended to the Zimbabwean Ndebele culture, there are different kinds of traditional healers (*Sangomas*) who are sometimes labelled derogatory as "witch doctors". However, Hund (2003:12) clearly states that *Sangomas* are not witches. All *Sangomas* (traditional healers) are herbalists and diviners, but not all herbalists and diviners are *Sangomas* (traditional healers); only a selected few who have received a calling can claim the title of *Sangoma*. According to Hund (2003:16), the Zulu *sangoma* (traditional healer) will only be effective in curing people from *thakathi* or witchcraft-related misfortune. This must be because he or she can understand and to some extent control the same

occult forces as does the witch. These claims suggest that there is a close relationship between witches and psychic abilities, which are maps of consciousness or extrasensory (sixth sense) capabilities.

2.9 CULTURAL RITES ON TRANSITION TO WOMANHOOD

Societies are products of a conscious effort. There are values, ideas, beliefs and world views that are responsible for creation of a particular society (Nyathi 2006:7). Nyathi believes that there is also an ideology that was critical in shaping society. Thus societies come into being because they are crafted according to set ideologies. Various components of society have specific roles to play and they are recognised stages in the person's development.

Nyathi (2007:7) further highlights that, in African societies, a human being is recognised as no more than a biological entity with the potential to learn from birth. It is the process of enculturation which fits them into a particular society. This purely educational process includes among other things such as the inculcation of those values that society cherishes. Traditional societies in Africa recognise various stages in the development of a child. Each stage has its own demands and a special culture unique to it. There are rites which are performed to assist the child to adjust to a new stage and these have been called rites to passage.

On becoming a woman, the African children undergo initiation schools so that they can learn from general education and imitation which prepares them for adulthood. The process of initiation has been defined by Mbugua (2000 cited in Chikunda, Marambire & Makoni 2006:146) as a traditional cultural rite of passage that guides young girls into adulthood and others into marriage at very tender ages. The initiation process involves circumcision and prepares youngsters for their future roles in life. Kenyatta (1953:107 cited in Chikunda et al 2006:146) postulates that the youth graduates into adulthood "comes of age and is born again" through circumcision. Krige 1937(cited in Schapera 1937:99) explains that the African tend to conceive of the development of the individual as a series of clearly demarcated stages. The author further explains that; to pass successfully from one stage to the next it is considered necessary to secure the aid of forces that can influence one's life for

good or bad. It is at such times that ceremonies take place and usually the initiate is strengthened by magic and an appeal to ancestors is made and a break with the faults and weaknesses of the previous stage is effected when the process begins.

2.9.1 Puberty as a rite to passage

Puberty rites are normally performed to initiate young females into womanhood during menarche; a common practice in most Southern African people. However, other African tribes such as Ghanaians also practice these rituals although with some modification (Donkor 2008:22). These rites prepare adolescents for new roles of marriage and motherhood for girls; marriage, and fatherhood for boys (Child 1968:52-53; Mbiti 1969 cited in Nyathi 2001:97; Van Gennep 2004:3). In the researcher's viewpoint the rites preparation are very relevant for adolescent as they envelop the concept of education and orientation to parenthood.

Schapera (1937:99) relates that in the Southern African people's history, the most important ceremonies are puberty ceremonies. In the traditional Zimbabwe Ndebele society, when children reach maturity, both sexes have to go through prescribed ceremonies to initiate them into womanhood and manhood. Child (1968:52-53) goes on to describe the custom of *ukudunduzela* (initiation) as linked with the beginning of womanhood. According to Child, this is a period of seclusion in a hut during which the girls are obliged to partake of medicinal concoctions and to refrain from eating *amasi* (thick milk). They are only allowed to eat pumpkin while given strengthening medicines or committed to the care of ancestors and taught a number of rituals and expected behaviours. Later the girls' fathers would provide beer for a series of feasts to be attended by relatives and friends (King 2003:127; Nyathi 2006:7; Informal discussion with Mtshayi, M. 2008. 19 December. Bulawayo).

At the "Vusha" the Venda girl is warned not to lose her virginity before marriage, and is shown how to have intercourse without this occurring. The educational importance of these puberty ceremonies, however, lies not so much in the teachings, as in the nature of the whole ceremony which is meant to impress upon the individual the fact that he/she is now no longer a child (Krige 1937 in Schapera 1937:100).

In the Zimbabwean Ndebele custom, puberty ceremony for girls (*induduzelo*) is a stage of passage from a protected stage of childhood to the new stage of adulthood which usually presents new challenges (Nyathi 2001:97). Nyathi further emphasises that, in the Ndebele custom, this is a critical stage when adolescents are helped along into the new world. During that time, adolescents are moving from being passive members of society into active members of society (Mbiti 1969 cited in Nyathi 2001:97). The rites prepare adolescents for new roles, such as marriage, procreation and family responsibility. Girls are introduced into roles of women in society.

Before the ceremony, each girl wearing her *umsisi* (ballet-like skirt) is taken into a hut by some old woman who smears her body with red clay (*isibuda*). Ox bladders are tied around her arms and she is anointed with fat. After the visitors leave, her father's village she is presented with presents (*ukukhunga*). After this she then wears "*cumuli*" a plaited skirt and is considered of marriageable age (Child 1969:53; Hetmans 1968:9).

King (2003:14) explains that a ritual marks entry into the adolescence world at puberty especially for girls who are removed from the parents' homes to a place where the rites are conducted. This is the business of the community elder. This new stage and participation in community life includes intensified gender sensitisation and added attention to sexuality. Women introduce girls to behavioural restrictions which they must observe during their menstrual period for the rest of their lives. The most important of these are abstinence from sex and some degree of avoidance of men in everyday life.

To confirm the above discussion, Nyathi (2007:7) describes human development as having distinct stages, some of them occasioned by important biological maturity that individuals need to be assisted through. Girls who reach puberty have their new status reflected not only in their dress, but also in their behaviour. Passage into the next stage needs careful management based on years of experience. An individual so assisted must be fully integrated into the next higher stage of social or spiritual being. Advancement from one stage to the next entails separation from lower society that one has been a member of. This is followed by a period of seclusion sometimes

in the bush or in a hut set aside for this purpose, during which the initiate belongs to no particular group save that of the fellow initiates. The next higher stage has its own culture that is practiced by its own members. For one to begin the process of integration one must undergo a carefully designed curriculum. Invariably, the teachers are members of the same sex; usually her married aunties and sisters (Nyathi 2007:7). Bennett (2004:299) concurs with the above information by stating that members of the set are subject to an initiation ceremony during which they learn to adopt a new identity that is marked by specific modes of dress, language and behaviour before progressing to the next age grade.

The author takes pains to explain that Zimbabwean Ndebele girls who reach puberty; that is, those who experience menses for the first time are gathered at the homestead of the girl who is first to reach the stage. The girls so gathered are taken to the entrance of the cattle kraal. Meanwhile, a boy is perched on the kraal fence. The girls wear skirts and nothing more. The boy is armed with a swish, *hamu* with which he mercilessly beats up each girl in turn in the coldest time of the year. From the cattle kraal, the girls are shepherded towards a large pool of water in the river. Sometimes the water is so cold that it will be having layers of ice on top. At the river there are more beatings, this time by an old woman. From the beatings, then comes bathing in ice-cold water. Before proceeding home, the girls apply red ochre on their faces. From there, the girls are taken to a hut belonging to one of the elderly women, where they receive further training and instructions pertaining to the roles of a married woman. With all this done, the girls are ready to take up their places as members of an adult society.

An analysis of the rites performed at puberty, shows that the girls are initiated to become part of the adult society under very harsh conditions which subject them to a lot of pain and endurance of difficult situations in an effort to make them stoic to very high levels of pain. Although the beating by a boy is some kind of training possibly for the girls to be stoic and be able to endure severe pain; this, in the researcher's view point is in preparation for labour pains; seeing the only major expectation of society for women is birth (Donkor 2008:22; Nyathi 2008:22).

On the contrary the researcher views beatings by a boy as having a negative psychological effect on the girl such that they should look at men as superior and are bound to be subservient to them to an extent that even in a marriage they are not able to make independent decisions pertaining to reproductive health issues; a typical cultural phenomenon in the Zimbabwean Ndebele culture.

2.9.2 Sexuality

Sexuality is taught at the "Byale or girls' circumcision school" (Krige 1937:105), discusses a situation where the day is spent working and performing various rituals, being subjected to hardships and being beaten severely and fed on hard porridge that must be eaten very quickly. At the circumcision school, the girls must be very humble and respectful to all and have to use the special terms characteristic of the school whenever they speak.

In preparation for marriage and sexuality, the nights are spent elongating the labia minora using medicine made of parts of a bat for effectiveness. Sometimes during the "circumcision school" (Krige 1937:105-106), the operation; usually a cut on the clitoris is performed and the ceremony is ended in a dance and feast. This is the time the boys and girls are taught about childbirth, marriage, and sexual life. However, the teaching can only be understood and valued within the context and setting, otherwise it can only be understood as obscene if not understood in the moral function.

Analysis of the information given above is that, while the significance of the "byale" is that it is closely associated with fertility and is in preparation for marriage, it is in fact a form of female genital mutilation (FGM). WHO (2001 cited in Huband, Hamilton-Brown & Barber 2006:173) defines FGM as all procedures involving partial or total removal of the external genitalia or other injury to the female genital organs whether for cultural or other non-therapeutic reasons.

According to Chikunda et al (2006:146), some cultural practices such as circumcision have been condemned in a number of communities and policies, bills and acts have been proposed to prohibit the cultural rite and some have actually

managed to enforce the laws against circumcision. Mbugua (2000 cited in Chikunda et al 2006:147) notes that female circumcision is being discussed at international and national contexts as a violation of human rights and is often viewed as oppressive, inhuman and destructive to female reproductive health. However, Zimbabwe has not yet passed any legislation governing circumcision and initiation practices. Chikunda et al (2006:147) believe that one reason for this could be that lawmakers do not consider initiation as an issue since it is only practised by a few tribes.

The other reason these authors believe could be the belief in *Ubuntuism* (humanness) which has led some schools of thought to argue in favour of such traditional cultural practices. The community defines *ubuntu* as a concept which implies that the community takes precedence over the individual (Wiredu 1995 cited in Chikunda et al 2006:147). *Ubuntu* serves as the spiritual foundation of most African societies. Low (1995:7 cited in Chikunda et al 2006:147) points out that "ubuntu is of Africans, by Africans and for the Africans". This could be the reason why the Zimbabwe government is not keen to ban such practices.

Other traditional cultures in the non-western countries such as the Persian region also perform female genital operations, usually done in childhood. This is most common in parts of the African zone and in the parts of the Middle East. Scattered Middle East societies practise clitoridectomy, removing part or the entire clitoris, in some cases all or part of the labia are removed as well. The main rationale is to reduce or eliminate the sexual motivation of women to ensure that they would behave honourably (Gulick 1976 cited in King 2003:58; Huband et al 2006:175).

The sad part about the rites ritual of circumcision and FGM as initiation is that as a medical procedure; it has negative effects on the labour process which is usually complicated and inevitably ends up in alternative modes of birthing, CS in particular. Huband et al (2006:173) also acknowledge that it is a medical and human rights issue as well as cultural practice which regrettably usually leads to complications of labour such as delay and obstruction in the second stage of labour from scarring of the perineum and vagina; a typical indication for medical intervention.

2.9.3 Sex life and marriage

African children, even before puberty are allowed playing in sexual intercourse, but it has no social consequences taking into account that no children are born, and there is some form of social control which varies from tribe to tribe. Definite instruction is given at puberty among Venda and Zulu societies on how to have intercourse without losing virginity. Only external intercourse is however allowed. Girls are periodically examined by their mothers to see if they are intact and there are effective sanctions to secure virginity till marriage (Krige 1937:109; King 2003:192). Girls are kept closer to home in preparation for marriage.

Among the African tribes, marriage occurs when an individual has passed through whatever schools and ceremonies for initiation into adulthood. In the Zulu and other tribes of Natal, marriage is either by customary arrangement *ukuganisela* or by *ukubaleka* (elopement) when she elopes with her lover. The Nguni people have the *ukuthwalwa* a kind of abduction in which the boy and his friends carry off the girl to his homestead. The girl runs away with her lover to some relative and the boy's people report the matter to the girl's father who usually accepts the position, but demands *lobola* (some kind of dowry) to be paid by the boy or his family (Krige 1937:13; Child 1965:21; Bennett: 2004:212). The same custom is practiced by the Zimbabwean Ndebele society as they are descendents of the South African Ndebele tribe and have never changed their culture.

In most African tribes the handing over of *lobola* is a life-long process and there is "no finality in it ..." as often, instalments are handed over after the birth of each child (Bennett 2004:222). Only through *lobola* can a man claim the children of a woman; once this has been paid, all her children are his, too, whether he is their real father or not. By giving *lobola* men, also obtained various rights relating to their wives, including labour, sexual access and affiliation of offspring with the father's kin group (King 2003:192). In the Zimbabwean Ndebele culture, this is what sometimes causes the men to believe that they have paid a prize for the woman and cause them to sanction their activities including seeking permission to visit a health care centre or even consent for alternative mode of birthing. In some settings women are not allowed to make decisions without participation from their husbands and if the

husband is away a woman would not be able to visit a health care setting (Global maternal Health in Crisis ... 2009). Payment of lobola also gives the children the right to become legitimate successors to the status and property rights of the father and his group. Until a new wife begins to bear children, her husband's group considers her a stranger. Lobola could also be viewed as a loan of capital in return for the woman's services.

Lobola is compensation to the group that has lost a member, to restore the equilibrium. It is also the blow or an attempt to soften the blow and try to obtain friendship from the girl's family so that there is a life-long bond between a man and his parents-in-law. The importance lies in the fact that *lobola* is marriage and for the Southern African peoples marriage without lobola is inconceivable (Kriger 1937:114).

2.10 CONCLUSION

Childbirth is a normal event and a socio-cultural expectation to perpetuate the human species (Zimbabwe television (ZTV) 1, 2008. Breath of life. 14 December 2008, 1700; Damasane, M. 2008. Informal discussion, 10 December. Bulawayo). In the researcher's experience, the Zimbabwean Ndebele society expects childbirth to occur without medical intervention.

There are very few studies done on the subject. Studies done mainly focus on infertility or childlessness and moreover the subject of childbirth has some areas that are culturally taboo to discuss. Information pertaining to the history of the Zimbabwean Ndebele is mostly narrated as people are only realising the need to document issues now (Truter 2007: 57).

In this chapter, relevant literature reviewed revealed that there is no available literature on societal perspectives on alternative modes of birthing in general and indeed on the Zimbabwean Ndebele society. Nonetheless, studies done relate to preference of home deliveries as compared to those that occur in public health institutions. This could suggest deliberate avoidance of utilisation of public institutions as they may be associated with medical interventions which often include alternative modes of birthing which are culturally unacceptable. Other studies done

reveal that; preference to home births in most African cultures seems to be attached to the desire to perform rituals at the birth of an infant (Matua 2004:34). Some studies done focused on TBA involvement in the birthing process. Reasons highlighted for women delivering with TBAs include good communication skills, being readily available in all areas as well as avoiding CS births and other medical interventions (De Villiers & Ledwaba 2003:664; Matua 2004:34; Aziken 2007:46).

Another area that was clearly outlined in the literature that was reviewed is the fact that the African tribes, the Zimbabwean Ndebele society included, believe in spiritual life and as such everything that happens to them is linked to supernatural powers (Mathema 2009:4). Thus medical interventions in the form of alternative modes of birthing appear to be avoided.

This raised concern for the researcher, hence this study which explored the views of the Zimbabwean Ndebele society on alternative modes of birthing.

CHAPTER 3

METHODOLOGY

3.1 INTRODUCTION

This chapter addresses the methodology that was used for the study. To fulfil the purpose of the study and to answer the research question(s), the research design, methods and the plan for data collection and analysis are described and discussed as these were implemented during the course of the study.

3.2 RESEARCH PARADIGM

A paradigm is a world view, a general perspective, a way of breaking down the complexity of the real world (Polit & Beck 2006:3, 2012:Loc24348). “Paradigms are also normative, telling the practitioner what to do without the necessity of long existential or epistemological consideration ...” (Pato 1978:203 cited in Lincoln & Guba 1985:15). Currently, the two major research paradigms are the quantitative and qualitative paradigms.

Qualitative research is a way of gaining insights through discovering meanings, not through establishing causality, but through improving one’s comprehension of the whole. It is a means of exploring depth, richness and complexity inherent in the phenomenon (Polit & Beck 2004:16, 2012:Loc24498; Schwarts-Barctt & Kim 1986 cited in Burns & Grove 2009:51).

Qualitative research is most often associated with naturalistic inquiry which attempts to deal with the issue of human complexity by exploring it directly. In the naturalistic tradition, emphasis is on the inherent complexity of humans, their ability to shape and create their own experiences and that truth is composite in multiple realities. Consequently, naturalistic investigations rely heavily on understanding of the human experiences as lived; usually through the careful collection and analysis of qualitative

materials that are narrative and subjective (Burns & Grove 2005:24, 2009:23; Jensen & Allen 1996, Sandelowski et al. 1997 cited in Zimmer 2006:312; Polit and Beck 2008:17). With regards the current study, child bearing is an aspect of social life which has been incorporated into the socio-cultural expectations in which individuals' perspectives on alternative modes of childbirth can be captured through subjective, unstructured qualitative approaches which are closely associated with the interpretive and critical paradigms (Burns & Grove 2009:24).

Willis, Muktha and Nilakanta (2007:97) state that whether it is called interpretive research or qualitative research, a core belief of this paradigm is that the reality we know is socially constructed. Making meaning is a group or social process. Humans in groups, and using the tools and traditions of the group (including language) construct meaning and thus are able to share their understanding with other members of the group (Willis et al 2007:97). Further, interpretivists proclaim that all research is influenced and shaped by pre-existing theories and world views of the researcher (Willis et al 2007:95). In this regard the researcher declared her westernised worldview as well as having sketched the socio-demographic context in which the current research was conducted.

The purpose of qualitative or interpretivist research is to arrive at understanding. Acceptable methods for research include both subjective and objective research methods in which data need to be understood in context (Willis et al 2007:367).

Foundational to the interpretivist paradigm is the theoretico-philosophical branching of Verstehen (Max weber), hermeneutics and phenomenology (Willis 2007:99). It is also the researcher's understanding that her research ultimately resides in these theories as "verstehen" means to understand; hermeneutics emphasise the importance of language in understanding. Language makes possible what we can say, and limits what we can say. Phenomenology and the related movement of existentialism, both accept that there are no universals that humans can know without doubt (Willis et al 2007:107).

3.3 RESEARCH DESIGN

A research design is “a plan or blue print of how you intend to conduct the research” (Mouton 2004:55 cited in De Vos, Strydom, Fouche & Delpont 2005:132). The research design gives an overall picture of the study that spells out the basic strategies and efficient methods that are used to extract relevant data, which when analysed, help in drawing inferences about the phenomenon under investigation in order to answer the research question (Polit & Beck 2004:14, 2012:Loc2141 and Loc24573; Burns & Grove 2005:211). The current study intended to answer the overall research question: “What are the Zimbabwean Ndebele perspectives on alternative modes of childbirth?”

According to Punch (2005:142), the design situates the researcher in the empirical world; while Burns and Grove (2005:40, 2009:41-2) profess that the research design directs the selection of a population sampling procedure, method of measurement and a plan for data collection and analysis. The choice of research design depends on the researcher’s expertise, the problem and purpose for study and the desire to generate knowledge and theory in the case of qualitative research or generalise findings in the case of quantitative research (Burns & Grove 2005:40).

The study was exploratory, descriptive and contextual in nature with purposively selected participants. The spouses related their stories of being closely related to the women who had given birth through alternative modes of childbirth.

3.3.1 Dimensions of the research design

Burns and Grove (2005:211) refer to methodology as the entire strategy from problem identification to final plans for data collection. Polit and Beck (2006:442, 2012:Loc523; Research methodology ... 2008) further impress that a research methodology defines what the activity of the research is, how to proceed, how to measure progress and what constitutes success. Methodology relates to how results will be achieved, and explains how data are to be collected and analysed. It also gives an explanation of methodological problems, their effects on the study and their solutions.

According to Polit and Beck (2006:217, 2012:Loc1881), not all qualitative research has a link to one of the qualitative traditions (or methodologies as labeled by Speziale and Carpenter 2011) discussed in the third paragraph of section 3.3. Some qualitative studies simply focus on describing a phenomenon in a holistic fashion. Generally most qualitative methodologies focus on exploring the contextually based, “lived” (as is), experience of individuals and social groups (Zimmer 2006:315). This is the general all-embracing aspect of qualitative research, which uses a descriptive, exploratory and contextual approach. It is a research approach in social research focussing on the insider perspective on social action (Babbie & Mouton 2001:270). Qualitative, descriptive, explorative and contextual research was adopted in the current study.

Qualitative research seeks to explain human behaviour, and is believed to embody humanistic and naturalistic philosophy which holds that the world is known through human perception and subjectivity. It is considered more closely associated with the interpretive and critical paradigms (Burns & Grove 2005:24). In the current qualitative study; which is largely generic, participants related their perceptions and world views to which they had been subjected in their natural settings through being part of the social environment within which alternative modes of birthing occurred. The natural reactions of the Zimbabwean Ndebele society in general and how these were interpreted are the core issues that the study addressed (Zimmer 2006:314).

General characteristics of qualitative research utilised in the current study were subjective reality, multiple realities, and self-reports rich in narrative descriptions from in-depth unstructured interviews and semi-structured interviews with small purposive samples. The researcher was part of the research process as the main data collection instrument. Other key characteristics of the qualitative research are that the research approach is context dependent and trustworthiness is a significant feature (Lincoln & Guba 1985:3).

The exploratory, descriptive and contextual qualitative research design was identified as suitable for the study purpose of exploring and describing the phenomenon because that which was investigated required in depth descriptions. The literature

review did not reveal any studies done in the area of Ndebele perceptions on alternative modes of child bearing. Thus, this qualitative approach was used because not much information has been documented in the area of study. The study's aim was to obtain in-depth rich information to gain a deep understanding of the phenomenon under study.

Historically, the development of qualitative research is largely associated with the disciplines of anthropology and sociology but has since become established in a range of other academic disciplines such as education, social policy, human geography, social psychology, history, organisational studies and health sciences. To emphasise the above assertion, Punch (2005:134) points out that qualitative research is multidimensional and pluralistic and is therefore not a single entity, but an umbrella term which encompasses an enormous variety.

Since the current study was conducted for academic purposes in health studies to investigate cultural (natural) reactions of the Zimbabwean Ndebele society on alternative modes of childbirth, the qualitative design was found to be most appropriate. This is so because the qualitative research design particularly accommodates the epistemology of theoretical and methodological assumptions of anthropology as the host discipline from which it evolved (Denzin & Lincoln 1994 cited in Avis in Holloway 2004:3; Burns & Grove 2009:23). In this regard, Holloway (2004:4) outlines four main methodological commitments that characterise qualitative research. These include: naturalism, flexible plan of inquiry, textual data and extensive interaction. A discussion of these, together with other main characteristics of qualitative research, follows.

3.3.1.1 *Naturalism*

This characteristic of qualitative research has its focus on describing and understanding an individual's experience from the ontological perspective of being-in-the-world and his/her interpretation of the social world (Zimmer 2006:314). Methodological naturalism holds that research techniques should be familiar to people being studied, respect their beliefs and have similarities with normal social interaction such as conversation (interviewing).

In naturalism, the application of sociological theory becomes very important when it comes to qualitative inquiry. The process is a social contract of commitment, because the research inquiry is subject to interpretation and researchers cannot detach themselves from the evidence they are generating. Any form of investigation is likely to influence participants' behaviour. Naturalistic methods of inquiry deal with the issue of human complexity by exploring it directly; hence naturalistic inquiry always takes place in naturalistic settings over an extended period of time, which is what was employed during the current study (Polit & Beck 2006:16, 2012:Loc1806 and Loc24274). The researcher, as the main data collection instrument, maintained direct interaction with the participants.

Qualitative researchers are less concerned with producing findings that can be generalised to a wider population because this process is not dependent upon sampling theory, but the way the results can be made to fit within general social and other theories. In qualitative research, "what is unique to one person cannot help us understand anybody else ... whilst recognising the possibility that unique human experience might be shared human 'experience,'" which is called fittingness (Paley 2006:113). Witt and Ploeg (2006:221) citing Sandelowski (1986:32) say that fittingness is "how completely the study participants represent the group of which they are members". "Fit" also refers to the integrated representation of the phenomenon under investigation as a whole.

Naturalistic studies yield rich, in-depth information that can potentially clarify the multiple dimensions of a complicated phenomenon. Polit and Beck (2006:16) assert that the findings from in-depth qualitative research are typically grounded in the real-life experiences of people with first-hand knowledge of a phenomenon. Lincoln and Guba (1985:7), profess that the naturalistic approach provides a paradigm shift whose other aliases are ethnographic, phenomenological, subjective, qualitative hermeneutics and humanistic.

Another characteristic of naturalism is the distinctiveness of qualitative research to explain social processes from the perspective of those participating in the study (Holloway 2004:13). However, having discussed all the above characteristics of

qualitative research, Holloway confesses that it is not easy to use qualitative research in a way that is acceptable to everyone.

3.3.1.2 *Exploratory research*

All qualitative research usually starts with research questions that ask how one can acquire an understanding of social behaviour by exploring people's subjective accounts of life (Holloway 2004:4, 2010:Loc3193). Subjectivity was used as a key component in eliciting the data deeply embedded in meanings of everyday life and language in order to make the unspoken Zimbabwean Ndebele perspectives of alternative modes of childbirth visible and audible (Van Maanen 2001 cited in Higginbottom 2004:12; Boyd 2001a; Munhall 1989 cited in Burns & Grove 2005:55, 2009:359-60).

Exploratory studies are not intended for generalisation to large populations. They are designed to increase knowledge of the field of study. Information gained from the study can be used to conduct confirmatory studies using large randomly selected samples. The study type was exploratory as it was aimed at exploring the Zimbabwean Ndebele perspectives on alternative modes of childbirth. The insight from the process can guide nursing practice and aid in the important process of theory development for building nursing knowledge which is what the current study aimed at (Popay 1992:100 cited in Holloway 2004:4, 2010:Loc3193; Burns & Grove 2005:357, 2009:359-60).

3.3.1.3 *Descriptive research*

Many qualitative studies focus on phenomena about which little is known and as such use in-depth methods to describe the dimensions, variations and the importance of phenomena (Polit & Beck 2006:21, 2012:Loc806). Qualitative researchers aim to give thick or complete descriptions ordinary conscious experience of everyday life. This involves social actions like hearing, seeing, believing feeling, remembering and deciding being analysed to make sense of the layers and layers of accumulated meaning seen from the perspective or view point of

one person as opposed to another (Polit & Beck 2006:47, Polit & Beck 2008:228; Brown et al 2003:210)

In the current study, the researcher made thick descriptions (see data displays in chapter 4) of all qualitative empirical materials in order to understand social interactions and perspectives of the Zimbabwe Ndebele on alternative modes of childbirth presented as themes and categories that were linked to one another. In chapter 5 these findings are interpreted in terms of the Theory of Human Becoming (Parse 1987). However, Parse's methodology has not been followed.

Descriptive study designs are designed to gain more information about characteristics within a particular field of study. Their purpose is to provide a picture of situations as they naturally happen; which is what the current study aimed at and thus was also contextually conducted in the community setting. Most studies contain descriptive components; however, methodology of some studies is confined to the typical descriptive design (Burns & Grove 2005:233, 2009:359-60). A qualitative descriptive study design is a critically important design for acquiring knowledge in an area in which research has not been done as is the case regarding the current research topic.

The current study also utilised a qualitative descriptive approach as the researcher intended to transcribe and interpret, in an understandable language, the verbalised opinions of the women who had given birth through alternative modes of delivery as well as the point of view of other members of the Ndebele community.

3.3.1.4 Contextual study

The context is the cultural, temporal and physical geographical setting in which the research occurs. In this regard also see the background to the research problem in chapter one. Being aware of the context starts at the beginning of the research until the final account has been written (Holloway 2004:275, 2010:Loc412). Holloway (2004:290, 2010:Loc412) further defines context as the background of culture, location and condition in which the research takes place. Contextual factors include social and environmental settings and individual variables that can influence study

outcomes. Studies done within contextual variables greatly increase the accuracy of the findings for practice (Holloway 2004:275; Burns & Grove 2005:170, 2009:693). Thus, the researcher was context sensitive because when collecting data on experience and perspectives and behaviour one needs to have context-intelligence. Contextualisation is critical for understanding the reality of participants and also links the reader to a storyline as the locality and culture are temporarily reflected in the write-up. Holloway (2004:275; 2010:Loc2554) professes that “A qualitative research account without contextualisation will be lifeless”. The current study is contextual, as it was conducted in the community and it centres on women who gave birth through alternative modes of delivery at the time as well as and other stakeholders. Community elders, men who were fathers or spouses, and traditional healers (*Sangomas*) and TBAs were all included in this study and were interviewed using different techniques. All interviews were done in the natural social settings to unravel perspectives on alternative modes of childbirth. This is supported by Zimmer (2006:315) who says that most qualitative methodologies focus on exploring contextually based, lived experiences of individuals and social groups. Contextually based “truths” may take the form of idiographic generalisations that can be understood only in facets as revealed by the particulars of various cases unlike the nomothetic generalisations produced through positivists-empiricist approaches (Lincoln & Guba 1985, Sandelowski et al. 1997, Sandelowski 1997 cited in Zimmer 2006:315).

3.3.1.5 Textual data

Qualitative research predominantly uses methods of inquiry that produce text rather than statistics; referred to as textual data which include transcripts of interviews or conversations, observation notes, case histories or entries in medical or nursing records termed as empirical information about the world. (Burns & Grove 2005:24). Denzin and Lincoln (1994 cited in Punch 2005:56) use the term “qualitative empirical materials”. Textual data allow people to express their thoughts and beliefs in their own words as happened during the current data collection process.

In qualitative research, there are the commitment and responsibility to analyse and present contextual data in a way that preserves their narrative and social character

as was the case with the current study on Zimbabwean Ndebele perspectives on alternative modes of childbirth. The researcher demonstrated this commitment in her use of direct quotations to illustrate her findings, as evidenced in the current study (Holloway 2004:5). With regard to the current research, the reader is presented with data displays containing all data units pertaining to a category or sub-category under a specific theme as it emerged from the data (chapter 4).

3.3.1.6 *Flexible plan of inquiry*

Qualitative researchers usually employ a plan of inquiry that evolves as the research progresses. The current research, to some extent, is an example of an emergent design. Qualitative researchers often start with a broad research question, negotiate access to people with relevant experience to offer and go on to develop the plan for sampling, data generation and analysis as the study progresses. The researcher adopted this approach for the study as it is flexible and allows for development of hunches and “working propositions” which were tested as the study progressed. To implement flexibility, the researcher was accommodating to participants as some would change interview appointments or venues and at times refuse to have their interviews tape-recorded for which a semi-structured interview guide was developed in the case of women who had given birth through alternative modes of childbirth. In situations where participants did not understand the question asked, the researcher clarified issues and probed for more information as the need arose.

3.3.1.7 *Researcher as main research instrument*

As the main data collection instrument, the researcher was capable of reflexivity by reflecting constantly and critically on the decision the researcher made during the course of the study, and the researcher definitely learned from her mistakes. Mason (2002 cited in Holloway 2005:6) states that researchers need to reflect on their own role in the social process of producing data. The process of reflexivity demonstrates transparency and leaves behind an audit trail, a record of the researcher’s design decisions about gaining access, and selection of data collection methods. Transparency denotes credibility of qualitative research, evidenced by allowing the reader to “see through” the researcher’s decision making and their analytic approach

to the data (Mason 2002 cited Holloway 2005:6). The researcher spelled out the “road map” of the current study in the methodology chapter.

Qualitative inquiry explores the meaning that people attach to their experiences as it identifies and describes social structures and processes that shape these meanings. Qualitative research captures social events from the perspective of the people being studied or provides an insider’s view of social life referred to by Bryman (1988:61 cited in Holloway 2004:4-6) as “seeing through the eyes of the people” which is what the researcher set out to achieve (Burns & Grove 2009:22).

3.3.1.8 Extensive interaction

Qualitative research heavily relies on extensive interaction with people being studied using unstructured interaction to explore meanings that people attach to their experiences. The interaction should be over an extended period of time in a fairly unconstrained manner using individualised open-ended unstructured interviews.

In the current study, data were generated freely through unstructured interviews, a semi-structured interview guide based on real stories told by the participants about their experiences and views, and by means of focus group interviews. Extensive interactions with the participants were made possible through the interview process of establishing rapport, explaining the purpose of the research, obtaining verbal consent, engaging in in-depth open-ended interviews and probing. The interviews had no time frame, and were governed by redundancy of data.

3.3.2 Rigour in qualitative research

In qualitative research, rigour is defined differently from quantitative research because the desired outcomes are different (Sandelowski 1986 cited in Burns & Grove 2005:55, 2009:720). In qualitative research, rigour is defined as the “goodness” of the qualitative research (Emden & Sandelowski 1998:206 cited in Witt & Ploeg 2006:217; Streubert Speziale & Carpenter 2007:48). Rigour relates to “fittingness” of all the components of the research process (see section 3.3.1.1.1). It is associated with openness, scrupulous adherence to a philosophical perspective,

exactness, preciseness, thoroughness in collecting data and consideration of all the data in the subjective theory development phase. In this regard, the researcher presented ample evidence for the categories and themes the researcher arrived at. Once this initial analysis had been completed, the researcher reinterpreted the findings in terms of Parse's Theory of Human Becoming (see chapter 5).

Evaluation of the rigour of a qualitative study is based in part on the logic of the emerging themes and categories with which to develop theory and make clarity to shed light on the studied phenomenon. To be rigorous in conducting qualitative research, the researcher must ascend on an open context and be willing to continue to let go of sediment views (referred to as deconstructing). Maintaining openness requires discipline. The current research examined many dimensions of the area that was studied and formed new ideas (referred to as reconstructing) while continuing to recognise that the present reconstruction is only one of many possible ways of organising ideas (Witt & Ploeg 2006:217).

In a nutshell "the goal of rigour in qualitative research is to accurately represent study participants' experiences... demonstrated through researchers' attention to and confirmation of information discovery" (Streubert Speziale & Carpenter 2007:49). Thus, credibility, dependability, confirmability and transferability have been identified as terms that describe operational techniques supporting the rigour of research and transferability in particular being labelled "fittingness" (Guba 1981; Guba & Lincoln 1994 cited in Speziale & Carpenter 2007:49).

3.3.3 Sampling and samples

3.3.3.1 Population

Population is the entire aggregation of cases in which a researcher is interested (Burns & Grove 2005:40, 2009:42; Polit & Beck 2008:337). In the current study, the population comprised the entire Ndebele community in Zimbabwe. There was a multiplicity of target populations and these included all women who had given birth two months prior to them being interviewed, spouses who were fathers to babies born through alternative modes of delivery, community elders, *Sangomas* (traditional

healers) and TBAs. It was from these populations that the researcher drew participants in order to obtain a larger or more diverse group of study participants' perceptions and experiences of the phenomenon under study (Polit & Beck 2006:32). Information obtained from participants from the populations of elderlies, sangomas and TBA's contributed to the contextualisation of the study.

3.3.3.2 Sampling

Sampling refers to the process of selecting a proportion of the target population to represent the entire population (Burns & Grove 2005:341, 2009:343; Polit & Beck 2008: 339). Non-probability sampling was used in the current study. Burns and Grove (2005:350, 2009:353-5) and Polit and Beck (2008:341) describe several types of non-probability sampling designs with each addressing a different research need.

With regard to the current study, purposive sampling was used since the study findings were not intended to be generalisable, but applied only to a specific target population that was under investigation (Murphy et al cited in Higginbottom 2004:14). Participants were selected through purposive sampling, a type of non-probability sampling in which the sample is selected on the basis of the researcher's knowledge of the elements of the population and which ones would be most useful or representative to serve the purpose of the study (Burns & Grove 2005:352, 2009:353-5; Punch 2005:187; Babbie 2007:184).

This type of sampling was appropriate for the study as it is designed to gather depth and richness of the participants' experiences on a specific experience of or perception about a social phenomenon. Purposive sampling was also used in order to assist me to understand the phenomenon of interest and capture a wide range of perspectives from data rich participants (Burns & Grove 2005: 352; Holloway 2005:110, 2010:Loc3380).

3.3.3.3 Sampling of participants

3.3.3.3.1 Inclusion and exclusion criteria during sampling

The first step in selecting a sample is developing a criterion that identifies those who should be included in the study sample. Polit and Beck (2008:338, 2012:Loc23906) refer to criteria that specify population characteristics as “eligibility criterion or inclusion criteria”. However; the afore mentioned authors further elaborate that, sometimes a population is defined in terms of characteristics that “people must not possess” referred to as “exclusion criteria”.

In the current study, sampling criteria were used to determine the actual study participants. Burns and Grove (2005:342, 2009:344-5) emphasise that sampling criteria may also include such characteristics as the ability to read, write or communicate using a specific language which is a key element in the comprehension of information on data collection instruments.

With regard to the current study, the ability to communicate, using the isiNdebele language, was an important element of the eligibility criteria. Although criteria should comprise all elements of the population, Burns and Grove (2005:342, 2009:343-5) argue that these should ensure a large target population of heterogeneous or diverse potential subjects in order to ensure a broad range of values for the phenomenon being studied, hence the inclusion of a multiplicity of population groups in the current study.

3.3.3.3.2 Different populations sampled

The research participants were divided into five purposively selected groups (or target populations). The populations are briefly introduced, and the sampling methods and techniques applied are discussed. Table 3.1 provides an overview on this as well as on the data collection methods and techniques that accompanied each sample (population) group.

TARGET GROUPS	SAMPLING TECHNIQUES	DATA COLLECTION METHODS	DISCRIPTION/OTHER DETAILS
Group 1 Women who have had an alternative birthing procedure performed	No-probability purposive	1. Unstructured in-depth face-to-face interviews 2. Structured face-to-face interviews	Women who had given birth by alternative modes of delivery within two months at the time of the study
Group 2 Spouses of women in group 1	Non-probability purposive	1. Unstructured in-depth face-to-face interviews	Men who were spouses or fathers to babies born through alternative modes of delivery
Group 3 Community elders	Purposive snow-balling	Unstructured in-depth face-to-face interviews	Community elders looked upon by society as guides on cultural issues on childbirth to perpetuate Zimbabwean Ndebele culture of <i>ubuntu</i>
Group 4 Sangomas	Purposive snow-balling	Unstructured in-depth face-to-face interviews	Traditional healers (<i>Sangomas</i>) with knowledge of Zimbabwean Ndebele cultural issues relating to child birth and had administered herbs at some stage to women in labour to facilitate natural birth in case of a complicated delivery
Group 5 Traditional birth attendants	Purposive snow-balling	Focus Group Discussions	TBAs who assist women and have administered herbs during labour to facilitate natural childbirth in case of a complicated delivery.

❖ Mothers

“Mothers” were women who had given birth through alternative modes of childbirth within two months at the time of the study irrespective of the reason and the number of times they had given birth. These women were selected from registers of two participating hospitals. This time criterion was set as culturally women might spend the first month with their parents with limited social interaction with the rest of the community. Two months after the birth of their babies, the women were also able to sit up and talk for a period of time required to relate their experiences without any pain or discomfort. The other important issue is that during that period, they had already interacted with the community and would have been subjected to the stigma and unfavourable treatment from their society regarding alternative modes of, or unnatural, childbirth (Donkor 2008:22).

❖ **Male spouses**

This group consisted of men who were spouses/fathers of babies who were born through an alternative mode. The men were able to give their views on the phenomenon as fathers and as husbands to women who gave birth non-naturally.

❖ **Community elders**

This group consisted of community elders; an older influential member of a family, tribe or community. A community elder is a role model who is capable of teaching individuals about the native culture and can facilitate certain ceremonies, for example, welcoming new arrivals into the family, including newborn babies (Elders definition ... 2008). It is for these reasons that the community elders are looked upon as cultural guides on issues of childbirth and to conserve and perpetuate the Zimbabwean Ndebele culture of *ubuntu* which emphasises the concept of communalism; a concept that is central to African ethics in most communities in sub-Saharan Africa (Mlaudzi, Mokoena & Troskie 2010:206). This group could share their views as custodians of tradition and culture and also give a historical view of the Zimbabwean Ndebele society in relation to childbirth.

❖ **Sangomas**

Sangomas (traditional healers) who had knowledge about cultural issues and beliefs related to childbirth were in this group. Their experience and involvement in issues of childbirth through prevention and treatment of labour complications by administering herbs at some stage to facilitate natural birth was found to provide a rich contribution to the study.

Snow-balling was used to identify the *Sangomas* (traditional healers) and TBAs who participated in the study, as these individuals are seldom willing to make themselves known as a way of protecting their sacred traditional values. Community elders were also selected through purposive snow-balling. The first participants were identified through convenience sampling in which subjects were included in the study because they happen to be in the right place at the time (Burns & Grove 2005:350). This

sampling method was used because it is an effective strategy for identifying participants who know other potential participants who can provide the greatest insight and essential information about an experience, event or phenomenon that is being studied (Patton, 2002 cited in Burns & Grove 2005:253).

❖ **Traditional birth attendants**

Traditional birth attendant (TBA), also known as a traditional midwife, is a primary pregnancy and childbirth care provider who usually learns her trade through apprenticeship, although some may be self-taught. They are not certified or licensed. According to Mathole et al (2005:943) TBAs are a diverse group, which includes ordinary women who acquired their skills through learning from others and may only provide antenatal care but have knowledge of special herbs known to be important for cervical dilatation.

Traditional birth attendants were also included in the sample as they contribute a lot in delivering women and considering the fact that their service is deemed more effective and less costly as compared to those offered at public health institutions (Matua 2004:35). Moreover, they have information on administration of traditional herbs administered during labour.

3.3.3.3.3 *Sample size*

According to Bowling and Ebrahim (2005:525), Paley (2006:112) and Polit and Beck (2006:219), qualitative research as a methodological approach involves collecting data from small sample sizes of 10 or fewer to obtain in-depth, contextualised understanding of human phenomena. It, therefore, may not be possible to fully specify the number of participants required at the start of the study. The number is also determined by the redundancy (saturation) point where no new and significant information is obtained for ongoing thematic development and theorising (Higginbottom 2004:13; DiCicco-Bloom & Crabtree 2006:317; Peek 2009:37).

In the current study, the researcher interviewed participants until data redundancy was attained and no new information was obtained from purposively selected women

who had given birth through alternative modes of childbirth, spouses/fathers, community elders and *sangomas* (traditional healers). Only then was it possible to determine the sample size. The principle of redundancy was applied within target populations and not across target populations. Thus, certain information (categories) emerged from each of the populations' data. Rather than viewing this as repetitious, the researcher see it as confirmation that certain cultural perceptions relating to alternative modes of birthing are found diffusely across the Ndebele culture and community.

3.3.3.3.4 *Site sampling*

An important task during research planning is to identify the sites (and settings) for the study. In many studies, the identification of an appropriate site involves considerable effort. Planning for this aspect of the study involves two types of activities namely selecting the site or sites, and gaining access to them (Holloway 2010:Loc3507).

Before entering the field, qualitative researchers must identify a site that is consistent with the research topic. A site may be well situated to the needs of the research, but if researchers cannot "get in," the study cannot proceed. Gaining entry typically involves negotiations with the gate keepers who have authority to permit entry into their world (Polit & Beck 2008:70, 2012:Loc24648; Holloway 2010:Loc1400-4).

The primary consideration in site selection is whether the site is appropriate to the research question – that is whether it is likely to have people with behaviours, experiences or characteristics of interest. The site must have a sufficient number of these kinds of people to achieve the research goals. In addition, the site must be one into which entry is possible or plausible and access to participants can be guaranteed. The ideal site is one in which methodological goals and ethical requirements (such as the ability to ensure privacy and confidentiality) can be achieved. The site should be one in which the researcher will be allowed to maintain an appropriate role: to study the participants for the duration of the study (Polit & Beck 2008:205-206, 2012:Loc2233).

Gaining entry requires strong interpersonal skills as well as familiarity with the customs and language found in the site. Certain strategies are more likely to succeed than others. For example, gatekeepers might be persuaded to be cooperative if it can be demonstrated that there will be direct benefits to them or their constituents or if a humanitarian purpose is served.

No matter how congenial the researcher may be, gatekeepers need information on which to base their decisions about gaining access and this information usually must be put in writing even if negotiation takes place in person. The letter or information sheet should cover the following points: purpose of the research and who the beneficiaries would be and why the site was chosen or considered desirable (Polit & Beck 2008:206).

The study was conducted in the Bulawayo area, the second-largest city in Zimbabwe after Harare the capital city, during the second half of 2009 and 2010. The 2002 national census estimated Bulawayo's population at 684 232 (City of Bulawayo 2004:1). The researcher utilised records from the two purposively identified government referral maternity hospitals to follow up purposively identified participants in the community. The two government maternity hospitals were identified because they offer consultant specialist services to clients referred from district hospitals, urban PHC clinics and from private practitioners. One centre is located in the high density suburbs and the other in the low-density suburbs. The specialist consultants in the participating hospitals offer alternative modes of childbirth in emergencies or electively when labour complications arise or when the clients opt for or demand elective alternative modes of childbirth which they consider a modern and painless form of birthing. These include caesarean births, instrument deliveries (vacuum extraction, forceps and symphysiotomies) (McCallum 2005:215); however, mostly caesarean births.

3.3.4 Data collection

In order to ascertain the perspectives and experiences of the participants, the researcher conducted interviews and focus group discussions (FGIs) with me being

the main data collection instrument (Lincoln & Guba 1985:39; Polit & Beck 2006:210; Speziale & Carpenter 2007:36).

3.3.4.1 Interviews

Qualitative interviews have a variety of categories loosely differentiated into unstructured, semi-structured and structured (Donalek 2005:124; DiCicco-Bloom & Crabtree 2006:314). Qualitative research is humane and uses the humanistic approach to gather knowledge with the researcher as the main data collection instrument. In the current study, the researcher used unstructured and semi-structured interview schedules to conduct interviews and could thus probe and clarify issues. FGIs were also used to collect data.

3.3.4.1.1 Individual interview

❖ Unstructured interview

Qualitative research mainly uses unstructured interviews where the interview questions and responses are not pre-established with interview questions deliberately open-ended (Holloway 2010:Loc2208).

○ Motivation for choice of the unstructured interview

The traditional type of unstructured interview is non-standardised, open-ended, in-depth interview sometimes referred to as an ethnographic interview (Punch 2005:295). An unstructured interview is the most powerful research tool capable of producing rich and valuable data. Unstructured interviews are widely used in social research and other fields which include health sciences. It focuses on a feminist perspective of openness, emotional engagement and the development of trust in a potentially long-term and intimate relationship (Punch 2005:172).

A qualitative interview is flexible, iterative and continuous rather than prepared in advance. It is continuous in nature because the questioning is designed throughout the project as it unfolds (Babbie 2007:305). It is generally a conversation in which

interviewer establishes a general direction and is able to pursue specific topics raised by the participants (Babbie 2007:306).

- **Developing and testing data collection instruments**

Since the researcher used unstructured and semi structured individual and group interviews for women, spouses, community elders, traditional healers and TBAs, there were no specifically structured instruments developed as the data collection process was conducted in a more natural, open-ended way. A semi-structured guide was only developed when the need arose when some mothers declined having their interviews taped for fear of being reported to hospital authorities as they still owed the institutions balances of maternity fees (Punch 2005:179; Polit & Beck 2006:61; Bulawayo mothers detained for maternity fees ... 2012).

Customary, qualitative researchers formulate one broad question that is narrowed through the actual process of data collection and analysis, as was the case in the current study. According to Fetterman (1989:59 cited in Duma 2007:27), grand tour questions help the researcher to focus on and direct the investigation to meet the research objectives.

- **Process of data collection**

In the current study, the researcher conducted all the interviews. This assisted me in probing and clarifying issues where necessary. However, in all cases the researcher participated minimally by only asking probing open-ended questions in order to assist the participants to respond. The researcher only nodded to acknowledge raised responses. Interviews allow probing of unclear statements and as such left me with an opportunity to clarify issues that were unclear to me.

Data collection was done until a point of redundancy was reached. According to Burns and Grove (2005:750), Polit and Beck (2008:70-71) and Nieswiadomy (2008:411) data saturation or redundancy has occurred when no new themes or essences have emerged from the participants and the information is repetitive with no new knowledge gained and only yielding redundant information.

The researcher audio-taped interviews the in-depth interviews as this left me with a more complete record than note taking during interviews would have allowed. Information that was audio-taped during the interviews was later transcribed verbatim and translated for close contextual analysis (De Vos et al 2005:304). The researcher informed participants that they had the right to ask for the tapes after the interview for information verification. However, notes were taken during the semi-structured interviews.

- **Interviews with mothers**

The mothers were interviewed in the community two months after giving birth when they were able to talk about their experiences and had interacted with the community. This would have subjected them to whatever views society might have on alternative modes of childbirth (Donkor 2008:22).

The researcher scheduled interviews mostly in the afternoon during the week when the women were more relaxed and had done most of their mother/child responsibilities and attended to some of their household chores. One face-to-face interview was held per day and was followed up over a period of time to affect extensive interaction (Polit & Beck 2006:16). This also gave me time to transcribe, interpret and translate the audio-taped interview following each interview. Each participant was in a private venue of her choice, and arrangements were made for the interview session not to be interrupted. Follow-up interviews were done a week later or/and even at a later date. Data analysis was initiated concurrently with the interviews.

The following were the two research questions through which the researcher probed for information:

What is your experience of having a child born through an alternative mode of delivery?

What is the community's reaction to this?

- **Interviews with male spouses**

The face-to-face interviews for the purposively sampled men who were fathers of children born through alternative modes of childbirth were held at various settings. The environment was convenient to the participants, at a venue of their choice where the researcher went to conduct the interviews as per appointment time that was agreed upon. The preferred venue was a home where they were comfortable and in private with no interruptions during the interview.

The questions that the men were asked on probing focused on how their experience of fathering a baby born through an alternative mode of childbirth as well as on how they viewed a wife or partner who gave birth through an alternative mode of childbirth.

The research questions were:

“What is your experience of fathering a child born through an unnatural mode of delivery?”

“How do you view your wife following the unnatural birthing?”

- **Interviews with community elders**

Community elders were interviewed individually using unstructured face-to-face interviews. Interviews were conducted at venues convenient to the participants. Most preferred their home where they were assured of privacy. The researcher observed the principles of confidentiality throughout the data-gathering process. Two men and two women were interviewed. This was due to their geographical location and the distance which would not allow them being grouped together for FGI.

The research question was:

“What are your views on woman opting for unnatural birthing from a cultural point of view?”

- **Interviews with *Sangomas* (traditional) healers**

Sangomas (traditional healers) administer indigenous plant and animal remedies to heal others (Nyazema et al 1992 cited in Mathole 2006:18; Kazembe 2007:55). It was impossible to bring this group of participants together for FGIs as was originally planned. This was due to their suspicions of one another and not wanting others to steal ideas from them. This led to the traditional healers (*Sangomas*) also being interviewed as individuals so that they could share their personal encounters in the management of women in labour and the interventions they offer as consultants to TBAs and as practitioners themselves in situations of complicated labour.

It was also necessary to establish what knowledge they have on alternative modes of childbirth and the possible interventions in the event of complicated labour. Although the interviews were held at different venues around the city of Bulawayo, the researcher observed the same principles of privacy and confidentiality with the traditional healers (*Sangomas*) as was done with all the other participants who were involved in the study.

The research questions were:

“What are your views on woman opting for unnatural birthing from a cultural point of view?”

“What can you do for women relating to unnatural child birthing?”

- ❖ **Semi-structured Interview guide**

The semi-structured instrument consisted of a number of open-ended questions derived from the open unstructured interview data obtained from women who have experience some form of alternative mode of birthing. The semi-structured interview

questions were guided by themes that had emerged from the unstructured interviews. Each of these questions was treated as an individual entity and was probed in depth (Polit & Beck 2008:414; Speziale & Carpenter 2007:37; Holloway 2010:Loc2237). In the current study, semi-structured interviews were conducted to collect data from mothers who did not consent to being tape-recorded during face-to-face interviews.

- **Motivation for choice of the semi-structured interview guide**

Speziale and Carpenter (2007:37) define the semi-structured interview as one in which researchers use a set of preselected questions that they wish to have answered.

In the current study, some clients would not consent to interviews being tape-recorded for fear of being reported and handed over to the hospitals where their babies were born as they still owed money to these hospitals; hence the study had to include a semi-structured interview guide with specific questions from the in-depth interviews providing participants with the opportunity to fully describe their experiences of unnatural birthing (Bulawayo mothers detained for maternity fees ... 2012). These semi-structured interviews allowed for easier note taking of what interviewees said than would be the case with totally open-ended interviews.

This confirms the flexible plan of inquiry that evolved as the research progressed; the emergent design. The researcher was able to apply flexibility by employing different data gathering methods to different sources, and as such was able to respond to the research environment and to adapt to the requirements of the research setting.

3.3.4.2.2 Development of the semi-structured interview guide

A semi-structured interview was compiled with specific questions from the themes that emerged from the phenomenological interviews. The semi-structured interviews were used for data collection for those participants who had declined to give consent to tape recorded interviews (See appendix I).

❖ **Focus group interview**

In the current study, focus group interview (FGI) and focus group discussion (FGD) are used interchangeably and are given the same meaning. Focus group discussions are discussions organised to explore a particular set of issues and are meant to obtain perceptions on a defined area of interest through group interaction in a permissive, non-threatening environment (De Vos et al 2005:300; Holloway 2005:56). According to Schutt (1996 cited in Peek & Fothergill 2009:31), focus group discussions are unstructured group interviews in which the group leader actively encourages discussion among participants who have personal experience with the topic being studied. Punch (2005:171) points out that group interviewing is a general term where the researcher works with several people simultaneously rather than one. Like other interviews, group interviews can be unstructured, semi-structured or highly structured because different types of interviews have different purposes and use depending on the purpose of the research.

In group interviewing, the role of the researcher is that of a mediator or facilitator and monitoring as well as recording the group interaction (Punch 2005:171). The researcher needs to be highly skilled to handle group interviewing. The researcher conducted the group interviews in person as she had the required skills to handle the group interviews.

With regards the current study, participants (TBAs) were purposively identified according to their expert knowledge, experience and practise on alternative modes of childbirth. The thoughts, feelings and views of TBAs about alternative modes of childbirth were explored using FGIs.

Kirtzinger (1994:103 cited in Holloway 2005:61) suggests an ideal group of between four and eight participants, while Burns and Grove (2005:543, 2009:513-5) and Peek (2009:37) advocate for a group of six to ten participants. Holloway 2010:Loc3130 suggests 4 to 12 participants. Their argument is that smaller groups tend to result in an inadequate discussion. Like the interviews, focus group discussions were conducted at a venue of the participants' choice that allowed privacy and freedom of expression. The questions of this group of participants focused on how society

views alternative modes of childbirth and what the expectations of society are for a woman with regard to childbirth. Prior to the discussion, permission was sought from the participants to take notes during the interviews. The researcher conducted all interviews in the local isiNdebele language using brief and unambiguous probes and questions.

- **Motivation for use of focus group interviews**

The following advantages motivated me to select the focus group interview as a data collection method:

- Focus group interviews are important in gaining access to what people know and experience. They are also ideal for exploring people's talk experiences, opinions, beliefs, wishes and concerns (Kirtzinger 1994a:103 cited in Holloway 2005:61).
- According to Punch (2005:171), group interviews are inexpensive, data-rich, flexible, stimulating, recall-aiding, cumulative and elaborative and can produce data and insights that would be less accessible without the interaction of a group. The group situation can stimulate people in making explicit views, perceptions, motives and reasons. This makes it easy for the researcher to probe those aspects of people's behaviour. FGIs can be used as the only data gathering technique or with other quantitative or qualitative techniques.

3.3.5 Data analysis

Leech and Onwuegbuzie (2007:564), Green, Willis, Hughes, Small, Welch, Gibbs and Daly (2007:545), define data analysis as a systematic search for meaning. "What is critical about data analysis is the process of examining the information collected and transforming it into a coherent account of what was found (Green et al 2007:545).

According to Leech and Ownuegbuzie (2007:557), Green et al (2007:545) and Smith and Firth (2011:54), there are multiple types of data analysis techniques as well as an array of data analysis tools that facilitate a systematic search for meaning. Leech

and Ownuegbuzie (2007:557) outline seven powerful procedures for analysing qualitative data: methods of constant comparison, keywords-in-context, word count, classical content analysis, domain analysis, taxonomic analysis and componential analysis. Numbers are also an integral part of qualitative data and can help generate meaning and show the work and complexity of qualitative research by identifying patterns in the data (Sandelowski 2001 cited in Beck 2003:232). Ratcliff (2008:120) disputes the above statement by saying, "... data must be analysed carefully. Words, not numbers are the data".

The use of more than one type of analysis strengthens rigour and trustworthiness of the qualitative data findings via methodological triangulation as was the case in this research where the researcher used content analysis and thematic analysis so as to understand the phenomenon better, generate more meaning, triangulate the results and enhance the qualitative inferences (Leech & Ownuegbuzie 2007:579). The researcher discusses two of the approaches (content analysis and thematic analysis) that she used in this section.

3.3.5.1 Content analysis

The initial data analysis occurred concurrently with data collection while conducting the interviews through observation of non-verbal communication and behaviour as well as listening to what the informants were saying. This was an ongoing process of 'testing the fit' between the data collection and analysis. The data were transcribed verbatim followed by interpretations of narrations of data and script reviewing while simultaneously listening to the audio-tapes.

"Repeated reading and re-reading of interview transcripts and contextual data and listening to recordings of the interviews is the first step in analysis" (Green et al 2007:547). The subsequent analysis after transcribing the interview is immersing oneself in the data to gain detailed insights into the phenomena under investigation; developing a data coding system and linking codes or units of data to form overarching categories or themes that can lead to the development of theory (Morse & Richard 2002 cited in Smith & Firth 2011:54; Ratcliff 2008:122; Green et al

2007:545 & Ratcliff 2008:120). Appendix D shows the whole process of content analysis through to thematic analysis to come up with themes that emerged.

3.3.5.2 *Thematic analysis*

"Thematic analysis is an interpretive process in which data are systematically searched for patterns to provide an illuminating description of the phenomenon" (Tesch 1990 cited in Smith & Firth 2011:54). Smith and Firth explain that the process of thematic analysis results in the development of meaningful themes without explicitly developing theory. Thematic analysis can provide rich insights into complex phenomena, can be applied across a range of theoretical and epistemological approaches, and can expand on existing theory as was the case in this study when the researcher re-interpreted the research findings applying them to the already existing Parse's Theory of Human Becoming (Braun & Clarke 2006 cited in Smith & Firth 2006:54).

Unlike content analysis, which begins with predefined categories, thematic analysis allows categories to emerge from the data (Ezzy 2002 cited in Saldana 2009:L2780). Theming of the data is not an expedient method of qualitative analysis. It is just as intensive as coding and requires comparable reflection on participant meanings and outcomes. The interviewer does not uncover some pre-existing meanings but supports the interviewees in developing their meanings through the course of the interview. (Saldana 2009:L2780).

However, some researchers have criticised thematic analysis for lack of depth and that in some sections, data can be fragmented from the original resulting in data being misrepresented and lacking transparency in how themes were developed (Smith & Firth 2011:54).

Qualitative data can be difficult to manage because of its large volumes. Data displays as tools for qualitative data analysis can improve data management as they provide a means to condense large amounts of data into a more manageable form. Data displays can take a number of forms, including the extended text itself, matrices and charts and networks. Data displays represent effective means of communicating

a study's findings in a visual and simple way that promotes transparency of the process of analysis from which both readers and researchers benefit. Thus, data displays simplify thematic analysis (Creswell & Plano Clark 2011:Loc2372; Sandelowsky & Barosso 2007:Loc2711).

3.3.5.3 Relating data to an existing theory

In a further attempt to transform the data into a coherent account of what was found (Green et al 2007:545), the researcher related the data to the structure of Parse's (2012) Theory of Human Becoming. In a sense this involved analysing and interpreting data according to predetermined categories; the overarching principles of *structuring meaning*, cocreating rhythmical patterns and *contrascending* with their related paradoxical processes (chapter 5) were used as "predetermined categories."

3.3.5.4 Manual processing

The data analysis process was done manually in four phases as proposed by Van der Wal (1999:341). In this regard see the appendices D.

3.3.6 Trustworthiness (scientific rigour)

Qualitative researchers do not use validity, but employ trustworthiness, defined by Holloway (2005:296) as the credibility of findings in qualitative research and the extent to which readers can have trust in the research and its findings. It refers to the truth value as well as the methodological soundness and adequacy of the research, which is judged through the criteria of credibility, conformability and transferability (Holloway & Wheeler 2010:Loc6957; Ulin et al 2002:31 cited in Duma 2007:27). Polit and Beck (2008:768) state that trustworthiness refers to the degrees of confidence qualitative researchers have in their data.

In the qualitative research perspective, the term rigour, which refers to trustworthiness, replaces reliability and validity in quantitative research. There has been considerable controversy among qualitative researchers about criteria to use for assessing "truth value" of qualitative research. Lincoln and Guba (1985 cited in

Polit & Beck 2008:539) suggest four criteria for assessing the trustworthiness of qualitative data: credibility, dependability, confirmability and transferability.

3.3.6.1 Credibility

The term credibility refers to confidence in the truth and interpretations of the data (Holloway 2010:Loc7050). Lincoln and Guba (1985 cited in Polit and Beck 2008:539) point out two aspects of credibility. Firstly, carrying out the investigation in a way that enhances the believability of the findings, and secondly, taking steps to demonstrate credibility to external readers. In the current study this was addressed by the face-to-face interviews that the researcher conducted. This ensured that participants' information was first-hand, and tape-recorded to ensure that participants, and those familiar with the study topic, would recognise the information as demonstrating credibility.

Using three different data gathering methods were also utilised to secured credibility, lowering the intrinsic bias that comes from single-method, single observer and single data source studies (Denzin 1989:313 cited in Polit & Beck 2006:333). Denzin (1989 cited in Polit & Beck 2006:333) and Holloway (2010:Loc7166) identify four types of triangulation, namely: data source triangulation which refers to using multiple data sources in a study, investigator triangulation; using more than one person to collect, analyse or interpret a set of data, theory triangulation; using multiple perspectives to interpret a set of data and method triangulation; using multiple methods to address a research problem.

the researcher interviewed diverse participants including women who had given birth through alternative modes, men (spouses), community elders, *sangomas* (traditional healers) and TBAs to address data source triangulation as a means of ensuring credibility. Method triangulation is another triangulation technique that the researcher used to evaluate credibility. This was done through the use of multiple data collection methods which included interviews (unstructured and semi-structured) and FGIs.

3.3.6.2 Dependability

The term dependability refers to data stability over time and over conditions (Holloway 2010:Loc7050). There are two approaches to assessing dependability; stepwise replication and inquiry audit. Stepwise replication involves other researchers who can be divided into two teams to conduct two independent inquiries using an audit trail through which data and conclusions can be compared. Inquiry audit on the other hand involves scrutinising data and relevant support documents (Babbie & Mouton 2004:278; King & Ehlers 2004:13; Polit & Beck 2008:539). To allow for the latter. The researcher has numbered data units so that they can easily be traced to their original location in the text to read them in context. In this manner a data trail has been left for a data audit.

3.3.6.3 Confirmability

According to De Vos et al (2005:347), confirmability captures the traditional concept of objectivity. This is corroborated by Holloway (2010:Loc7073) as well as by Polit and Beck (2005:336, 2012:Loc19678) who define the term confirmability as the objectivity or neutrality of data inquiry audit as discussed in the above section. An inquiry audit was used in the current study to assess confirmability.

An audit trail is a record of the researcher's design decisions about gaining access, and selection of data collection methods. In utilising the audit inquiry, the researcher developed an audit trail which is a systematic collection of documents such as transcripts and audiotapes to allow an independent auditor to come up with his/her own conclusions about the trustworthiness of the data and the meanings attached to them. A decision trail was maintained to confirm data by categorising and making inferences in the analysis which was shared with other researchers in order to evaluate the soundness of decisions about the trustworthiness of the study (Mason 2002 cited in Holloway 2005:6).

3.3.6.4 Transferability

Transferability is the extent to which findings from the data can be transposed to other settings or groups. This is greatly affected by the sample of participants and the design rather than the soundness of the data (Polit & Beck 2008:539). A rich, thorough description of the research setting and the process observed during the inquiry is necessary to enable someone to decide on the possibility of transferring findings.

3.3.7 Ethical considerations

According to Pera and Van Tonder (2005:1) ethics refers to a system of moral values that is concerned with the degree to which procedures adhere to the professional, legal and social obligations. This means that the participants' rights and the rights of others in the research setting are protected as there are usually some risks with every study. The researcher discussed the ethics in relation to the study as guided by the four basic ethical principles; respect for autonomy, justice, beneficence and non-maleficence. This was done in consideration of participants, participating health institutions, the researcher's scientific integrity and ethics pertinent to the research topic (Van der Wal cited in Pera & Van Tonder 2005:151; Punch 2004:277; Burns & Grove 2005:83, 2009:611; Babbie 2007:62-74; Holloway 2010:Loc1505).

3.3.7.1 Participants

When studying any human behaviour, ethical concerns are paramount, particularly in studies with sensitive topics that are highly personal, or studies requiring some kind of protection of some traditional values as was the case with the current study (McKinney in Babbie 2007:68). Core issues of ethical considerations, pertaining to participants in the current study, involved autonomy, informed consent and respect of individuals.

Before going into the field, qualitative researchers must identify a site that is consistent with the research topic. They need to make preliminary contacts with key actors in the site to ensure cooperation and access to participants (Polit & Beck

2006:58). This process involves negotiations with the gate keepers who have authority to allow entry to the research sites.

With regard to the current study, the researcher involved different populations and the ethical issues were dealt with according to what applied to the specific sample. In order to identify potential participants, who were women who had given birth through alternative modes of childbirth, the researcher sought permission from the medical superintendent of the participating hospitals. She then took along the letter from the medical superintendent of each of the two hospitals confirming permission to access information. Unit matrons of each of the participating maternity units were approached to request permission to be allowed entry into the unit (see appendices D and F).

Once allowed entry, the researcher proceeded to the labour ward where the nurse-in-charge had a delivery register for all the women who had given birth. Having been granted permission to review the delivery register, the researcher proceeded to identify the women who had given birth through alternative modes of delivery in the participating hospitals. The women were visited at their physical residential addresses in the community two months after the delivery of their babies.

After gaining access to the residential addresses of the women who had delivered through alternative modes of childbirth, the researcher personally approached each potential participant to explain the purpose of the study. She also obtained informed consent from the participants which Burns and Grove (2005:193, 2009:201) define as the prospective subjects' agreement to participate in a study as a subject, which is reached after assimilation of essential information. The participants were guaranteed confidentiality and further informed that they were free to choose whether to participate or not and that they would be allowed to discontinue at any point should they wish to withdraw from participating in the study if and when they wish or refuse to answer any specific question with no negative consequences for them (Burns & Grove 2005:181, 2009:198; Mchunu & Gwele 2005:34; Van der Wal 2005:153; Babbie 2007:68).

The same process of informed decision making was used in all the other purposively selected samples of the study that included men who were fathers or spouses, community elders, traditional healers and TBAs. In the current study, verbal consent for the face-to-face interviews was sought from individual participants after an explanation on the importance and purpose of the study. Information given to participants prior to their verbal consent to be interviewed is provided in appendix A.

The other groups of participants who included men (spouses/fathers), community elders, traditional healers (*Sangomas*), and TBAs were identified purposively and through snow-balling from among the Bulawayo community where the study was conducted.

Polit and Beck (2006:87) assert that the principles of beneficence and non-maleficence bind the researcher to prevent or minimise harm to study participants. The harm and discomfort may take many forms which include emotional or psychological distress, as well as physical harm which may occur as a result of the research method; for example manipulation of subjects in experimental research. However, emotional harm is a possibility in all studies related to sexuality (Babbie 2007:68; Burns & Grove 2005:83), including related issues such as pregnancy and child bearing. The psychological consequences of participating in a study may be subtle and require researchers to be very sensitive, particularly in qualitative research which requires in-depth exploration into highly personal issues as was the case with current study.

Anonymity and confidentiality assist researchers in the protection of participants' identity by having them generate their own codes using family names, first alphabet or/and numbers (Burns & Grove 2005:189, 2009:196; Van der Wal 2005:148). Anonymity is when the researcher cannot match a given response with a specific respondent. On the other hand confidentiality is when the researcher can identify a given respondent's response, but essentially promises not to do so in public (Babbie 2007:64-66).

To ensure measures of anonymity and to observe the primary ethical principle of responsibility and concern for the clients, no names appeared on the transcripts and

the information was treated with strict confidentiality; and transcripts were only marked with alphabet letters, A, B, C to the last participant according to the groups they belonged to; which in turn were named numerical from Group 1 to 6. When meeting clients personally in the community, it was stressed that neither they nor the maternity unit at which they delivered would be identified in the study. It was therefore indicated in the information given to participants prior to obtaining informed consent. According to (Burns & Grove 2005:188) confidentiality is grounded on the basis that individuals can share information to the extent that they wish to do so and are entitled to have secrets as well as privacy.

With regards the current study, both unstructured and semi-structured interviews were not linked to participants, and that ensured anonymity. Participants were also assured that no information would be used against them for confidentiality's sake and they were assured that their identity will remain anonymous in presentations, reports and publications of the study (Burns & Grove 2005:194, 2009:194).

3.3.7.2 *Institutions*

To undertake the study, the researcher obtained ethical clearance from the Higher Degrees Committee (Ethics Committee) of the Department of Health Studies at the University of South Africa (see appendix E and F). She also obtained permission from the Research Ethics Committee of the Medical Research Council of Zimbabwe to carry out the study, while permission to review delivery registers was successfully sought from the Medical Superintendents of the participating hospitals (see appendices D, F and G respectively). This findings of this research might assist hospitals in Zimbabwe to become more pertinently aware of cultural issues relating to alternative birthing in the Ndebele community, once the recommendation made in this report are implemented.

3.3.7.3 *Scientific integrity of the researcher*

The researcher was morally obligated to observe her professional code of conduct during the current research and thus endeavoured to make informed decisions throughout the research. All conclusions are based on empirical evidence (Burns &

Grove 2005:191). As Holloway (2010:Loc7750) pertinently states the researcher is “to write with integrity”.

The researcher also respected the tradition, values and sacred issues of the Zimbabwean Ndebele society by adhering to confidentiality and human rights. During the data collection process, the researcher focused on the topic under study and did not diversify in order to avoid causing emotional and psychological trauma. The participants were informed about the dissemination of the study findings. During the whole data collection process, sacred traditional cultural values were respected and the researcher used clear unambiguous *isiNdebele* language which the participants understood (Donalek 2005:24).

The researcher found reflexivity instrumental in maintaining her integrity as a researcher and she is comfortable with sharing these results with the readers.

3.3.7.3.1 *Reflexivity*

In this section, the researcher reflects on her experiences during and after the research. Reflexivity as defined by Grove, Burns and Gray (2013:707) pertains to: “Self-awareness and critical examination of the interaction between self and the data during collection and analysis of qualitative data may lead the researcher to explore personal feelings and experiences that influence the study”. Wolf (2012) as cited by Grove, Burns and Grey (2013:168), states that reflexivity “consists of the ability to be aware of your biases and past experiences that might influence how you would respond to a participant or interpret the data”. This is corroborated by Creswell (2014:247).

The experiences discussed take into account both those of the qualitative design as a method of research and personal ones. The important aspect of reflexivity is that the “researcher’s own experiences affect every aspect of the research from conceptualisation of the issues he/she researched, relationships with research participants, data analysis, interpretation of research findings, writing up of results , and dissemination of results” (Gilgun 2010:1). Reflexivity is a retrospective examination of one’s own experience of the research which facilitates understanding

of both the phenomenon under study and the research process; what the researcher went through while conducting the research. Reflexivity can be through writing relevant thoughts, experiences, emotions, biases, and talking to others about one's reflections (Gilgun 2010:2; Watt 2007:83). Thus "reflexivity is valuable as it gives a personal narrative both during and after a study and may help to demystify the research process for those new in the field" (Watt 2007:82). Reflexivity is a reflection on the researcher's journey as it enriches personal experiences of the research (qualitative research – the researcher's voice ... 2010). It is for these reasons that the researcher decided to insert her reflection report under the "integrity of the researcher" as part of the ethical obligations and moral conduct.

- **The researcher's motivation for undertaking the study**

The reason why the researcher embarked on this research was to respond to the research question: "What are the perspectives of Zimbabwean Ndebele on alternative modes of childbirth?" The question partially derived from a concern about Zimbabwean maternal mortality rates that remain high at 550:100 000 with most of the deaths occurring as a result of delayed interventions. In Zimbabwe, 30% of deliveries are home births performed by TBAs, a situation similar to what happens in South Africa (Truter 2007:56). The scientific process of alternative modes of child delivery has always been practiced without considering the resultant cultural and traditional perspectives. Decisions in this regard appeared to be rather one-sided, with biomedical personal making these decisions. Despite the proclaimed "orientation towards transcultural/culturally sensitive midwifery care", there is no documentation indicating a consultative process between the midwife and the woman and her family in view of the Zimbabwean Ndebele perspective on alternative modes of childbirth. It is against this background that the researcher was prompted to carry out the study.

- **The researcher's experience during the study**

When the researcher embarked on the study, she did not appreciate the demands of the qualitative design as a research method, but soon started gaining insight into the

task that was before me. This became clearer as she was reviewing literature, reading over and rewriting her work chapter by chapter. Reflecting on her work became an inevitable reflective process whilst she was doing and undoing her work. This was an “epistemological experience” into discovering new knowledge which could have been lost had it not been for constant reflection. Particularly, in her assumptions she had not really considered the issue of multiple realities (Watt 2007:83).

The qualitative design, as a method of inquiry, became a way of understanding herself as a researcher. Especially, the researcher came to realise that being the main research instrument there was always “... a personal tale of what went on in the backstage of doing research” (Ellis & Bochner 2000:741 cited in Watt 2007:83). Initially, the researcher was conducting research as a systematic objective process; reviewing literature related to the research topic and methodology, planning her research, writing the research proposal and refining all the theoretical aspects of the research. The understanding of the research and the expected involvement on her part slowly dawned upon me as the researcher continued reading and systematising information chapter by chapter. The whole picture of the research became clearer and clearer as she employed the concept of reflexivity and reflection going back and forth between her growing understanding and the diversity of perspectives found in textbooks. As the research continued, this movement between theory and practice was also echoed between information informants provided, information from the literature and her personal orientation and views on issues that surfaced during the interviews and of which she became intensely aware during data analysis.

Interviews often became very emotional as participants who had had a caesarean section, lamented being denied the process of giving birth naturally; some of them to the point of shedding tears as they expressed the wish to have an opportunity to give birth naturally before they die. The informants expressed that:

“I also want to have that experience (natural birthing) and my only prayer is that before I die I should have at least had that experience” (Data: 295.3).

“It pains me that in my whole life I will never have the opportunity to know what it is like to push” (Data: 292.4).

The above expressions were very emotional which also brought me to a tearful state. As the researcher was immersed in the in-depth interviews she sometimes felt guilty and wondered whether she was asking questions that were too personal and/or insensitive. At the same time, she appreciated that such responses could be therapeutic to the women who uttered them.

In addition, the researcher sometimes wondered whether she did not intrude into the lives of the informants considering that people have their own programmes with busy schedules which she might have taken for granted should fit into her schedule.

Selecting participants from the different populations was difficult as explained in section. The researcher also found the interviewing process cumbersome, though in the end, enjoyable. It yielded volumes and volumes of data. Initially she was afraid that the interviews would not yield enough data or data that were relevant to the focus of the study. At the end of each interview she had to translate tape recordings from the local isiNdebele into English. In this process she had to be very careful not to lose something in translation. Nonetheless, from a reflexive point of view, it really is at the translation point of data management that bias in the form of preferred ways of translation could have slipped into the research. Thinking back, the researcher also regard data analysis “Coding and categorising the emergent themes on its own [as] another form of reflexivity as it also requires reading and reflecting on one’s own work (Developing reflexivity in research ... 2012; Watt 2007:90; Reflexivity – the researcher’s voice in qualitative research ... 2010). The interpretation of the findings in terms of Parse’s theory presented me with yet another way of reflecting on her experiences (see chapter 5).

- **The researcher’s experience as a student**

My testimony as a doctoral student is that undertaking this study was an experience of a life time. The study for the D Litt et Phil literally took over her life (Watt 2007:98). During the course of her studies, the researcher sometimes wondered what other PhD students went through. She as determined to undertake a post graduate study on newly qualified PhD graduates’ experiences during their studies.

By having undertaken this study, a lot has been revealed to me. What the researcher thought she knew by virtue of belonging to the Zimbabwean Ndebele culture was only the ears of the hippopotamus. A lot of detail of cultural and traditional practices was unveiled through use of different population samples and data collection methods. In the end the study has drawn the lace curtain from the window through which she used to see (remember) the Zimbabwean Ndebele and their perspectives on birthing and alternative modes of childbirth.

- **On a more personal note**

Traditionally there is nothing like a caesarean section in the Ndebele culture. A women must get pregnant and a woman must give birth – naturally. These are cultural issues the researcher grew up with. It was understood as such. This is how it is and will be; culturally. Technology or procedure in this respect does not exist in the traditional Ndebele culture – but the Ndebele have visions and herbal knowledge. The researcher cannot tread on the area of vision and herbal medicine. She appreciates it and respects it but she does not believe in it. Now, the researcher would say, these are all myths. When she took up the profession of nursing, she was taught to respect people’s rights and religion. And cultural beliefs and practices to me is more of a religion than knowing what is really happening in a scientific way. And, people are convincing one another to believe what they believe. This is how culture perpetuates. The researcher’s view is based on her western sciences orientation. She trained as a nurse in the western tradition.

Notwithstanding her hesitation to tread on cultural beliefs and religious grounds, the researcher believe that if culturally oriented people would gain knowledge about the anatomy of the female reproductive system and especially about obstructed labour, the size of the baby and the dimensions of the pelvic cavity, this might enhance their understanding of birthing and might assist in overcoming some of the traditional beliefs that serve as barriers to obtaining timely medical and nursing care. the researcher also believe that such knowledge should permeate the whole of society and should definitely involve not only mothers to be, but also the gatekeepers of

cultural practices surrounding pregnancy and birthing; TBAs, traditional healers and the elders of the community.

Looking at herself, being Ndebele is what she is.. There is nothing she can do to change it or that she wants to do to change it. But her thinking cap changed. She has gone through a training programme that has cleared her beliefs and her disbeliefs, and she is longer, much as she is Ndebele, in that camp, religiously. My worldview does have an element of the magico-religion, but it is Christian now.

The researcher is married to a Shona and he was not very well accepted in her family. And she was also not very accepted because of the history among the two tribes: “these are the people that killed our forefathers and stole our cattle...” and so forth. It is still there although intermarriage has equalised much of that. It is more or less the same in the Shona culture. And one does not know whether one culture was sort of acculturated, and to what extent. There are, however, pockets – societal relatively isolated – groups of Ndebele where the difference between the Ndebele and the Shona are still prominent. The Ndebele is a minority group in Zimbabwe. However, Zimbabwe’s government strives towards equity and equality of all indigenous peoples of Zimbabwe. The researcher also realise that as sin is a concept in Christianity, or rather of failure to be a Christian proper, their cultural practices to them is doing what is right (not sinful). She understands them where they are coming from and that their culture to them is a heritage such that they feel that to be is to have your own identity, and that can only be according to their culture and tradition. She thinks they feel that once they leave that they will be nothing; be without life. They actually believe that spirits or mediums want them to carry on the same traditional way. A caesarean section would interfere with family unity, and it is an action unacceptable to ancestral spirits. The researcher grew up hearing the culture and before her further education she also believed it. After her Western education the researcher can see clearly between the two. Had it not been for her western education and her traditional upbringing, this whole issue of the Ndebele perception of unnatural birthing would not have bothered her. As previously indicated, the researcher is proudly Ndebele, despite her westernisation. However, and due to this the researcher has great compassion with, in fact sympathy for the Ndebele women. This together with her scientific knowledge on birthing in a sense

morally obliged me to conduct this research. In the final analysis then, she finds herself in the paradoxical situation of not bluntly trespassing on cultural holy ground but to further investigate the possibilities (the possibles ala Parse) with which this paradox furnished her. This may be a lifelong undertaking which the researcher is more than prepared to pursue with her people, and as a nurse educator, with her future nursing students.

3.4 CONCLUSION

This chapter gives an explanation of how the researcher conducted the study on Zimbabwean Ndebele perspectives on alternative modes of childbirth. The study design, methodology, and the different approaches of data collection that were used were discussed in this chapter. My attempt at triangulation is also indicated. The data analysis process is described. Ethical considerations, data analysis and measures of establishing trustworthiness were also highlighted. In the following two chapters the data will be analysed, interpreted and presented.

CHAPTER 4

DATA ANALYSIS AND PRESENTATION OF THEMES AND CATEGORIES

4.1 INTRODUCTION

In the previous chapter, the methodology that was followed in conducting the current study was discussed. In this chapter, themes, categories and subcategories that emerged from the data obtained through unstructured in-depth individual interviews, structured individual interviews and focus group interviews are presented. The evidence supporting categories is exhibited in data displays. These data displays contain all data units pertaining to the category or subcategory as these emerged from the interview data. The process used to analyse and present the data was guided by the work of Van der Wal (1999:387-481).

The numbered data displays of categories and sub-categories that contain data units were utilised in order to allow the reader to focus on one specific issue at a time. Each data unit or data chunk that is quoted verbatim is given a reference number by which it can be identified in the data supplement that the researcher compiled; for the purpose of an audit trail should this become necessary.

Themes and categories that emerged were compiled from raw data. For these to emerge, the researcher had to reread the individual transcripts repeatedly. Literature to support themes that emerged was pursued after themes and categories had been established; an exercise which was on its own a very time consuming and demanding one.

4.2 OUTLINE OF THEMES AND CATEGORIES

The data are presented according to the different sampling populations. These populations were:

- Mothers
- Spouses
- Community elders
- *Sangomas* (traditional healers)
- Traditional birth attendants (TBAs)

Below is the key for codes placed next to the data chunks in the data displays to indicate quotations by informants in order to provide a perspective to the reader in terms of “who said what”.

Alphabetical codes of ABC up to F (depending on the number of informants in the group) are used to indicate informants in each of the groups. Every group has the first informant starting with A. For the women who gave birth through alternate modes of childbirth, the code “W” is used in combination with the code for the type of alternative mode of childbirth CS for caesarean section and FD for forceps delivery. The informants’ groups are represented by numerical figures of 1-5 in the sequence in which they are listed above. Below are the codes for participants and type of delivery as used in the data displays.

- W Woman who gave birth through alternative mode of child birth
- SP Spouse
- CE Community elder
- S/TH Sangoma (traditional healer)
- TBA Traditional birth attendant (the numerical figures in this group indicate the place the responding TBA was given- 1 for first place, 2 for second place; 3 for third place and 4 for fourth place.
- CS Caesarean section
- FD Forceps delivery

4.3 DATA ON MOTHERS’ EXPERIENCE

Five themes emerged from the data obtained from the individual open-ended in-depth interviews and structured interviews based on the initial in depth interviews with mothers who had experienced unnatural child birth. These themes include:

- Expectations (natural birthing, motherhood and womanhood)
- Natural proceeding of the events
- Unnatural proceeding of the events
- Sequelae of unnatural birthing
- Outcomes: Gains and losses (motherhood and womanhood)

These themes and main categories are presented graphically in figure 4.1.

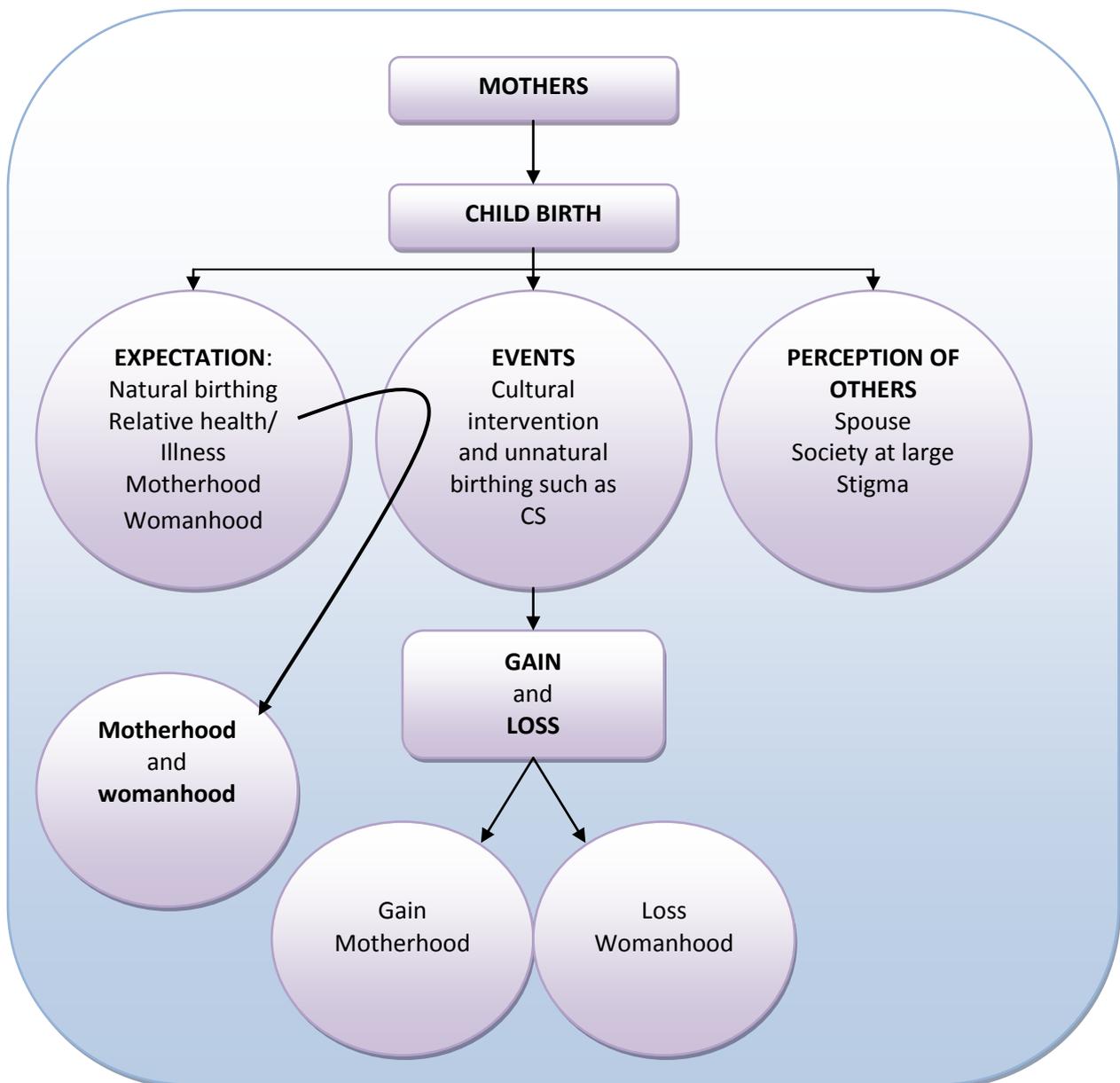


Figure 4.1: Mothers: Themes and main categories

4.3.1 THEME 1: Expectations

An expectation is a prediction of an outcome before it actually happens; something one is looking forward to. Sometimes the expectation is based on the outcome on previous experiences or pattern of activities (Thesaurus Collins English dictionary 1995:248).

A pregnant woman is expected to give birth naturally to an alive and well baby at the end of a specific period of gestation. Data display 1 gives an overview and summary of the main categories in this theme concerning the expectations mothers had of their pregnancies.

DATA DISPLAY 1
THEME 1: Expectations
Overview

Natural birthing
Relative health/illness degree
of pregnancy
Motherhood
Womanhood

Falling pregnant and having a baby are accompanied by various culturally oriented values and significant issues. Schapera (1946:413) and Jordan (1992 cited in Van Hollen 1994:501) confirm the above statement by saying that beliefs and practices of birthing reflect a large area of unopposed significant cultural patterns. These authors further postulate that pregnancy and having a baby are viewed as an area within which culture is produced, reproduced and revised in order to perpetuate traditional values. The experience of natural childbirth has significant socio-cultural meaning in many African cultures and indeed, in the Zimbabwean Ndebele society where it is perceived as a rite of passage to womanhood. The reader should note that, the life of an individual in any society is a series of passages from one age to another which in most semi-civilised people is more often than not accompanied by ceremonies and birthing, motherhood, and even fatherhood are among such passages. In such societies the belief is that every change in a person's life involves actions and reactions between the sacred and the profane; actions which are regulated and guarded so that society as a whole will suffer no discomfort or injury. Most of the

ceremonies performed are magico-religious. The essential purpose of such passage of rite ceremonies is to enable the individual to pass from one defined position to another without disturbing the life of society or the individual and it is the function of the rite of passage to reduce their potential harmful effects (Van Gennep 2004:3, 13).

4.3.1.1 Category 1.1: Natural birthing

Normality is defined as “the way things are under normal circumstances” (Encarta Dictionary 1999:1290 cited in Reid 2007:21). Normality also means “occurring naturally, maintained or in a natural state” (Reid 2007:3). “Normal labour/childbirth occurs at term and is spontaneous in onset with the foetus presenting by the vertex. The process is completed within 18 hours and no complications arise” (Cassidy 1993:149). This author further expanded the definition to include the concept that there is also physiological transition from pregnancy to motherhood which results in an enormous change in every woman physically and psychologically. In fact, every system is affected and this is what represents a major “rite of passage” in a woman’s life (from being a pregnant woman to being a mother of a new born baby) as a societal expectation.

Data display 2 contains evidence pertaining to “natural birthing” and informants’ perceptions and experiences with regards to natural birthing. The data indicate the importance of natural birthing, the yearning to be able to “push” to give birth naturally and hope for future fulfilment of these expectations which have not as yet been realised.

DATA DISPLAY 2
THEME 1: Expectations
CATEGORY 1.1: Natural birthing

Naturalness

- ... for one who gives birth naturally, you are just as you were. ...you are just a normal person (Data: 18) (A1WCS).
- It (giving birth by CS) hurts because I would have loved to give birth naturally (Data: 249.2). I was emotional. I was crying. I was crying because I did not give birth naturally (Data: 257.1) (D1WCS).
- One should bear children through the respected natural mode and not through an operation (Data: 295.1). Maybe now it is about time I did that (using herbs) so that I can also give birth naturally (Data: 303.1). I also want to have that experience (natural birthing) and my only prayer is that before I die I should have at least had that experience (Data: 295.3) (E1WCS)
- I would like to give birth naturally as in my previous deliveries. (Data: 340) (F1WFD).

The yearning “to push”

- It would also make me happy to push my baby nicely (Data: 113.1). I so much wish I could give birth naturally, just to experience what it is like to push like any other woman who has children (Data: 286.1) It pains me that in my whole life I will never have the opportunity to know what it is like to push a baby at birth (Data: 292.4).I wish to deliver the natural way pushing my own baby (Data: 294) (E1WCS).
- If you push that is the time you bond with the baby (Data: 233.1) (D1WCS)

Future expectations

I thought maybe next time I will have a baby, the birth canal would be opened and I would be able to give birth naturally (268.2) (E1WCS).

Evidence given in data display 2 depicts a yearning by informants to experience natural birthing as the belief is that natural birthing is the culturally respected mode of birthing as opposed to alternative modes of childbirth (Data: 303.1) (E1WCS). Throughout the study more evidence from other population representatives (informants) will be available.

Culturally, labour pain and “pushing” are understood to create mother-to-child bonding. It is the woman’s culture and religious belief system that determines how she will perceive, interpret and respond to and manage the associated pain. Thus, women strive for stoicism during labour in order to achieve pure naturalness in birthing. The women will even refuse pain relief measures as they appear to value stoicism and believe that if they can withstand pain, it is enough proof of their womanhood since it appears that culturally natural birthing is the yard stick for

measuring womanhood. Literature reviewed reveals that many women view experiencing pain as part of the natural process of giving birth. “One Dutch woman who gave birth without any pain medications said ‘It was a beautiful experience, including the pain’” (Selin & Stone 2009:36). The midwife needs to recognise that, although a woman’s behaviour in response to pain may vary according to her cultural background, it may not accurately reflect the intensity of the pain she is experiencing (Pairman et al 2006:420; Hockenberry & Wilson 2010:396).

4.3.1.2 Category 1.2: Relative health/illness degree of pregnancy

This category is closely related to the perceptions on the naturalness of child bearing and birthing as depicted in data display 2. Data display 3 contains evidence given by participants on the wellness/illness mix of being pregnant and giving birth.

DATA DISPLAY 3

THEME 1: Expectations

CATEGORY 1.2: Relative health/illness degree of pregnancy

General indicator

- Zimbabwean Ndebele men in general, are not the kind of men who would jump. You would tell him that you are not well ... they do not take it seriously, they think may be “she is pretending (Data: 52.7) (B1WCS).

Mother unwell/Medically well/Culturally well

- A pregnant person is normal, there is nothing they should do about it, because they would be taking it that the person is alright (Data: 59.3) A pregnant person is taken as an ill person because it is not known what will happen to her (Data: 59.4).Culturally, they (people) say that the (pregnant) person is normal (Data; 59.4.1) (B1WCS).
-

There are multiple realities on the issue of wellness/illness mix of being pregnant and giving birth; and from a medical point of view, “Pregnancy and birth are normal life events” (Page & McCandlish 2006:85), which is congruent with the cultural understanding of the pregnant state of a woman (Data: 59.3) (B1WCS) and (Data: 59.4.1) (B1WCS). However, the authors (Page & McCandlish 2006:85) admit that Western societies have embraced science and technology to such an extent that the trust in normal physiology appears to have been lost. On the other hand, evidence given by the informants (Data: 59.4) (B1WCS) also suggests that when a woman is

pregnant they are perceived as an ill person because of the unpredictable eventualities during the prenatal period. The advantage of such a viewpoint medically is that the women are encouraged to attend Goal Oriented ANC where such eventualities of pregnancy such as induced hypertension and other risk factors are possible to be diagnosed and treated early. However, evidence given by the informants seems to suggest that culturally nothing must be done about pregnancy because it is a normal process of life, a concept in line with what Page and McCandlish (2006:85) (Data: 59.3) (B1WCS).

What informants need to realise is that non-attendance of ANC might lead to complicated labour possibly necessitating a CS; unnatural childbirth. These views are congruent with the literature relating to ANC non-attendance (see section 2.1.9.2.2). However, it could not be explained why the same informants believed in cultural herbal and non-herbal interventions if pregnancy and birthing are so natural that “nothing” should be done about it.

4.3.1.3 Category 1.3: Motherhood

The third expectation mothers had, was that of motherhood attained through the natural birthing process and through the process of bonding. “Motherhood is an essential feature of women’s lives, and one of the few universal roles allotted to women despite there being no universal experience of motherhood” (Raynor & England 2010:35). It should, however, be noted that as a cultural construct, the meaning of motherhood varies with time and place. The term attachment is used interchangeably with bonding, when the mother feels emotionally connected to her baby. While the definition of bonding is quite explicit, these authors further give bonding a much higher level of relationship as they say “... the relationship between mother and baby is of great intimacy” (Raynor and England 2010:159).

Data display 4 shows mothers’ fear of separation from their babies and a strong desire for immediate parental bonding after the birth of the baby, whether naturally or by alternative modes of childbirth.

DATA DISPLAY 4**THEME 1: Expectations****CATEGORY 1.3 Motherhood through bonding**

Fear of separation from the baby

- I was afraid that if I am operated, will I ever see my baby or I will die ... I do not know (Data: 69.1) (B1WCS).

Parental bonding

- When I woke up the first thing I wanted was just to see the baby (Data: 103.1). The father went to the nursery and spent some time with the baby (Data: 103.5). I went to first floor on my own because I was not able to stay back and not see the baby after CS (Data: 105.5) (C1WCS).

Gratification of maternal bonding

- If you push that is the time you bond with the baby (Data: 233.1)...but when you push, when the baby is born the nurses place the baby on your chest and that is when you bond with the "kid" (Data: 233.3) (D1WCS).

Motherhood despite

- I do not have a baby that I delivered naturally, but what I can say is that, I love my children the same. I love them very much, because they were born in a way (CS) that helped them to live even if they were meant to die, but they survived (Data: 290) (E1WCS).

Delayed maternal bonding

- I was worried because nobody showed me the baby after CS or even came to tell me how things went. At last, they (care givers) came to tell me baby was alright (Data: 103.2). I cried (she laughs) when I did not see the baby. "Shame!" not knowing whether the baby was alive or not. I was very anxious (Data: 105.1). The nurses do not take you upstairs where the babies are before you are well. It pained me not to see my babies (twins) (Data: 245.1). All I wanted was to bond with them (twin babies) after waiting for nine months. I waited for three days without seeing the babies because I was not able to walk. I never thought I would see them (twin babies) (Data: 243.1). The moment you came they (nurses) took you (referring to baby) away before I had a chance to hold you after waiting for 9 months' (Data: 241) (D1WCS).
- I also wanted to go through that experience so that I know what it is like to push a baby being a woman, because you also want to be a perfect woman (Data: 272). The scar will be painful such that you are not able to hold your baby (Data: 292.1) (E1WCS).

Women want to be mothers through natural birthing because the experience of birthing yields motherhood; hence, the hope of every woman is to give birth through the natural mode of birthing (Data: 272) (E1WCS). Despite the recommendation and societal expectations that, for one to become a mother and a woman they should

deliver naturally; sometimes motherhood is inevitably achieved through alternative modes of childbirth, which can occur as an emergency from a complicated labour or electively during pregnancy in a situation where the mother is at risk (Hannah 2004 cited in London, Ladewig, Ball & Bindler 2006:555).

Parental bonding also referred to as attachment, which is reflective of motherhood, is a long-term process that actually starts with conception and becoming aware of pregnancy. The uterus is the environment in which the foetus is embraced, rocked and supported in the amniotic fluid in preparation for holding and rocking in the mother's arms while being breastfed with milk in place of drinking the amniotic fluid. This bonding grows through the prenatal, intranatal and postnatal phase where it is enhanced by parent-to-child interaction of breastfeeding, changing the baby's nappies and intimate cuddles. Furthermore; activities by the baby that enhance development of baby-to-mother attachment extend over months and years (Raynor & England 2010:158).

The immediate mother-to-child bonding is initiated by natural birthing where the baby is put on the breast within thirty minutes after birth. The skin-to-skin contact with the mother at delivery is what enhances maternal bonding (Data: 233.3) (D1WCS). It has been observed that: "Bonding has usually referred to the affectional tie between a mother and her infant believed to occur immediately after birth ... As such, bonding was conceived as a rapid, mainly unidirectional, process facilitated by skin-to-skin contact" (Klaus & Kennel cited in Page & McCandlish 2006:39). .

The other important issue that promotes strong bonding in natural birthing is the pain that the mother endures for the love of the baby and the whole process of going through the experience of the stages of labour until the mother finally bears down and pushes the baby out (Data: 233.1) (D1WCS) (Selin & Stone 2009:36).

Studies done reveal that oxytocin receptors are enriched in the brain areas that are in the manifestation of social and maternal behaviour including oxytocin in the mothers during breastfeeding is associated with reduced levels of maternal anxiety and may play a role in rendering the mother more receptive to the transmission of baby cues to mother and encouraging other parenting behaviours. Thus, the stress of prolonged mother-baby separation can be associated with reduced maternal

sensitivity and negative patterns of mothering. For example, some hospital routines may interfere with the bonding process and bring about negative effects on the experience of families and early relationships between the mother and her baby by separating mothers and babies too early and too long, for no medical reason. The belief is that, separation of mother and baby causes serious damage “past the point of repair” (Reid 2007:199). Klaus and Kennel (cited in Page & McCandlish 2006:39) and Raynor & England (2010:161) concur with this assertion.

However, the situation is different when the woman gives birth through the CS; a number of factors contribute to delayed bonding. A study by Swain et al in 2008 (cited in Raynor & England 2010:162) showed that stimuli produced by the baby activate brain circuitry in the mother that processes motivation, attention and empathy. Among the key factors that influence these brain circuits, is that they consider that the mode of delivery/birth is important in the development of maternal behaviours. The mother’s experience of vaginal birth compared with CS uniquely involves the pulsatory release of oxytocin from the posterior lobe of the pituitary gland. The investigation hypothesised that the maternal brain responses to the cries of their own babies 2-4 weeks post-partum were more enhanced in mothers who had vaginal births than in mothers who gave birth by CS.

Generally, the mothers who give birth by CS under general anaesthesia will not hear the baby’s initial cry such that even if there is the oxytocin release she cannot be receptive (Data: 103.1) (C1WCS). However, if the mother gives birth naturally by pushing the baby out and also hearing the baby’s initial cry; bonding is immediate. Bonding may be delayed from failing to hold the baby because of the pain from the raw CS incision (Data: 292.1) (C1WCS). The insensitivity of health care givers could also contribute to the delay in bonding (Data: 103.2) (C1WCS).

Another factor that affects mother-baby attachment is that complications of pregnancy might affect the attachment process. This is attributed to the differences in the woman’s perception and experience of health care. It is suggested that women who do not feel comfortable in the health care system react to pregnancy complications with increased concentration on their own wellbeing and thus withdraw some of their emotions from the relationship with their developing baby (Raynor &

England 2010:175). The above discussion emphasises the need and the importance of health care institutions to have health care givers who are sensitive to clients' physical, psychological as well as emotional needs.

The impression derived from data display 4 is that some health care givers do not seem to care about the bonding process by delaying mother and child physical contact. It appears that, once the CS delivery has been successful, their role as caregivers has also ended. Both the data and the literature discussed up to this point make for "cultural involvement and traditional birthing" as practiced by Zimbabwean Ndebele to be a very positive experience supporting many western medical assumptions.

4.3.1.4 Category 1.4: Womanhood

Culturally, womanhood is closely linked and cannot be divorced from giving birth and having children such that "for those who are childless not by choice the shame and humiliation can feel overwhelming" (Jaffe & Diamond 2011:21). Women without any children are stigmatised as being barren (Krige 1977:61 cited in Nyathi 2001:89). Data display 5 contains evidence of informants' experiences relating to attaining womanhood through birthing. It seems that the concept and experience of "pushing" are foundational to the experience of becoming a woman through natural child bearing.

DATA DISPLAY 5
THEME 1: Expectations
CATEGORY 1.4: Womanhood

General indicator

- Womanhood is all about child bearing (Data: 295) (E1WCS).
- Culturally, child bearing is the sign of being a woman and as a woman one wants to experience what other women go through during natural birthing (16.3.1) (A1WCS).
- I wanted natural birthing because I wanted to feel like a woman (Data: 233) (D1WCS).

Pushing towards womanhood

- As a woman, one also wants that experience of pushing their baby out because it also gives one the respect of being a full woman (Data 10.2.1) (A1WCS).
 - You feel jealous and wish you were the one delivering naturally (Data 251.2) (D1WCS).
 - I also wanted to go through the experience of natural birthing so that I
-

know what it feels like to push a baby being a woman, because you also want to be a perfect woman (Data: 272). I so much wish I could give birth naturally, just to experience what it is like to push like any other woman who has children (Data: 286.1) (E1WCS).

Tainted womanhood

- It embarrassed me a lot for me to fail to push the baby out when the head was sitting right there (points to outlet). I really felt embarrassed (Data: 319). It is embarrassing for an adult woman to fail to push the baby out. It was embarrassing because I wondered what people were saying (Data: 325.2.1). I feel as if I have lost dignity as a woman who is not able to bear children at the time of pushing (Data: 327.1) (F1WFD).
- I feel inadequate as a woman, I feel that maybe given a chance I could be able to push my baby out like other women (Data: 14.1.2) (A1WCS).

The curse of the scar

- That scar is like a permanent mark and a label for not being able to give birth naturally like other women (Data: 18.1.1) (A1WCS).
-

Evidence given by the informants seems to suggest that natural birthing is the ultimate achievement by which to attain womanhood. It seems to be a prescription from a cultural perspective in order to earn respect from society (Data 10.2.1) (A1WCS); (Data: 16.3.1) (A1WCS). Considering the above evidence, it is therefore not surprising that there is a strong desire among the informants to bear children through the natural mode of birthing in order to achieve womanhood and fulfil the cultural expectations as well as to experience what it is like to give birth “pushing a baby” (Data: 272) (E1WCS). Expressing the loss of womanhood through alternative modes of childbirth, informants shared demoralising experiences of embarrassment and loss of dignity and a feeling of inadequacy as women because of failing to push the baby out at the time of delivery (Data: 325.2.1) (F1WFD). Evidence given by the informants seem to suggest that, to the women who gave birth by CS the idea of a permanent scar is like a label and judgment that stigmatises them forever (Data: 18.1.1) (A1WCS).

The feeling expressed by the informants indicates that womanhood is all about childbearing (Data: 295) (E1WCS). Indeed this premise has been emphasised in various studies done in relation to childbirth (Nyathi 2001:89).

What seems to surface from the evidence, from a cultural point of view, is that despite the achievement of motherhood, one is not a perfect woman if they have not experienced giving birth naturally (Data: 272) (E1WCS).

4.3.2 THEME 2: Natural proceeding of events

In this theme, “events” refers to two issues articulated upon the expectations referred to in theme 1. With regard to the expectation of natural birthing the “event” includes different cultural practices pertaining primarily to normal child bearing. The other “event” involves the reality of unnatural birthing. The main categories of the theme “events” and main categories of “Events relating to natural expectations” and “Events relating to unnatural birthing” are displayed in data display 6.

DATA DISPLAY 6
THEME 2: Natural proceeding of events
Overview
Cultural interventions
Traditional beliefs and practices
Cultural beliefs regarding inability to give birth naturally
Preference for traditional medicine (Data display 4.3.2)

4.3.2.1 Category 2.1: Cultural interventions

Culturally, it appears that when a woman falls pregnant, there are cultural and traditional health practices that have to be performed based on a traditional philosophy that includes the utilisation of traditional herbs and medicine with the objective of physical or mental preparation of an individual for pregnancy and birthing. In some instances the cultural interventions may be used as protective measures for the woman and the foetus against adverse and unpredictable outcomes from witchcraft (Truter 2007:56; Mathole et al 2005). Data display 7 contains evidence by informants on “expected” cultural events and interventions.

DATA DISPLAY 7**THEME 2: Natural proceeding of events****CATEGORY 2.1: Cultural intervention**

General indicator

- Culturally, it is said that it (CS) is taboo (data: 52.1). They (*sangomas*) will be making one drink some roots (she laughed) which one does not know what they are, let alone how they will help you (Data: 61.1). They (*sangomas*) do not even tell you what herbs are being used (Data: 65.1) (B1WCS).
- A traditional healer (*sangoma*) is looked for to come and give the woman some herbs that reverse the effect of *ukubotshwa* (being tied) (Data: 282) (E1WCS).

Herbal medicine

- The *roots drive* away evil spirits and make the baby to lie in a proper position or maybe there *would be* something that would be threatening to complicate, then these herbs will stop that (Data: 63) (B1WCS).
- I have heard that the herbs hasten labour and they also have an effect of reversing *ukubotshwa* (being tied using herbs and /or magic to complicate labour) and then one delivers naturally (Data: 307) (E1WCS).
- Ah! They (others) would be drinking (traditional herbal medication) in order to have uncomplicated natural birthing (Data: 125) (A1WCS).
- Then my mother-in-law had told me about the wasp; that mould made of sand as the wasp's nest. One should drink the solution made from the mould as she walks; and let the cup from which they are drinking from to drop and then jump over it (some ritual) (133.2) (C1WCS)
- What I know is *inkunzane* (a slippery herb) that is given to women to drink in order to hasten labour (Data: 356). That slipperiness (*of inkunzane*) is what makes the baby to just slip out (Data: 356.1) (F1WFD).

Non-herbal traditional medicines

- I have heard about the donkey's placenta. I hear it is ground soaked in water for drinking time and again starting from 6 months pregnancy in order to hasten labour (Data: 305). The other thing that I heard about is the *nyeluka* (water snake). The skin is what is soaked in water and they (pregnant women) drink it so as to have non-complicated labour (Data: 305.1) (E1WCS).

Non-medicinal cultural interventions

- One should try soap. One should take a piece of it, shape it on one end, shape it in such a way that it goes into the mouth of the womb so that when they are towards term they will be widening the outlet (Data: 36.4). I did use some soap with my previous baby after whom this one comes but it (natural birthing) did not work out (Data: 36.3) (A1WCS).
 - *She (mother-in-law) would keep asking. ...“Did you look for those things (traditional medicines)”?* (Data: 135.1) (C1WCS).
-

It appears that cultural interventions in pregnancy and childbirth in the Zimbabwean Ndebele society are inherent in their tradition and culture whether there are labour complications or not. It appears that cultural interventions in this sense are a means of ANC in preparation for pregnancy and childbirth; more so to aid natural birthing in order to achieve both motherhood and womanhood.

Informants knew about most of the herbal medicines used in pregnancy and labour. The herbal medicines particularly mentioned are *inkunzane* (some slippery herb) (Data: 356) (F1WFD), *nyeluka* (water snake /fish) (Data: 305.1) (E1WCS). Donkey's placenta and the nest of a wasp which is a mould made of mud. Other cultural interventions that are used include some non-medicinal agents like soap (Data: 36.3) (A1WCS).

It is not clear how the herbal medicines work, but it appears that the slipperiness that is in most of them, including soap, is what is believed to make the baby slide out of the vagina during birth (Data: 356.1) (F1WFD). The donkey's placenta might have a different effect. One would like to believe that; since all placentas have some hormones; oxytocin in particular, the donkey's placenta might happen to have a high levels which could precipitate labour when ingested by women (Data: 305) (E1WCS). The mud-moulded nest of a wasp has a more inexplicable *magical* effect since its use seems to be ritualistic (Data: 133.2) (C1WCS).

Traditional medicine seems important, even when patients are in hospital recuperating after a CS. As one participant indicated: *She (mother-in-law) would keep asking, "... did you look for those things (traditional medicines)"?* (Data: 135.1) (C1WCS). It appears that the use of cultural interventions/traditional medicines cut across barriers; whether or not the woman gives birth in hospital where there could be scientific medication.

4.3.2.2 Category 2.2: Traditional beliefs and practices

Practices that are performed in the name of tradition, because society believes in them and as such are some kind of religion, makes it clear that these cannot be disputed. Data display 8 contains evidence on cultural interventions and traditional beliefs and practices.

DATA DISPLAY 8**THEME 2: Natural proceeding of events****CATEGORY 2.2: Traditional beliefs and practices**

Sexual relations as preparation for birthing

- Others say that one should continue having sexual relations with their husband. "You will be widening the outlet" (Data: 36.5). They (others) say that the fact that you keep having sexual relations loosens your pelvic muscles in readiness for birthing (Data: 38) (A1WCS).
 - **Mechanical**
 - Ah! Even when I was bathing, I would push my hand inside and try to feel the mouth of my womb so that it can widen, but it would be closed (Data: 36.2) (A1WCS).
-

The evidence by informants that sexual relations can continue between spouses (Data: 36.5) (A1WCS), is one practice that is congruent to scientific knowledge that prostaglandins can stimulate the cervix and cause uterine contractions hence they are used for induction of labour. It is therefore possible to convince one that the same concept works culturally. Coitus at term as a mode of initiating labour is a popular belief and it can be used as an effective method of prompting labour (Tan, Andi, Azmi & Noraihan 2006:140). These authors further postulate that semen contains prostaglandins and prostaglandin concentration in the cervical mucus of pregnant women has been demonstrated to be 10–50 fold higher than normal 2-4 hours after intercourse. Sexual intercourse can also have some effect on uterine contractility. Maternal orgasm alone achieved by genital manipulation without intercourse has also been associated with increased uterine contractions, which is a confounding factor to the hypothesis that prostaglandins induce uterine contractions (Tan et al 2006:134-136; Schaffir 2006:1310).

According to Sayle, Savitz, Trop, Hertz-Picciotto and Wilcox (2011:283), sexual activity has long been suspected to be a potential cause of preterm delivery and there are several biological mechanisms that could explain an adverse effect of sexual activity on preterm delivery. These include the fact that maternal orgasm might release oxytocin and initiate uterine contractions, prostaglandins in seminal fluid also have oxytocin properties and the fact that coitus during pregnancy can increase exposure to infectious agents that could result in preterm labour. Tan et al (2006:137) confirm that the effect of intercourse enhanced labour promotion which

was evident throughout term gestation with the peak occurrence of birth within 24-48 hours after intercourse.

Despite all the evidence pointing towards the possibilities of sexual intercourse causing labour it should be noted that other studies indicated no meaningful relationship between sexual intercourse and onset of labour since uterine contractions can occur as a result of maternal orgasm from genital manipulation and also release oxytocin just as much as coital prostaglandin would release oxytocin and prompt the onset of labour (Syle et al 2011:287; Schaffir 2006:1310).

With regard to sexual relations widening the vaginal outlet, (Data: 36.5) (A1WCS) there are “some African women who think that sexual activity in pregnancy might help widening the vagina and facilitating labour ...” (Sydow 1998:36) which indeed seems to be the same belief that the Zimbabwean Ndebele society holds in an effort to promote natural labour or birthing.

4.3.2.3 Category 2.3: Cultural beliefs regarding inability to deliver naturally

This sub category moves the attention away from any natural expectations to the reality of unnatural birthing. Data display 9 contains evidence in this regard.

DATA DISPLAY 9

THEME 2: Natural proceeding of events

CATEGORY 2.3: Cultural beliefs regarding inability to deliver naturally

Cultural beliefs – “being tied”

General indicators

- That one (who cannot deliver naturally) would be “tied” (use of herbs/magic to complicate labour) Data; 161.1). This (“tying” someone to cause labour complications through use of herbs/magic) is how African science works (Data: 179.1) (C1WCS).

Hatred by others

- ... something bad would have been done to you or something so that you are not able to deliver naturally (Data: 165). ...it is what they (people) say, that the “tying” would have been done by someone who does not like you (Data: 167.2) (C1WCS).
 - At times one could be “tied” (using herbs/magic on one to cause labour complications) so that they are not able to give birth naturally (Data: 344). People do it (“tying”) using herbs so that you can develop labour complications (Data: 346). ... someone who hates you and
-

would like to see you suffering, deliver a stillborn or see you die with your pregnancy could do it (“tying”). That is witchcraft (Data: 348) (F1WFD).

Punishment

- Usually they (people) say maybe there is something you as a pregnant person that you would have done wrong (Data: 56) (B1WCS).

Due to witch craft

- ... it is the same as being bewitched using herbs that are believed to cause the baby to get stuck in the womb and die inside or the mother dies or both mother and baby to die (Data: 280) (E1WCS).

Tying as beneficial to TBA

- At times it would be the TBAs, those who want clients for themselves so that you do not go to other TBAs for “untying” or to medical practitioners for medical intervention (Data: 348.1) (F1WFD).

Tying and unnatural birthing

- So when it (CS) happens it is said that the woman has been bewitched by tying (59.4.2). Sometimes it (CS) is taken as witchcraft when a person gives birth through an operation or the baby being pulled, they (society) do not like it they say it is not something normal (Data: 52.2) (B1WCS).

Torturous coercion for mother to confess infidelity as reason of unnatural birthing

- ... the spirits are refusing them (babies conceived out of wedlock) to be born alive because they do not belong to the family (Data: 278.1). The aunties, mother-in-law and other elderly women of the community and the TBA question the woman, slap her until she tells the truth and confess that the pregnancy is not from the husband (Data: 284) (E1WCS).
-

In the whole of Africa no illness or whatever adversity related to life ever happens naturally. All such events are believed to be caused by some super natural powers or evil spirits. In traditional healing, the diagnosis is a method of discovering the origins of the disease and determining its cause and nature. The diagnosis process not only seeks answers to the question of how the disease originated, but also who or what caused the disease and why it has affected this particular person at this point in time as the people believe in which craft (Data: 280) (Truter 2007:59).

Evidence given by the informants confirms their beliefs in witchcraft such that the reference to CS and vacuum extraction within the scope of “being tied” also indicates elements of the negative perceptions concerning unnatural birthing (Data: 52.2).

Infidelity is also believed to be a cultural reason for the inability to give birth naturally for the reason that African culture in general links unnatural birthing with adultery and witchcraft. The TBAs assisting the woman usually force the woman to confess the infidelity to them in order to reverse the labour complication (Data: 284) (E1WCS). (Van Roosmalen & Van der Does 1995:22).

Tying is a topic that surfaces repeatedly during the analysis of the data in relation to other concepts. Thus, tying will be discussed in more depth as the data presentation proceeds.

4.3.2.4 Category 2.4: Preference for traditional medicine

Traditional medicine is part of the African culture and indeed also of the Zimbabwean Ndebele culture. It is a part of the day to day life of society as well as being a religion that people believe in. Hence, it is preferred to Western medicine.

The second category under events relating to unnatural birthing provides evidence of the preference of traditional medicine over Western medicine. Data display 10 exhibits the evidence in this regard.

DATA DISPLAY 10**THEME 2: Natural proceeding of events****CATEGORY 2.4: Preference for Traditional medicine**

- It is like a belief that they believe so much in traditional herbs and medicine. It (traditional medicine) treats the person and they become alright (Data: 63.1). ... they must go to the *Sangomas* and be treated by traditional healers and be delivered by TBAs and not go to hospital because they believe that at the hospital ... If she (woman) drinks western medicine it will disturb traditional medicines that she would have been taking (Data: 59.4.3). She (pregnant woman) should not go to the doctors, one would have done it wrongly, it should have been done this way and that way and referred to that elder (Data: 59.6) ... sometimes it happens that one delivers by operation and still not get a live baby. So, when it is like that, they end up thinking it that the problem is that she went to the doctors (Data: 59.7). TBA would say she (pregnant woman) should not have gone to hospital she should have left it to us; we would have managed the delivery at home (Data: 59.8) (B1WCS).
-

What seems to emerge from the evidence given by the informants in this section is that preference for traditional medicine is not a matter of choice, but part of the cultural orientation and a norm in the Zimbabwean Ndebele society. This implies that seeking medical treatment would be some kind of deviation (Data: 59.6) (B1WCS). Society believes that things go wrong in hospital (Data: 59.4.3) (B1WCS); (Data: 59.7) (B1WCS). It would appear that since the belief is that the woman would have been bewitched to be unable to give birth naturally, the situation should be managed traditionally (Data: 59.4.3) (B1WCS). Literature relating to birthing states that women prefer to give birth under the care of TBAs for various reasons. Firstly, the women would be in a familiar environment which is non-threatening and believed to have better outcomes influenced by seeing familiar faces around one. One other reason discussed in the literature is that the family might want to perform rituals, which is unheard of in formal health care settings. In fact, the principle in health care settings is to discourage some of the cultural rituals since they are regarded as being potentially harmful practices. An example of such traditional practices is the application of cow dung to a baby's umbilical cord at birth; a practice that could introduce tetanus (researcher's experience during years of clinical practice and by virtue of belonging to the Zimbabwean Ndebele culture) (Matua 2004:34).

The preference of traditional medicine and practices are further due to the belief that TBAs offer better services than those offered at health care centres and services offered by TBAs are less expensive and affordable, since payment can be in kind, chickens, goats or with whatever the women can offer (Finger 2003:13; Matua 2004:35; Awfung 2004:27; Nyazema et al (cited in Mathole 2006:18). See section 2.1.6 and subsection 2.1.9.2.1).

4.3.3 THEME 3: Unnatural proceeding of events

The focus in this theme of unnatural proceeding of events is the reality of unnatural childbirth and the cascade of events following the unnatural event. The main categories "Events relating to unnatural proceeding of events" and "Events relating to unnatural birthing" are displayed in Data display 11.

DATA DISPLAY 11
THEME 3: Unnatural proceeding of events
OVERVIEW

Category 1:Caesarean section (CS)

- Mothers' views on CS
- Reasons for CS
- Acceptability of CS to significant others
- Social support

Category 2: Forceps delivery

4.3.3.1 Category 3.1: Caesarean section

Caesarean section emerged as the unnatural birthing process, mostly experienced by women who participated in the current study. The only other procedure that participants alluded to was forceps delivery. Data display 12 contains evidence about the view point of participants on CS. This should be read in conjunction with the previous displays on “tiedness” and preference for cultural medicine and practices.

4.3.3.1.1 Category 3.1.1: Mothers' views on CS

The Collins English Thesaurus Dictionary (1995:779) defines a view as an opinion or as a process of thinking about something. In this category the discussion focuses on the way mothers felt about CS, given the cultural point of view of societal expectations of natural birthing. Data display 12 relates to this.

DATA DISPLAY 12
THEME 3: Unnatural proceeding of events
CATEGORY 3.1: Caesarean Section
SUB-CATEGORY 3.1.1: Mothers' views on CS

General Indicators

- There are too many women who deliver through an operation (Data: 83.1). It was as though everyone in hospital delivered by operation (Data: 83.3) (B1WCS).

Cultural rejection

- Sometimes it (CS) is taken as witchcraft when a person gives birth through an operation or the baby being pulled, they (society) do not like it they (society) say it is not something normal (Data: 52.2). So when it (CS) happens it is said that the woman has been bewitched (59.4.2) (B1WCS)).
-

Suspicion/regret surrounding CS

- It (giving birth by CS) pained me because now it was the second time to give birth by operation (Data: 268) (E1WCS).
- ... I had a chance to give birth naturally like other women, but it did not work I ended up having a CS (Data: 270) (BIWCS).

Non-involvement of the mother

- The fact that when one comes round from anaesthesia they find themselves with sutures on their body without knowing how it all happened (Data: 249.1) (D1WCS).
 - ... and not just find myself with a baby not having seen how things went (Data: 286.2) (B1WCS).
-

Informants' views indicated that they thought that too many women delivered their babies by CS (Data: 83.1) (B1WCS). Evidence given by the informants in Data display 12 indicates the degree of rejection of CS by society to the extent that its occurrence is linked to witchcraft (Data: 52.2) (B1WCS). Besides total rejection by the Zimbabwean Ndebele society, the informants expressed dejection and disappointment that they seemed to have lost all possible chances to give birth naturally; an indication of hope lost. (Data: 270) (B1WCS).

With regard to non-involvement, the experience of CS described by the informants is of activities happening around them. Data display 12 consequently relates to non-involvement of the informants in birthing as the baby is delivered by CS while the mother is under anaesthesia; general or epidural. In neither case does the mother participate or witness fully the birth of her baby. Related literature confirms loss of control during CS as one woman commented "I lost control over what was happening to me and felt very disempowered" (Fenwick et al 2003:12). This section should also be read and understood in the light of the importance to "push" the baby out as indicated in data display 5 and 9.

Informants gave information on their experiences of unnatural birthing as including the fact that they are not part of the procedure and are not involved in the birthing process in anyway. One informant gave the process of birthing by CS an analogue of some kind of dream because by the time they come round from the anaesthesia everything would be over (Data: 249.1) (D1WCS); (Data: 286.2) (B1WCS).

It is important to note that the concept of non-involvement of the mother during a CS or any alternative mode of birthing negatively affects maternal bonding, is intertwined with inability to push during birthing, and thus leads to the mother's womanhood being scorned by society (Data displays 4, 5 and 9).

4.3.3.1.2 *Category 3.1.2: Reasons for CS*

CS can be performed on two major medical decisions, elective CS where a risk factor is diagnosed in the ante partum period and a booking for the CS is made, and/or emergency; an unpredicted situation where labour complications may arise during labour threatening the life of the mother or baby or both (Hannah 2004 cited in London, Ladewig, Ball & Bindler 2006:555).

Information obtained from participants on the reasons for CS is displayed in data display 13. All the reasons given have some medical and/or physiological foundation to them despite the fact that they are given on cultural basis.

DATA DISPLAY 13**THEME 3: Unnatural proceeding of events****CATEGORY 3.1: Caesarean Section****SUB-CATEGORY 3.1.2: Reasons for caesarean section**

Prolonged labour

- ...labour took so long and the doctor said that the mouth of the womb was not opening and I had to have another CS (Data: 297.2) (E1WCS)

Cephalo-pelvic disproportion

- With the first born, they (doctors) said I had been in labour for too long, plus the fact that my bones are too short. Then with the other one they said that it means that I will always deliver by CS. With this one that I have now, they (doctors) said that there is no outlet. They (doctors) said that it is possible that when I am in established labour and they ask me to push, the uterus can rupture, because there would be no outlet for the baby to come out (Data: 12) (A1WCS).
- ...the head was not coming down (Data: 342) (F1WC).

Cord presentation

- ...with the first pregnancy I had a CS because the baby was presenting with a cord (Data: 297.1) (E1WCS).

Pregnancy induced hypertension

- For me to give birth through an operation, it is because I had a problem with BP (raised blood pressure) (Data: 52). When I fell pregnant all was well, but at 7 months, I started having problems; my feet were swollen as well as my face, in fact my whole body was swollen (Data: 52.6) (B1WCS).
-

Macrosomia

- At first they (doctors) had said the baby is too big and I should have CS done (Data: 141.3) (C1WCS).
- ... the cervical dilatation has been on one centimetre since the weekend (two days before delivery) (231.1) (D1WCS).

Foetal distress

- I was tired but trying to push. ...the doctor said that it had taken me a long time trying to push. The doctor said that the baby was also tired (Data: 319.2) (D1WCS).

Malpresentation

- The baby was presenting the wrong way (Data: 159.2). ... the doctor kept trying to deliver the baby, but the foot that was presenting came out first (99.4). The doctor pulled the foot, but ah! It got stuck; he then decided that I should go to theatre for CS (99.4.1). ... baby was fine except for the swollen foot, the one that was presenting before the CS was performed (105.4) (C1WCS).
 - One of the babies was not lying in the right position, (Data: 253) (D1WCS).
-

Although expressed in the layman's language, informants were well informed about reasons for CS. The reasons given were scientific, such as prolonged labour, cephalo-pelvic disproportion, cord presentation, pregnancy induced hypertension, a big baby, malpresentation and foetal distress. As evidenced in data display 13 all the above mentioned reasons would warrant a CS. In this regard performance of CS would be inevitable for the survival of both mother and baby. Nonetheless, the cultural belief of "tying" is not abolished by these obstetric emergencies that warranted CS.

4.3.3.1.3 Category 3.1.3: Acceptability of CS to significant others

Culturally, alternative modes of birthing, with CS in particular, are unacceptable to the Zimbabwean Ndebele society. Data display 14 contains information on the perception on CS as well as the perceptions some of the participants hold on the perception others have of CS.

DATA DISPLAY 14**THEME 3: Unnatural proceeding of events****CATEGORY 3.1: Caesarean Section****SUB-CATEGORY 3.1.3: Acceptability of CS to significant others**

Acceptance of CS by spouse

- According to how he (spouse) was talking he was disappointed. It was worrying him. He did not want it (CS) because the doctor had said that there was a possibility that I could be operated on, but he (spouse) was saying he did not want it (CS) (Data: 143) (C1WCS).

Delayed acceptance of the CS

- He (spouse) also eventually accepted it (CS) (Data: 52.11). I should think that he (spouse) ended up accepting it (CS) as it is because he (spouse) realised that I was unwell, so he (spouse) accepted it and was also happy because he (spouse) sees that both of us me and the baby are alright (Data: 75) (B1WCS).

Acceptance of CS in certain cultural circles.

- But no, when I am now discharged and when people see me and the baby growing well, they (people) seem to accept what happened (giving birth by CS) (Data; 73) (B1WCS).
- Socio-culturally, the people see me as a perfect woman (Data: 235.5.3). There is nothing wrong, people see me like any other woman. They (others) see nothing wrong with me because they live a Western lifestyle (Data: 255) (D1WCS).

Perception of husband's concern

- ... he (husband) just said 'Ah! Maybe you should wait. Would it be possible for you to push because giving birth through CS is not right?' (Data: 24). He (spouse) just shows that he worries about it (CS)... he actually came and asked that "sister is there no other way you could do this (delivering the baby)"? Should she deliver by operation? (Data: 28) (A1WCS).
- This is when he (spouse) started getting worried and was dashing all over, when it was an operation, now, it was as if it was him who was going to have the operation, as if he was the one who was unwell (Data: 52.9) (B1WCS).
- ... he (spouse) was disappointed. It was worrying him because he did not want it (CS) (Data: 143) (C1WCS).

Perception of the perception of the mother-in-law

- She (mother-in-law) was also shocked and disappointed that I gave birth by CS (Data: 145.1) (C1WCS).

Perception of the perception of other family members

- I cannot say I heard any relatives say anything negative to CS (Data: 81) (B1WCS).
- Maybe they (other family members) look at me like a woman who is not complete or maybe a woman who is promiscuous getting pregnant from other man outside her marriage and when it is time to deliver she gets stuck with complications (Data: 299.2) (E1WCS).

Perception of the perception of the general public (society)

- I think they (people) see as if ... I see as if I am no longer dignified...as if they (people) look at me and say ,but this one why doesn't she try other means so that she can give birth like other women (Data: 14). They (people) are not verbalising, but just the thought that people will be

asking you 'this time Mrs. so and so how did you deliver'? You then tell them, ah! It was the same way' that way they will be suggesting to you 'why don't you try even the church, pray or try something'? (Data: 16) (A1WCS).

- Others (members of the public in general) may be back-biting you taking you for a woman with mischief... they do not accept CS as something good; even the spouse maybe he feels undignified (Data: 325.2.2) (F1WFD).
-

The impression given by informants in this section on the acceptance of CS is that CS is not acceptable to spouses in the first instance (Data: 143) (C1WCS). However, eventually CS becomes acceptable to spouses after considering the favourable outcomes of a live baby and a healthy mother (Data: 75) (B1WCS). From the evidence, given in data display 14, it appears that in some cultural circles, CS is acceptable where the Zimbabwean Ndebele culture is not valued even if the people themselves are Ndebele. This cultural dynamism is mostly a result of life style, level of education, occupation and the environment within which people live; for example in cities such as the one where part of the current study was conducted, because of societal enculturation.

Acceptability of CS is a welcome finding as it is in line with the MDGs 4 and 5 which recommend reduction of neonatal mortality and maternal mortality by two thirds (66.6%) and seventy five percent (75%) respectively by 2015 through such interventions as the CS (NHS for Zimbabwe 1997-2007: xi, 26; RGSDG 2001:23).

In data display 14, informants describe how they perceived perceptions of others in relation to their having given birth through an alternative mode of birthing and how they view the CS procedure itself taking into account the cultural values, beliefs and practices.

The informants who had given birth by CS gave evidence of their perceived perceptions of their spouses as people who were concerned about them (women) having to have a CS. One woman stated that her spouse expressed disappointment and worry when he learnt that the only possible mode of birthing was CS (Data: 28) (A1WCS). Perceptions of significant others who include spouse, mother-in-law and close family members were crucial to consider. Data: 143 (C1WCS) express the concern and spousal shock and disappointment of unmet spousal expectations of

natural birthing. Other family members who included some relatives also expressed shock and disappointment when they learnt of the news.

A concern that the informants expressed was about what the family members were thinking about their faithfulness to their spouses (Data: 299.2) (E1WCS) as it is deeply situated cultural perception that labour complications are due to unfaithfulness (Van Roosmalen & Van der Does 1995:22).

Evidence given by the informants on what they perceived as perceptions of the general public appears to have had some varied psycho-social implications as the women perceives the general public to be concerned about their image and the spouse who may both have lost their dignity because of CS (Data: 325.2.2) (F1WCS). In fact the evidence seems to be pointing to the fact that the woman feels that the general public is labelling her as a mischievous and promiscuous woman who is the talk of the town.

4.3.3.1.4 Category 3.1.4: Social support

“The meaning of social support is so broad and diffuse, that it may seem impossible to define and study” (Page & McCandlish 2006:59). However, these authors point out that people perceive social support in three distinct ways. Firstly, emotional support which is probably the most commonly recognised which implies a warm and caring relationship that conveys esteem and may be as simple as presence or companionship and willingness to listen. Secondly, informational support which usually empowers an individual and gives him/her confidence to make positive life choices. Thirdly, practical and tangible support which can be varied during pregnancy and birthing from comforting the woman in labour, teaching her how to breast feed and/or helping with household chores.

Closely related to the acceptability of significant others, one would expect that with the general cultural rejection of unnatural birthing, social support to women having undergone a CS would also be withheld. Data display 15 contains information in this regard.

DATA DISPLAY 15**THEME 3: Unnatural proceeding of events****CATEGORY 3.1: Caesarean Section****SUB-CATEGORY 3.1.4: Social support****Social support by mother-in-law**

Social support by mother-in-law

- No. I have not met with any problems yet, because recently my **mother-in-law**, paternal grandmother of my children was around. All she encouraged me was 'Ah! Daughter-in-law, there is not much spacing in between your babies' (Data: 22). I am happy about my mother-in-law, she understands my situation at one time she advised me of child spacing (Data: 22.1.1) (A1WCS).
- I sent my **mother-in-law** to go and check baby in the nursery (Data: 103.3). She (**mother-in-law**) came, that is when she went to the nursery and was told about the baby's condition (Data: 103. 4). I was helped by **my mother-in-law**. She came and asked about the baby (Data: 105.3) (CIWCS).

Spousal support

- Yes I do have social support from my **husband** ... he is very responsible, he assists me a lot (Data: 352) (FIWCS).
- The **father** came to see the baby in hospital (Data: 103.4.1). The father went and spent some time with the baby (Data: 103.5) (CIWCS).

Social support by significant others

- I do have a social support system. I would had visitors everyday, and being bathed by my mother. My husband's **friend** would go to the nursery and change the babies' pampers, feed them and talk to me (Data: 257) (D1WCS).
- The **other children** are big now, they would help me with the baby and other household chores, and my sisters visit me. I do have people who assist and support me (Data: 352.1) (F1WFD).
- My **mother** and my **sisters** usually help me with everything (Data: 301.1) (E1WCS).
- Ah! We discuss a lot and share experiences that ... no, as for me on day one of the operation I was feeling ... I did not believe I would make it even up to two days because; the pain would be too much. So, we do discuss to say "how was that?" After how many days did my wound heal? When did you feel strong enough to start walking? No, we discuss a lot with **other women** because I realise that in hospital now it appears many women delivered by operation during the time I was there (Data: 83) (B1WCS).

In any social system, social support is a human need for whatever circumstances one faces in life, whether positive or negative life event. The evidence given by the informants indicate a strong social support system. The support came in the form of advice, physical presence and assistance in identifying and checking on the condition of the baby following the CS (Data: 22) (A1WCS). It appears that the mother-in-law played a huge supportive role as an elderly person and grandparent; more so because the African tradition holds grandmothers in esteem as highly

respectable matriarchs with a lot of say in family issues (Bennett 2004:179). Moreover the mother-in-law has to perform the role of identifying the baby as belonging to the clan by way of resemblance to the father or any member of the family.

4.3.3.2 Category 3.2: Forceps delivery

Two unnatural birthing procedures surfaced from the current data: forceps delivery and CS. The latter yielded much more information than the former. Data display 17 contains information in which informants gave evidence of their experiences of forceps delivery.

DATA DISPLAY 16

THEME 3: Unnatural proceeding of events

CATEGORY 3.2: Forceps delivery

General experience

- He (doctor) said that the baby was also tired it was better for him to pull the baby out using forceps because he could see the head (Data: 319.3). I did not take it (forceps delivery) well. You think of this and that and you keep wondering what could have happened (Data: 325.1.1) (F1WFD).

Fear of mothers

- There is nothing really that I would like to ask except that I was worried that what if they decapitate the baby while pulling with the forceps and baby dies? (Data: 360) (F1WFD).
-

Evidence given by one informant in data display 16 is that the informant did not like having the baby delivered by forceps; because she did not understand what was going on. The concern that the informant had was about the well-being of the baby; whether the procedure would harm the baby (Data: 360) (F1WCS). It would appear that the doctor made the decision to deliver the baby by forceps without involving the informant which could have been an unpleasant experience (Data: 325.1.1) (F1WCS).

The concern raised by the one informant is that the procedure for forceps delivery could injure or even kill the baby is quite genuine and a possibility as traumatic effects on both the mother and the baby do sometimes occur with assisted deliveries. For example, in a forceps delivery injury, there is commonly a linear mark

across both sides of the baby’s face that is in the shape of the blades of the forceps. However, the fear of the baby being decapitated is more exaggeration than prospect, but understandable from a point of view of someone who has no idea of how the procedure is done and just depending on her own imagination (Data: 360) FIWCS).

4.3.4 THEME 4: Effect of unnatural birthing

Unnatural birth/alternative modes of childbirth although unacceptable in the Zimbabwean Ndebele culture do sometimes occur inevitably and may occur as an emergency and for this reason, psychologically “the loss of the reproductive story has profound effects on one’s sense of self” (Jaffe & Diamond :2011:54). However, the effects of loss of expectations are not only psychological but extend to economic, physical, and socio-cultural effects that women go through because of the mode of childbirth. Data display 18 contains an overview of the main categories and subcategories of Theme 4.

DATA DISPLAY 17
THEME 4: Effects of unnatural birthing
Overview

- Economic sequel of CS
- Physical health sequel of CS
- General
- Guilt
- Poor self-image
- Self constructed
- Socially constructed
- Social sequel of CS
- Stigma and discrimination

4.3.4.1 Category 4.1: Economic effects of CS

CS as a means of birthing and strategy for the reduction of both maternal and neonatal mortality is an effective means of intervention. However, the costs attached to CS have been found to be harsh. The reasons may be that in most instances the procedure is performed as an obstetric emergency for which the informants are not often financially prepared; a typical situation in Zimbabwe being a developing country with many poor families especially with the current economic recession

(Hockenberry & Wilson 2011: 514; researcher's experience of over 30 years in midwifery practice)

Women who are poor and less educated have limited or no access to health facilities at all because they cannot afford the service fees as compared to more educated and employed women. The limited access to ANC could be the possible cause of labour complications, which may result in alternative modes of birthing, such as CS, and the extra and unforeseen costs that it carries (ZDHS 2005-2006:47). Data display 18 contains evidence in this regard

DATA DISPLAY 18**THEME 4: Effects of unnatural birthing****CATEGORY 4.1: Economic effects of CS**

- I would like to do that (sterilisation) to prevent but because I don't have enough money, maybe the money that the doctors would need would be too much ... like now for the CS we were left with many bills ah! (Data: 42). Yes, it (CS) is expensive (Data: 44). For natural delivery, I saw that the fees are low. They are lower than ours who have that (CS) done to them (Data: 46) (A1WCS).
 - The fact that you have used the medicine that puts you to sleep ... it means that those drugs that they (doctors) will be giving you in the form of injections also makes it (CS) expensive. What made it more with me is that I stayed longer in hospital (Data: 79) (B1WCS).
 - At least the charges (for CS) should be slightly less than what they are now (Data: 195). It (charges for CS) should be reasonable, not huge sums (Data: 19 5.1). They (doctors) should reduce the charges (for CS) (Data: 197.1). I wish they (doctors) could make payment reasonable (for CS) (Data: 202.1.1). It (payment for CS) is too much (Data: 204). USD (United States Dollar) 900 is far too much. One is not given the birth record if they had not paid the maternity fee. They (nurses) did not give us the birth record; they want USD (United States dollar) (265.00) (Data: 199) (C1WCS).
 - The expenses will be more when they were not even planned for. When one delivers normally, it takes only one day. You deliver; spend one night and the next day one is discharged. So, if you spend so much time, some of the medication has to be bought (Data: 75. 2) (B1WCS).
-

In Data: display 18 informants indicated that CS had certain economic implications and that indeed the intervention was a financial burden to them (Data: 195.1) (C1WCS). Besides the culturally sanctioned preference for natural birthing, it would appear that informants would have preferred giving birth naturally because of the comparatively low charges for natural birthing (Data: 46) (A1WCS).

An observation that was made is that it appears that CS is lucrative business for the obstetricians and in some instances women have had CS where there would have been no obstetric indication; which in fact has increased CS rates where there does not seem to be an explanation by a change or increase in obstetric complications (Black et al 2001 cited in Pairman et al 2006:738; Reid 2007:33).

4.3.4.2 Category 4.2: Physical health effects of CS

Studies done have shown that vaginally delivered mothers are fit to participate in normal activities soon after delivery while more of the CS mothers still felt unwell. In one study, 49% of the CS respondents felt that they had not yet returned to “their normal selves” three months after their CS compared to 30% of their counterparts who had delivered vaginally (Nive 1992:131). The major physical health effect for CS can be classified as temporal and long-term. Data display 19 contains evidence given by informants on the physical health effects of CS right from the time the woman is operated upon.

DATA DISPLAY 19

THEME 4: Effects of unnatural birthing

CATEGORY 4.2: Physical health effects of CS

Temporal physical effects to health

- No, the pain that I felt when I came round was from the operation. I was in a lot of pain; pain that I had never experienced before; real pain. I was not able to say where the pain was (Data: 89). When I came round (from anaesthesia)... but after sometime I ended up telling them (health workers) that I was feeling pain (Data: 91) (B1WCS)
- The operation was painful (Data: 245). ...you take time to heal, up to 10 days because you heal outside, but inside you feel pain (Data: 249.4) (D1WCS).
Nothing changed, I still feel alright except for the pain in stitches that I have (Data: 323) (F1WFD).

Permanent physical effects on health.

- Ah! It (having CS) is not a good feeling. Is it not that an operation is a wound that one has to live with for the rest of their life? Plus, you no longer have good health because of the physical trauma one always suffers with each CS (Data: 6). The scar will always be there even if the wound heals. When it is cold or when there is rain it is painful from inside and one cannot carry heavy things (32.2.1) (A1WCS).
 - What I do not like is the scar that I now have because it is something that is permanent and as I said it is the second one (Data: 276). When it is cold the scar is itchy and sometimes it is painful (Data: 276.2) (E1WCS).
-

Physical effects of CS are to be expected and the most immediate one is pain at the incision site. Even much later after the scar had healed, informants still had pain. Considering that CS is performed under anaesthesia, the expectation would be that there should be minimal pain during an immediately after surgery. All the same it cannot be disputed that a woman might feel a lot of pain following CS, attributable to surgical incisions into the skin, fascia and uterus.

"The woman's pain is as bad as she thinks because her pain is exactly as she perceives it" (Raynor & England 2010:137) (Data: 89) (B1WCS); (Data: 323) (F1WFD). Post CS pain might be aggravated if sepsis sets in. The chances for wound sepsis are good in cases of complicated labour where the membranes had been ruptured for some time prior to the performance of the CS.

While it is understood that the mother may experience pain, the baby may also experience physical effects because of manipulation during delivery in an effort to achieve natural birthing. This usually happens in a breech or forceps delivery or a CS. Literature also gives evidence of trauma to both the mother and the baby during instrument deliveries, including possible long-term effects (see section 2.6.1.1 of this report).

4.3.4.3 Category 4.3: Psychological effects of CS

Women who give birth through alternative modes of birthing, CS in particular, go through a lot of psychological trauma, emotional abuse from socio-cultural influences, family lore and probably self-inflicted psychological trauma from failure to achieve societal expectations of natural birthing. The women may be accused of infidelity and suffer stigmatisation and loss of respect (Schapera 1946:413; Van Roosmalen & Van der Does ... 1995:23).

Several subcategories relating to "psychological" effects of CS emerged from the data. Data display 20 contains evidence on what is labelled "general" psychological effects. Following on these are two major categories namely "guilt" and "poor self-image" of the mothers.

4.3.4.3.1 Category 4.3.1: General psychological effects

As indicated Data display 21 the general psychological effects following CS includes fear of permanent ill health, fear of future CS, fear of falling pregnant again and living with the physical scar. Psychologically women are affected by CS in a number of ways some of which are contained in the evidence given in Data display 21.

DATA DISPLAY 20

THEME 4: Effects of unnatural birthing

CATEGORY 4.3.1: General psychological effects of CS

Fear of permanent ill health

- No, as for me I do not like it (CS) anymore because what I see is that if I keep having CS I will never have a healthy life again, because haa... for one to get used to going to theatre for more than four times, haa... this last one is the one who encouraged me to say no, I should not do it again (Data: 30) (A1WCS).

Fear of repetition of the procedure

That (having another CS) is what I am afraid of because it is said that if you give birth by CS now the next one will also be CS (Data: 235.2). ...the more you give birth by CS the more chances of dying. I am scared (Data: 235.3) (D1WCS).

- What I can foresee is that this thing will end up killing me. I am scared because I may not always be able to wake up (from anaesthesia) I will sleep forever and die and leave my children (Data 276.6) (E1WCS).

Fear of falling pregnant

- I am now really afraid to fall pregnant again (Data: 276.7) (E1WCS).

The scar

- Ah! It (having CS) is not a good feeling. Isn't it that an operation is a wound that one has to live with for the rest of their life (Data: 6). The scar will always be there even if the wound heals. (Data 32.2.1) (A1WCS).
 - What I do not like is the scar that I now have because it is something that is permanent (Data: 276) (E1WCS).
 - Physically – the appearance of the scar might affect my spouse and he might not find me attractive anymore (Data: (235.4) (D1WCS).
-

The dominant effect of CS that the mothers expressed in their evidence of perception was that of fear as "...fears are often unvoiced and create a great deal of anxiety, especially because fears are usually unfounded in reality" (Jaffe & Diamond 2011:77). Informants gave evidence of fear of permanent ill health following CS (Data: 30), falling pregnant again (Data: 276.7) (E1WCS) and getting the procedure

repeated (Data: 235.2) (E1WCS). Evidence on fear of dying from giving birth by CS was also clearly expressed (Data: 235.3) (D1WCS); (Data: 276.6) (E1WCS) (Mathole 2004:129; Matua 2004:35).

The idea that the CS scar is permanent was of great concern to informants (Data: 276) (E1WCS); (Data: 32.2.1) (A1WCS). However, informants seemed to refer to the physical scar only; yet one would like to believe that the women would also relate to the psychological aspect of internal scars they suffered from being unable to give birth naturally as women in a socio-culturally sensitive society which seem to attach stigma and loss of womanhood to unnatural birthing (Data: 276) (E1WCS).. One informant expressed that she felt less attractive for her husband because of the physical appearance of the scar from the CS (Data: 235.4) (D1WCS).

4.3.4.3.2 *Category 4.3.2: Guilt*

Guilt involves feelings that one has done something wrong. It is the fact of being responsible for the commission of an offense. It is also a cognitive or an emotional experience that occurs when a person realises or believes – accurately or not – that he or she has violated a moral standard, and bears significant responsibility for that.

Data display 21 contains evidence of guilt experienced by informants who had given birth unnaturally/by caesarean section.

DATA DISPLAY 21**THEME 4: Effects of unnatural birthing****CATEGORY 4.3.2: Guilt**

- It (being a parent of a child born through unnatural birthing) bothers me because when the baby came out she was tired and did not even cry until later on. (Data: 329). I feel bad about it (not being able to push) such that if baby could hear me now I would apologise (Data: 329.2.2). I blamed myself for not having had the strength to push my baby out up to the extent that when she was born it was as if she was ill... baby was traumatised by the forceps delivery (Data: 329.1). If I had managed to push the baby out, she would not have had any problems of failing to cry at birth; she (baby) would have been born an active and lively baby like any other newborn (Data: 329.2) (F1WFD).
 - When I look at my baby, I feel 'I was not mother to you because I did not push' (Data: 241) (D1WCS).
-

The informants who gave birth through CS perceived themselves as being guilty of an inability to 'push the baby at delivery' because they could not give birth naturally. The evidence was that there was a general feeling of self-blame (Data 329.1) (F1WFD). Informants expressed fear that at birth, the baby might not have a good apgar score (an assessment tool for baby's well-being at birth) because of prolonged labour and seemingly felt guilty. Informants also gave evidence of feeling guilty because they felt that had it not been for the fact that labour or delivery took long the baby would have been born active and lively (Data: 329.2) (F1WFD).

Self-blame and guilt is a psychological process that helps an individual to cope with a crisis before he/she can accept what has happened and as such it is an accepted reaction to a difficult situation. Evidence given in data display 21 indicates that informants felt guilty because of being unable to achieve their reproductive story "... as so many others can – and with what seems like great ease" which could be quite demoralising and devastating (Jaffe & Diamond 2011:54).

4.3.4.3.3 Category 4.3.3: Poor self-image

Understandably, from the point of view of most Southern Bantu people, the Zimbabwean society included (and other African tribes such as the Ghanaians) cultural emphasis on natural birthing and the passage of rite into womanhood has significant meaning in a woman's life (Donkor 2008:22). Women who have undergone CS could thus suffer a poor or low self-image, whether self-constructed or socially constructed. In both instances the simple definition of a person's self-image is his/her answer to this question: "What do you believe people think about you?" (Self-image ... 2011)

4.3.4.3.3.1 Category 4.3.3.1: Self constructed poor self-image

Data display 22 contains evidence pertaining to self-constructed poor self-image with regard to womanhood due to unnatural birthing.

DATA DISPLAY 22**THEME 4: Effects of unnatural birthing****CATEGORY 4.3.3: Poor self-image****SUB-CATEGORY 4.3.3.1: Self constructed**

- ... that (giving birth by CS) also means that the women will never regain their respect and dignity (Data: 8.4.3). I think they (society) do not think much of me. Maybe I have even lost respect. Some might think that I am a coward that is why I am not able to push when giving birth (Data: 14.4.1). It (CS) is embarrassing and one feels like a failure in being a woman (Data: 24.1.1). You end up not knowing whether you are still a normal woman or are you alright or 'is it my other private parts which are that side' (Data: 34.1) (A1WCS).
 - I am a failure. I failed. I see myself as a failure (because of the CS) (Data: 137) (C1WCS).
 - I do not feel like a proper woman because the rest of my life I must give birth through an operation (Data: 235.1). I have no self-confidence. I do not feel like a perfect woman anymore because of (CS) (Data: 235.5). I do not see myself as a perfect woman because of failing to give birth naturally (Data: 237) (D1WCS).
 - It means that to them I am no longer dignified, with no respect and I am no longer whole because of CS (Data: 276.9). I feel that I am just a person without dignity and not the same as other women who give birth naturally (Data: 286). Somehow you do not carry the respect that other women who give birth naturally carry (Data 274) (E1WCS).
 - That (not carrying respect) stresses me a lot (Data: 350.1.1) (F1WFD).
-

Evidence given by informants seem to indicate that self-image, is emotionally violated by the event of alternative modes of birthing and informants' self-image is indeed disturbed. Jaffe and Raymond (2011:55) posit that failure to give birth may represent the loss of a woman's sense of self as a fully functional female; which indeed would mimic the same sense of loss of self-image in failure to achieve natural birthing. Informants seemingly perceived themselves as having lost their respect and dignity because of having given birth in an unnatural manner/CS (Data: 8.4.3) (A1WCS). The data display also gives evidence that some participants felt embarrassed and regarded themselves to be total failures in achieving womanhood once they gave birth unnaturally/by CS (Data: 137) (C1WCS). All of these points towards self-constructed poor self-image.

4.3.4.3.3.2 Category 4.3.3.2: Socially constructed poor self-image

Closely related to self-image is the perception a person has about what others

might think of that person. Data display 23 contains evidence in this regard.

DATA DISPLAY 23

THEME 4: Effects of unnatural birthing

CATEGORY 4.3.3: Poor self-image

SUB-CATEGORY 4.3.3.1: Socially constructed

- Culturally, society does not like a woman to give birth through an operation, it means that she failed to be a complete woman (Data: 292.3). Getting sterilised would be the answer, but the problem is that when one does not bear children, their husband and his family may not understand what would be going on and wondering why his wife is no longer bearing any children (Data: 276.8). Maybe the family I married into may be thinking of taking me back to my family (Data: 276.10). As long as she will be bearing children, she is better than the one who is barren; but they (society) would still be grumbling and asking why she cannot give birth naturally (276.11). If one is not able to do hard work or carry heavy things; they are said to be lazy (Data: 278.2) (E1WCS).
 - It would appear as if I have not got enough strength and I am a coward, something which does not earn a woman respect (Data: 327.1.1). I do not think the others (meaning society) still have respect for me like they do for other women (Data: 350) (F1WFD).
-

An observation that has been made is that culturally, society does not consider the residual physical effects that might affect the woman during the process of birthing by CS; should she be unable to carry out the daily chores of a woman as expected by society, she is labelled as being lazy (Data: 278.2) (E1WCS). Informants also expressed that culturally, they were considered as cowards and women who were not perfect. In this regard, informants might feel that they were not respectable people in society. It would also appear that the informants were doing some self-evaluation as to what society thinks about them; an expression which seems to answer the question posed earlier in the introduction of this category namely: "What do you believe people think about you?" (Data: 327.1.1) (F1WFD); (Data: 350) (F1WFD). .

One informant uttered a counter argument/point namely "As long as the woman will be bearing children she is better than the one who is barren" (Data: 276.11) (E1WCS). This appears to reflect that some dignity had been maintained even though it was achieved by reflecting other more unfortunate women.

4.3.4.4 Category 4.4: Social effects of CS

Natural birthing is a societal expectation and if not achieved the woman suffers emotionally and psychologically. This also has psychosocial implications involving the woman's family. Society has a say, sanctions and monitors cultural norms to such an extent that if the situation is not culturally acceptable, in this instance unnatural birthing, it might result in the woman being stigmatised and discriminated against. It has been the researcher's observation that in the Zimbabwean culture, the husband and the in-laws might accuse the woman of infidelity if she is unable to give birth naturally. This might lead to emotional abuse through insults and threats of divorce (Schapera 1946:413; Van Roosmalen & Van der Does 1995:22).

4.3.4.4.1 Category 4.4.1: Stigma and discrimination

The Thesaurus Collins English dictionary defines stigma as dishonouring or to label someone (Thesaurus 1995:682). While dishonouring is stigmatisation, it can be used to discriminate against persons with the aim to encourage segregation. The informants perceived themselves as being stigmatised and discriminated against; phenomena which could be the result of cultural influences towards women who are unable to give birth naturally.

Data display 24 contains evidence of psycho-social effects of discrimination and stigmatisation.

DATA DISPLAY 24**THEME 3: Perceptions****CATEGORY 1: Psycho-social effects****CATEGORY 1.1 stigma and discrimination**

- ... when people are being hired for jobs, once you tell them (prospective employers) you have a CS, in both the army and the police; they will not offer you a job (Data: 8.2). They will tell you that your life is no longer the same as that of others (Data: 8.3) (A1WCS).
 - It (unnatural birthing) removes one's dignity (Data: 295.2) (E1WCS).
 - One should bear children through the respected natural mode and not through an operation (Data: 295.1) (E1WCS).
 - The appearance of the scar might affect my spouse and he might find me not attractive anymore (Data: 235.4) D1WSC).
-

The most significant and demoralising psychosocial effects of CS are those resulting from stigmatisation, which according to the informants' perceptions affect life in

general. Examples given were that securing a job might be impossible (Data: 8.2) (A1WCS). This might be a result of the belief that one's life is no longer the same, health wise following CS (Data 8.3) (A1WCS). The informants also experienced a feeling of loss of dignity once one gives birth through a CS (Data: 295.2) (E1WCS). This might be so (loss of dignity) because culture prescribes the accepted mode of birthing to be a natural vaginal delivery (Data: 295.1) (E1WCS).

4.3.5 THEME 5: Outcomes of unnatural birthing

The fifth theme that emerged from the current study is that of gains and losses. In the African culture, and in specifically among the Zimbabwean Ndebele, motherhood and womanhood are achievements which should be attained through becoming a woman through natural childbearing which is considered a rite of passage to womanhood (Raynor & English 2010:32; Reid 2007:21).

4.3.5.1 Category 5.1: Gain: motherhood

Motherhood establishes the woman's sexuality and defines her as an adult woman. Becoming a mother is central to a woman's identity whether as a result of societal expectations or innate biological drive most women consider motherhood as a major life goal (Kitrell 1998, Levison 1978 cited in Jaffe & Diamond 2011:61).

Thus, although not culturally acceptable, alternative modes of birthing have gains, which is motherhood, which can restore some dignity to a woman who might otherwise feel that she has been denied womanhood.

Even if one gives birth by CS, one would have at least managed to meet some societal expectations; the major role of women namely that of procreation would be realised. In the Zimbabwean Ndebele culture being barren is regarded as being the worst curse that can befall a woman (Nyathi 2001:89; Donkor 2008:22).

Data related to motherhood as a social gain are presented in data display 25.

DATA DISPLAY 25**THEME 4: Gains and losses****CATEGORY 1.1: Gain: Motherhood despite**

- I do not have a baby that I delivered naturally, but what I can say is that, I love my children the same. I love them very much, because they were born in a way (CS) (Data: 290). ... that (CS) helped them to live even if they were meant to die, but they survived (290.1) As long as the woman will be bearing children she is better than the one who is barren (Data: 276.11) (E1WCS).
-

Evidence given by informants in this section suggests that despite the fact that the informants gave birth unnaturally through alternative modes of birthing, they gained the status of motherhood (Data display 25). The love expressed by the informants for their babies was an indicator for motherhood gained despite unnatural birthing (Data: 290) (E1WCS).

Culturally, a woman's sense of self is often defined more by her role than by any official title. An example in the Zimbabwean Ndebele culture is that when a woman becomes a mother she ceases to be identified by her first name, but is identified by the name of her first-born child forever; for example, *mama ka Musa* (meaning Musa's mother). Never shall her own name be called again; not even by her husband. That becomes her identity by the whole clan and by society, such that calling her by her own name becomes taboo. At least Ndebele women accomplished this social rite of passage by becoming mothers, even if by CS.

4.3.5.2 Category 5.2: Loss: Womanhood

A woman's sense of identity as truly female is often achieved through pregnancy and birthing; "but when a reproductive loss occurs there is no sense of mastery instead there is a feeling of personal failure" (Jaffe & Diamond 2011:35). Likewise, with womanhood, when repeated attempts to give birth naturally are unsuccessful trauma that leaves a permanent scar may occur and loss of womanhood ensues. Failure to achieve natural birthing may represent the loss of a woman's sense of herself as a fully functional female. The loss of the experience is very painful emotionally, physically and psychologically (Jaffe & Diamond 2011:55).

In contrary to the above discussion, data display 26 presents evidence given of the loss of womanhood by virtue of the participants' inability to give birth naturally.

DATA DISPLAY 26**THEME 4: Gains and losses****CATEGORY 1.2: Loss: Womanhood**

- Culturally, child bearing is the sign of being a woman and as a woman one wants to experience what other women go through during naturally birthing (16.3.1). As a woman one also wants that experience of pushing their baby out because it also gives one the respect of being a full woman (Data 10.2.1). I feel inadequate as a woman, I feel that maybe given a chance I could be able to push my baby out like other women (Data: 14.1.2) (A1WCS).
 - I wanted natural birthing because I wanted to feel like a woman (Data: 233) (D1WCS).
 - Culturally, society does not like a woman to give birth through an operation, it means that she failed to be a complete woman (Data: 292.3) E1WCS).
 - I feel as if I have lost dignity as a woman who is not able to bear children at the time of pushing (Data: 327.1). I do not think that others (meaning society) still have respect for me like they do for other women who give birth naturally (Data: 350) (F1WFD).
-

It appears that generally in the Zimbabwean Ndebele culture, womanhood is achieved through natural birthing. Studies related to women's feelings of not achieving a vaginal birth revealed that they experienced trauma from "lack of womanhood". While some talked about the feeling as "deeply disappointed" others felt a "failure" and described how their bodies' inability to deliver their babies normally was equated to a sense of being unable to fulfil their role as women (Jaffe & Diamond 2011:55; Fenwick, Gamble & Mawson 2003:13)

The informants gave evidence of their perceptions of the Zimbabwean Ndebele society that despite mothering, the woman would not be accredited womanhood status as long as she did not give birth naturally. Evidence given by the informants suggests that women who give birth through alternative modes of birthing are not worth any respect as they are not complete women (Data: 10.2.1) (A1WCS). The impression was created that the informants lost out on womanhood although they gained on motherhood. Information in data display 26 indicates that there was an overwhelming sense that the informants had lost or had been denied an integral life

experience. In this discussion the data seem to confirm that for some women the failure to have a normal birth caused feelings of inadequacy as a woman.

4.3.6 Conclusion

The nomothetic data analysis of all the evidence on the experience of the informants on alternative modes of birthing indicates that the informants were subjected to a lot of the negative experiences more than the positive ones. This seems to have been a result of cultural expectations for the informants to achieve both motherhood and womanhood. From the evidence given by the informants, it is apparent that the whole experience of the informants is a result of the cultural beliefs and practices of the Zimbabwean Ndebele society.

4.4 DATA ON SPOUSES' PERCEPTIONS AND EXPERIENCES

Three themes emerged from the data that were obtained from the individual open-ended in-depth interviews held with spouses of women who experienced unnatural childbirth. These themes include:

- Perception of unnatural childbirth
- Spouses' distress
- Spouses' cultural perceptions

These themes and main categories are presented graphically in figure 4.2. The diagram emphasises the spouses' psyche and experience within the context of the mother giving birth unnaturally to his offspring. Spouses' preference for natural childbirth and their cultural consultations relate directly to the event of unnatural childbirth while distress and resolution implied a stabilising, formally disturbed equilibrium with the spouse.

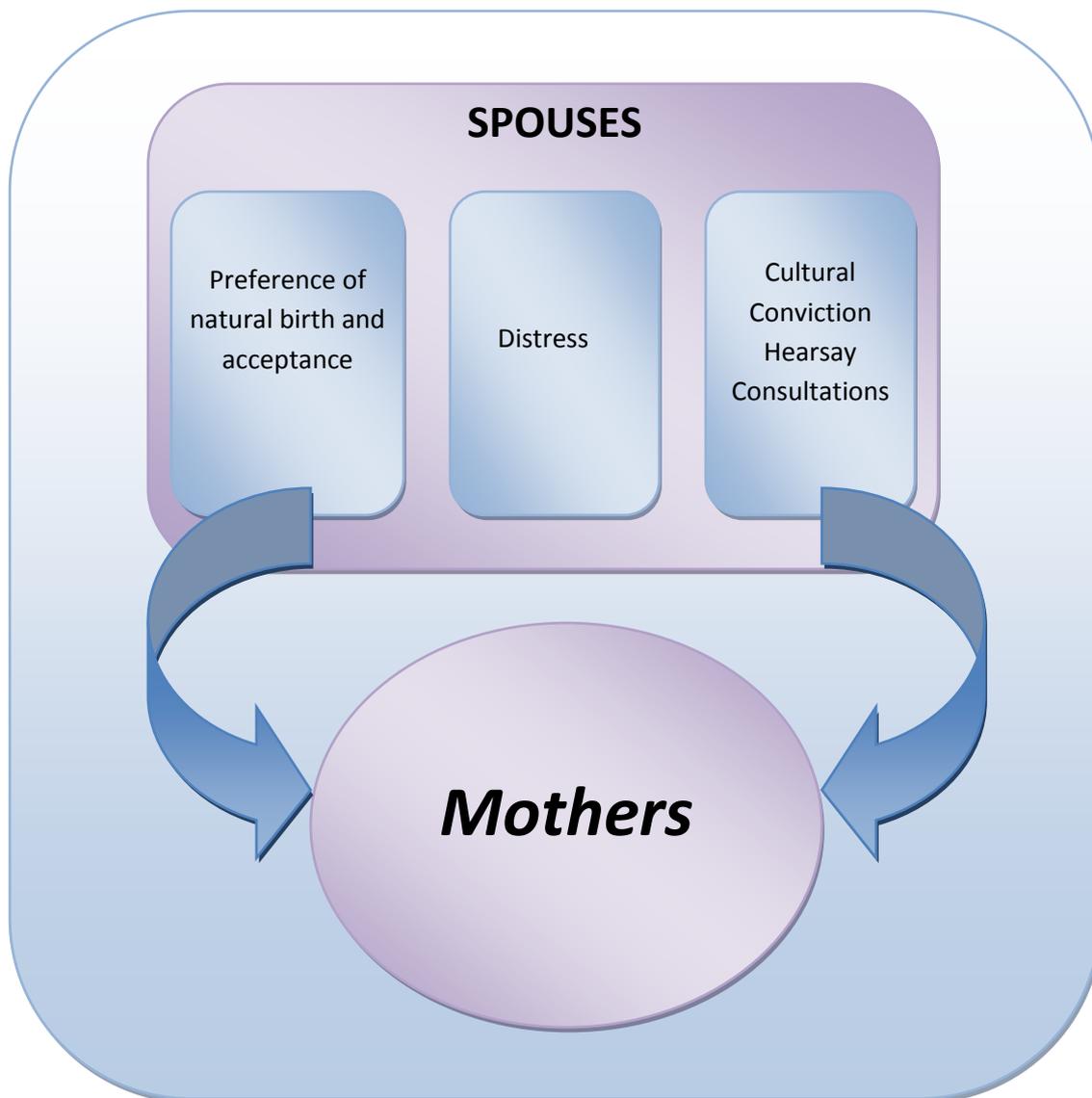


Figure 4.2: Spouses' experience of unnatural child birth and relationship to the event

Where possible, literature pertinent to the content of data displays is given. The literature on spouses' (or individuals fathering a child born unnaturally) is, however, very scarce. It would appear that if any, very little research has been conducted on this issue. No information radically different to that which mothers gave emerged from the data obtained from spouses. Literature sources to substantiate what spouses said was extremely difficult to obtain. Opinions and experiences were included where relevant.

4.4.1 THEME 1: Preference of natural childbirth

DATA DISPLAY 27**THEME 1: Preference of natural child birth****Overview**

Non-acceptability of unnatural childbirth
Provisional or qualified acceptance of unnatural child birth
Delayed acceptance of unnatural child birth
The baby as factor in unnatural child birth

As indicated previously, in most African cultures alternative modes of childbirth, CS in particular, are unacceptable as they are associated with spiritual reasons such as witchcraft and are also believed to be punishment for marital infidelity, hence the preference of natural birth against unnatural birthing (Van Roosmalen & Van der Does 1995:22; Awoyinka, Ayinde & Omgbodun 2006:209; Aziken et al 2007:46). Data display 28 contains evidence given by spouses regarding their preference for natural child bearing over CS or any other unnatural child birth method or procedure.

DATA DISPLAY 28**THEME 1: Preference of natural child birth**

Non-acceptability of unnatural childbirth

... sometimes it (CS) worries me ... especially on the mother's side who is the one who gets operated on (Data: 366). I would be scared that maybe when she goes to theatre she might not come back. She might die while being operated. That is my biggest worry (Data: 366.1). Yah ... I have a problem with CS, because when people, ... a person is giving birth they must deliver naturally (Data: 378). I would like her (wife) to give birth naturally like other women (Data 386.1). I was just thinking I should go to the doctors and find out whether there is nothing else that can be done for her (wife) to give birth naturally like other women (Data: 437). Yes, if there is another way of doing it (giving birth) at least, because I think it would be better ... because I am not comfortable with it (CS) at all (Data: 443). I don't like it (CS), I am not happy about it (CS) ... for her to give birth by operation. It is not the natural way of giving birth (Data: 386) (A2SP).

Provisional or qualified acceptance of unnatural child birth

- Yes, I think it (CS) helps; ... there is no other way ... except by operation, that (CS) is the only possible way (Data: 388). But I should think that the woman herself would be the one having a physical problem (Data: 384). Maybe it will be her womb obstructing her, maybe she is not physically adequate as a woman (Data: 378.1) (A2SP).
- I was told that she (wife) must have an operation (CS). So, that is when I got the shock (Data: 411.1) B2SP).

Delayed acceptance of unnatural child birth

- I was not comfortable with it, but I could see that there was no other
-

way. So, I had to accept it as it was (403.1.1). I realised ... that she (wife) had to be operated there was no other way, because ... she would have many complications if she is not operated upon. It would be the only way that she should give birth (Data: 484). I also thought that if there is no other way of her giving birth, we would have to accept it that way (Data: 493.1). No, it would appear it (CS) did help ..., had it not been for the operation, the baby would have suffocated and died (Data::486) (B2SP).

The baby as factor in unnatural child birth

- Then it comes to the baby; I do not see the problem since baby was born without interference or problem from the mother (Data: 366.5). I know that sometimes because of pain that the mother goes through during delivery, one might run and do things ... and baby might be hurt, but if baby would have been born by operation ah ... I do not see a major problem (Data: 366.5.1) (A2SP).

Evidence given by the spouses indicated that they experienced different negative feelings, including shock (Data: 411.1) (B2SP), worry (Data: 366) (A2SP) and fear that the wife might die while being operated upon (Data: 366.1) (A2SP). These feelings influenced the degree of acceptability of CS by spouses. Evidence given by the informants seems to suggest that CS was not acceptable to spouses as it was not a natural mode of childbirth (Data: 386) (A2SP). One informant was prepared to engage in a dialogue with the doctors in order to negotiate for his wife to be given a chance to give birth naturally because failure for the woman to give birth naturally has some cultural implications as alluded to earlier in this thesis (Data: 437) (B2SP). Other studies also confirmed that fathers with babies born through CS experienced some degree of psychological impact by experiencing emotional effects that included dissatisfaction with unnatural birth, stress, loss, fear, worry, disappointment, guilt, anger and role failure in coaching the mother in preparation for natural childbirth. It would appear that the fear, worry and loss are related to fear of losing the mother and even baby during surgery (Mutrin 1993:1276).

However, not all the spouses were uncomfortable with their wives giving birth through CS. Some spouses also expressed that they later realised that CS was the only way the woman could have given birth and they had to accept that as a fact (Data: 403.1.1) (B2SP); (Data: 493.1) (B2SP). One spouse was convinced that CS was helpful as it saved the life of the baby (Data: 486) (B2SP). It appears that the informants were convinced that giving birth by CS was safe and did not interfere with

the baby in any way (Data: 366.5) (A2SP). Although the informants were aware that in some instances the woman might be overwhelmed by labour pain and might behave in a manner that could endanger the baby, they were sure that there would be no major problem if the baby would be born through CS (Data: 366.5.1) (A2SP).

Data display 28 contains evidence, given by the informants, on the reasons for CS. In this section, evidence given by the informants indicates an understanding of reasons for CS, including that it could be a problem of physical inadequacy on the woman's side (Data: 384) (A2SP). The other reason given by the informants was that it could be that the woman's womb was causing an obstruction (Data: 378.1) (A2SP). This understanding of the reasons for CS is highly commendable coming from lay persons because it is congruent with the scientific reasons for performing a CS; These scientific reasons include inadequacy of the pelvis that results in cephalopelvic disproportion and uterine inertia with resultant prolonged labour and eventually foetal distress. .

4.4.2 THEME 2: Spouses' distress

For fathers of babies born by CS, the experience of CS could be dramatic, particularly in an emergency occurring unexpectedly. The psychological and emotional impact of CS might be stressful and frightening (Mutrin 1993:1276). Data display 29 gives an overview of the major categories and sub-categories of the theme on spouses' distress.

DATA DISPLAY 29
THEME 2: Spouses' distress
Overview

Personal Distress
Distress relating to the mother
Distress relating to the baby
Distress relating to denigration of manhood
Distress relating to financial concerns
Reconciling/making peace distress

4.4.2.1 Category 2.1: Personal distress

The CS comes with a number of stressful issues such as economic, psycho-socio-cultural as well as worrying about the well-being of both mother and baby. In addition to these stressful events, such a baby's father might also have to cope with personal psychological issues. Data display 30 relates to evidence given by the informants in this regard.

DATA DISPLAY 30
THEME 2: Spouses' distress
CATEGORY 2.1 Personal distress

- I love those children ... I do not want anybody who does anything wrong to them ... how do they think the mother feels especially that she does not deliver the way others do? If I find them crying, I feel pained (Data: 397). Sometimes it (CS) worries me ... especially on the mother's side who is the one who gets operated on (Data: 366). I would be scared that maybe when she goes to theatre she might not come back. She might die while being operated. That is my biggest worry (366.1) (A2SP).
I was told that she (wife) must have an operation (CS). So, that is when I got the shock (Data: 411.1). I was not comfortable with it (CS) (Data: 403.1.1). ... in an operation anything can happen (Data: 445.1). At times she (wife) might not make it... maybe there would be some complications (laughs). Maybe they (mother and child) may not come back to life (Data; 449).
- Denial**
- It is still difficult for me to talk about it (CS) (Data: 413.2) (B2SP).
-

Spouses also look forward to fatherhood which they achieve through the parental bond. Evidence given by the informants shows that spouses became protective of and loved their children, more so because of the mode of delivery that the mother went through when giving birth (Data: 397) (A2SP). In the African culture children are a proof of manhood and are deemed essential for the prestige and social position of both men and women. A father's statements in "defence" of the mother might indicate his self-defence and his acceptance of the (boy) child, as he would have accepted any child born naturally. Literature reviewed confirms this premise (Marino 2004: 262; King 2007:192).

In general, the African believes that the main reason for marrying is procreation rather than personal fulfilment which the African believes is achieved mainly in having offspring, because children have always been regarded as a prolongation of self;

particularly the boy child and is often believed to be a fulfilment of immortality as one man put it “A man who had no children would consider himself dead and finished. His life has come to an end: it has no continuation” (Marriage and the family in Africa ... 2010). Like the Zimbabwean Ndebele society, most societies value children as part of the culture and male children are often more highly valued and parents invest more in their upbringing because they take care of ancestor worship and their elderly parents and maintain family lineage. Chinese parents have been observed to place a heavy emphasis on their children. It is believed that it is because of their ability to become successful and achieve perfection through education.

On the contrary, in most industrialised modern societies, children are valued for emotional reasons rather than socioeconomic reasons, and gender differences are rather disregarded, women can have a career of their own and do not have to marry; they may even make decisions whether to have children or not and live alone or with the father of their children. In other Western societies, children are valued for emotional reasons rather than socio-economic reasons and gender differences are not considered.

In the researcher’s view point the issue of value for children, although relevant and of importance is a very broad subject and therefore is beyond the scope of this study.

4.4.2.2 Category 2.2: Distress relating to the mother

It is the researcher’s experience as a midwife practitioner of many years that caesarean babies’ fathers usually present with feelings of nervousness and anxiety about their wives and babies. Maternal morbidity is another issue that could be the source of distress relating the mother. The CS may prove traumatic to the father, but at the same time he is still expected to support his wife and the baby (Mander 2007:149).

Data display 31 contains evidence given by spouses relating to their perception of what physical effects CS might hold for women.

DATA DISPLAY 31**THEME 2: Spouses' distress****CATEGORY 1: Distress relating to the mother**

General indicator

- Some babies when they are born, they are checked by the elders for normality ... there are ways to see that baby may have had something wrong as a result of CS and baby may not cry quickly at birth as a result of CS (Data: 366.6) (A2SP).

Uncertainty of labour outcomes

- I don't know because when the time comes for her (wife) to deliver, one would not really see how much hardship she would really be going through because that time (time of delivery) is really a difficult time (Data: 490). I wouldn't know about the future, but as for now the baby is growing well ... I wouldn't really know whether having been born this way (through CS), there is something that would affect him (baby) (Data: 441) (B2SP).

Short-term physical effects to health

- They (women) will be complaining of pain on the incision (Data: 482). I also know that her health will not be smooth ... I would ask around whether there is something that can be done culturally or send her back to the hospital for the doctor to give her some pain killers so that she (wife) is not always in pain (Data: 435) (B2SP).

Long-term physical effects to health

- Ah! I wouldn't know, but in most instances when it is cold like this (interview done on a cold day), she (wife) usually complains of pain on the operation scar) (Data: 409). ... because she (wife) will always have a permanent scar on the abdomen which does not look nice (Data: 484.1) (B2SP).
-

In this section, informants gave evidence of what they perceived as physical effects of CS; some short-term and others long-term for both the mother and the baby. For the mother, pain at the incision site was perceived as a short-term effect of CS because the informants believed that there was a possibility of relieving the pain using analgesics (Data: 435) (B2SP).

Informants gave evidence of the long-term physical effects of CS on the mother as pain on the operation scar when the weather is cold (Data: 409) (B2SP). A permanent scar on the abdomen was also given as a physical effect of CS which one of the informants clearly said does not look nice (Data: 484.1) (B2SP). The information in this section confirms the fears of one woman who said their husband might not find her attractive anymore because of the abdominal CS scar (see section 4.3.4.3.1 data display 20 (Data: 2.35.4) (D1WCS).

4.4.2.3 Category 2.3: Distress relating to the baby

The major concern that the fathers had about the baby was that they were unsure whether the baby might die later in life from implications as a result of CS.

Data display 32 contains evidence about fathers' distress relating to baby.

DATA DISPLAY 32**THEME 2: Spouses distress****CATEGORY 2.3: Distress relating to the baby**

Short-term physical effects to health**For baby**

May be when a baby is born through an operation, it takes a long time to cry like mine, the mother tells me that she was told that babies take some time before they cry following CS. So, I will not know whether it is because baby was born through an operation (Data: 366.7). It (baby delaying to cry) would worry me because I would be thinking that it is possible that the baby may never cry which would mean that it is not able to breathe and there would be no life in the baby (Data: 366.7.1). Plus, all my children have a problem that they are born with a tongue tie (Data: 366.8). I think even the younger one has a tongue tie). I do not know whether it is because of the CS (Data: 368) (A2SP).

- One would be worrying about their loved ones, whether they (mother and baby) will survive the CS (Data: 447.1) (B2SP).
-

Generally the informants believed that it might take long for the baby to cry at birth as a result of CS (Data: 366.6) (A2SP). Another thing that the participants expressed was that the delay by the baby to cry would be a concern to them, lest the baby never cries which would be a stillborn baby (Data: 366.7.1) (A2SP). The concern raised by the participants that the baby's delay to cry at birth might be a result of CS could also be considered scientifically. Literature reports reveal that the CS would not cause a baby's delay in crying per se, but that a baby's delay to cry could be a result of the reason for CS. For example, if a CS was performed for foetal distress or maternal distress or for whatever reason that would cause a low Apgar score at birth, the baby might need resuscitation before the baby starts crying.

It would appear that the informants linked whatever physical problem the baby might have had at birth to the CS. In one case an informant gave evidence that the baby was unable to cry properly even later in early life as a result of a CS (366.8) (A2SP). As is always the situation in African culture, for all illnesses, informants preferred traditional medicines/remedies (Data: 370) (A2SP).

The reason for preference of traditional medicine is that in the African context, and indeed in the Zimbabwean context, all illnesses are believed to be a result of having been bewitched or an offence committed by the woman earlier in life (Aziken, Omo-Aghoja & Okonofua 2007:46). So a direct line was probably drawn between the child's inability to cry and CS.

4.4.2.4 Category 2.4: Distress relating to denigration of manhood

Anxiety of the spouse also related to the fear that the mother might be unable to cope with the tasks of caring for the baby when she recovered from surgery. This might imply that the husband would need to go through task shifting and role assumption on his part in terms of caring for the baby and doing other house hold chores which could be regarded as being culturally demoralising and denigrating to manhood, but mandatory at this point in time because of the mother's physical inability to carryout physical work is a result of CS.

Data display 33 contains evidence given by participants showing that the spouses of women, who had given birth through CS, had to assume a responsible participatory role to support the mother to cope with the situation following CS.

DATA DISPLAY 33**THEME 2:Spouses' Distress****CATEGORY 2.4: Distress relating to denigration of manhood**

General indicator

- ... for the operation to heal, she (woman) will need proper care and monitoring to see if she is taking medication that she would have been given by the doctors (Data: 386.2). ... when she is now discharged, she will need care because she will need to wash the nappies. She will go out to hang the wash on a high clothes line ... meanwhile; the operation will not be allowing her to lift her hands up. I find myself worried, and then it means we should look for someone to assist her (Data: 366.2). At times I myself end up helping her especially washing nappies, me being a man, which is culturally not acceptable because one would be like a lesser man and it removes one's dignity. It worries me but there would be no option (Data: 366.3). Even the baby I need to monitor and see if she (mother) is managing (Data: 366.4). At times just after discharge from hospital, she will still be sleepy, such that she sleeps heavily... and does not hear the baby crying until I wake her up. ... at times she sleeps and forgets to breastfeed the baby ... I must wake up and be responsible for seeing that she breastfeeds. I must say that is what really bothers me most (366.4.1) (A2SP).
-

Evidence given by the participants in this section seem to reveal that besides being supportive, some spouses assumed responsible roles which would normally be done by the women following giving birth naturally. The new role that the spouses assumed could have had psycho-social implications as the informants indicated that the newly assumed role was culturally degrading to men who also felt that they lost their dignity as men, but had no option (Data: 366.3) (A2SP). Spouses also took on a supervisory role where they made sure that the women breastfed the babies and complied with their prescribed medication regimens (Data: 366.4.1) (A2SP); (Data: 386.2) (A2SP). It became apparent that even if the spouses were supporting their wives, it might be necessary for these spouses to get support from other family members such as the woman's mother, sisters or mother-in-law as the spouses expressed difficulty in handling the situation (Data: 366.4.1) (A2SP).

4.4.2.5 Category 2.5: Distress relating to financial concerns

Related to the physical, psychological implications, are financial concerns because of the fact that a CS is a more costly procedure than a vaginal birth and that delivery services are not free in Zimbabwe, not even in the public hospitals/clinics. The high costs of CS have been counted as a non-cultural reason for not accepting CS. Data display 34 contains evidence on the economic effects of CS.

DATA DISPLAY 34

THEME 2: Spouses' distress

CATEGORY 2.5: Distress relating to financial concerns

General indicator

- ... for example with the first baby; it was because one would buy their own drips (fluid replacement solutions), injections, gloves. One would buy everything that is used in an operating theatre. It was a problem to get money to buy all that. Sometimes one would not know the day the mother would deliver. So, one would need to buy in advance (Data: 390) (A2SP).

Financial Preparedness for CS

- What one needs to do when they know that the wife delivers by operation is that as soon as they realise that she is pregnant, they must come up with a budget (Data: 391) (A2SP).
- That (costs) is what is giving us a problem which is what made me decide to go back to work ... because the costs are too much (Data: 453). The doctor asked for eight hundred and fifty (850) United States Dollars (Data: 455). We only had three hundred (300) United States dollars (Data: 457) (B2SP).

Negotiation for payment of hospital bills

- We are trying to talk to them (hospital authorities) ... and tell them that we are still looking for the money ... I will pay part of the balance ... they also understand (Data: 459). He (baby) has no birth certificate because we wanted

to solve that (money) issue so that we can go and pay them, they (nurses) can give us the birth record (Data: 461) (B2SP).

Sanction of services for non-payment of hospital bills

- You are not given the birth record, Ah! That is what will make you end up paying because the baby also needs that (birth record) as his right (Data: 463) (B2SP).

Bargaining for hospital services

- Would it not be a good thing that all women pay the same amount of money when they go to deliver in hospital regardless of the mode of delivery...It would not a choice to give birth unnaturally (Data: 393.1) (A2SP).
-

Informants explained that the costs of having a child born by CS were too high (Data: 453) (B2SP). Obtaining sufficient money to pay for a CS was a problem particularly in Zimbabwe with the current economic recession and the use of multi currencies (Data: 390) (A2SP). CS deliveries are more expensive than natural birth. Participants believed that it would be a lot easier for them to come up with a budget and save money on time if one knew that a specific woman would deliver her baby by CS (Data 391) (A2SP).

This is so because one needs to buy everything that is used in an operating theatre which includes drips (fluid replacement solutions), injections, and gloves (Data: 390) (A2SP). However, the participants said that the consolation was that clients were allowed to pay the balance in instalments (Data: 459) (B2SP). It seemed to be a problem being unable to pay hospital bills in full, as the baby's birth record was only issued to parents once their hospital bills had been fully paid (Data: 463) (B2SP).

4.4.3 THEME 3: Spouses' cultural perceptions

Much of the spouses' distress might, in addition to factors displayed in theme 4, be due to their apparent non-involvement in women's affairs and cultural practices surrounding pregnancy and childbirth.

DATA DISPLAY 35
THEME 3: Spouses cultural perception
Overview

Hearsay and conviction
Perception on being tied
Consultation with family elders
Consultation with non-traditional advisors

4.4.3.1 Category 3.1: Hearsay and conviction

Data display 34 indicates both hearsay aspects of cultural interventions during pregnancy and child birth as well as pertinent convictions. Data display 36 contains evidence relating to cultural interventions. Culture guides the norms and controls the behaviour of members of a society.

DATA DISPLAY 36
THEME 3: Spouses' cultural perception)
CATEGORY 3.1: Hearsay and conviction

- Ah! I used to hear about that (women being given herbs to facilitate natural birth) (Data: 469). They (women) are given some herbs to drink to aid natural child birth (Data: 471) (B2SP).
 - Culturally, when a woman gives birth by CS I think she would not have been given some herbs by the elders to prepare her outlet for the baby to pass through (Data: 372) (A2SP).
-

It would appear that in the Zimbabwean Ndebele culture it is a norm to prepare women for child birth using traditional herbs, as a preventive measure against unnatural birth and, to aid natural birth which is culturally the expected mode of childbirth (Data: 471) (B2SP). Should the woman give birth through an alternative mode of childbirth, the belief is, that she might not have been given traditional herbs (Data: 372) (A2SP). Men seem to be aware of, but not particularly informed about or interested in women's affairs such as culture and traditions surrounding pregnancy and birthing.

4.4.3.2 Category 3.2: Perceptions on being tied

African culture in general believes that unnatural childbirth is associated with adultery and witchcraft (Van Roosmalen & Van der Does 1995:22, Aziken et al 2007:46). Although the concept of *being tied* translates to being bewitched as

evidenced by information given by informants from all five purposively selected community samples, no literature is available to substantiate the *being tied* phenomenon since no research has been reported in this area. Data display 37 contains evidence given by participants in this regard.

DATA DISPLAY 37

THEME 3: Spouses' cultural perceptions

CATEGORY 3.2: Perception on being tied

- In the event that the woman is not able to give birth naturally, some people believe that the woman would have been "tied" (use of magic or herbs to cause labour complications) by ancestors either mine or hers (Data: 372.2). I have heard some people saying that it (unnatural birth) happens when one's ancestors are angry about some family issues. It is possible for them (ancestors) to stop the woman from giving birth naturally (Data: 374). So, they (ancestors) obstruct the delivery, that is the tying, they (ancestors) "tie" her (woman) and prevent her from giving birth naturally (Data: 374.1) (A2SP).
-

Evidence given by the participants on the reasons for CS seems to suggest that a woman should be able to give birth naturally unless she has been "tied" (use of magic or herbs to cause labour complications) by ancestors; the reason being that the ancestor would be angry for some reason (Data: 374) (A2SP). The participants expressed that obstructed labour was interpreted as "tying" believed to obstruct the delivery of the baby through the use of magic or herbs (Data: 374.1) (A2SP). The participants' perceived cultural reasons for a woman's inability to give birth naturally were congruent with those given by the participating mothers.

However, scientifically the reasons for the inability to give birth naturally include cephalo-pelvic disproportion, cord prolapse, placenta previa, placenta abruptio and eclampsia. However, culturally some of these cause a chain reaction of cultural and unscientific speculations. Most of these speculations imply that the ancestral spirits were responsible for causing evil things and could even punish someone by causing labour complications (Van Roosmalen & Van der Does 1995:22; Awoyinka, Ayinde & Omgbodun 2006:209; Aziken et al 2007:46).

4.4.3.3 Category 3.3: Consultation with family elders

Culturally, family elders are responsible for giving advice and guidance in issues of childbirth because of their socio-cultural knowledge and experience because their advice is linked to kinship and family history. Data display 38 contains evidence given by the participants in this regard.

DATA DISPLAY 38**THEME 3: Spouses' cultural perception****CATEGORY 3.3: Consultation with family elders**

- Ah! We would need to sit down with the elders and find out from them whether they have knowledge of how this (giving birth by CS) could be prevented culturally (Data: 425). Ha! They (elders) would have to say how they will assist because we often inform them first of most issues; then they teach us how these things should be handled as they (abnormalities such as tongue tie) maybe a result of unnatural child birth (Data: 427) (B2SP).
 - I took the elder baby to go and have an excision of the tongue tie done by the elders (Data: 370) (A2SP).
-

In the African culture, no illness or mishap befalls an individual naturally, but is believed to be connected to magico-religious events, hence the preference of traditional medicine when it comes to interventions (Data: 370) (A2SP). What one needs to understand in this situation is that it is not only the traditional healers who will always give medicinal prescriptions or perform procedures for cultural interventions, but family elders, who might also be herbalists, could also use home remedies enabling younger people to learn the trade of managing illnesses (Data: 427) (B2SP).

4.4.3.4 Category 3.4: Consultation with non-traditional advisors

In any African society, elders of the community are accorded a very respectful status and are viewed as advisors because of the life experiences and knowledge enabling them to advise, educate and empower the community.

In this section, data display 39 contains evidence given by participants on non traditional medicine seeking behaviours.

DATA DISPLAY 39**THEME 2: SPOUSES' CULTURAL PERCEPTION****CATEGORY 3.4: Consultation with non-traditional advisors**

Against traditional medicine

- Ah! I have not gone out. I just do not like the way of going out to seek traditional medicine from the *Sangomas* (traditional healers) (Data: 376) (A2SP).

Magico-religious

- She (spouse's mother) just says "no that is the way God gave her (woman) to use for child bearing" (395.1) (A2SP).
 - Yes, in this (CS) God must have laid His hand (Data: 495) (B2SP).
-

It appears that Zimbabwean Ndebeles believe in traditional medicine as an intervention for illness or for whatever event befalls them (Data: 376) (A2SP). Some of the people within the Zimbabwe Ndebele society seem to have a strong Christian background and believe that God gives different people different gifts (Data: 395:1). Again in the Christian context the belief is that God has a healing hand through the power of prayer and faith. (Data: 495) (B2SP). The belief is that when one is ill and people pray for him/her "such a prayer offered in faith will heal the sick" (James 5 verse 15, 2004:932) and that only God can save one's life when giving birth. In a failed spontaneous vaginal delivery, the belief is that the failure is due to lack of prayers for supernatural intervention and as such recourse to supernatural divination would then appear to be the solution for a complicated labour, rather than a CS delivery (Aziken et al 2007:46; Selin & Stone 2009:35).

4.4.5 Conclusion

In the nomothetic analysis of the evidence given by the participants it appears that the experiences both positive and negative that the informants underwent were linked to culture and tradition within the Zimbabwean Ndebele context. The psychological effects of CS that the informants experienced were fear (Data: 366.1), denial (Data: 413.2) (B2SP) and shock (Data: 403.1) (B2SP) which seem to have left an indent in their (informants') lives in as far as CS is concerned.

No information, radically different from that which the mothers provided, emerged from the data obtained from spouses. Literature to substantiate what the spouses said, apart from personal experiences and opinions, was extremely difficult to obtain.

4.5 DATA ON PERCEPTIONS OF SANGOMAS

It appears that few studies have been conducted about the influence of traditional healers on women's experiences of CS. Thus, it appears that there is a notion that the child could become bewitched through the CS. Hence frequent references need to be made to a limited number of publications. Literature search shows that, although studies have been done on traditional and cultural issues across societies, they do not link up with the current topic under study. Even those studies that have been done, people were "relying exclusively on practical experience and observation handed down from generation to generation whether verbally or in writing" (Truter 2007:57). Nyika (2006:28) confirms the preceding quote by saying that indigenous knowledge about medicinal herbs is passed on from one generation to another without documentation.

According to Mutwa (cited in Hund 2003:167) a *sangoma* is the "guardian of people and his culture" thus in the Zimbabwean Ndebele culture *sangomas* guide cultural activities including the birthing process. It was important to interview this group of informants in order to provide the researcher with critical information relating to cultural practices and beliefs associated with the research topic. The themes that emerged from the individual in-depth interviews reflect that whatever happens in the Zimbabwean Ndebele culture, in relation to birthing, has psycho-socio-cultural and religious implications particularly when a woman gives birth through CS. Culturally, CS is believed to be necessitated by spiritual reasons and/or witchcraft and/or infidelity.

Thus the concept of traditional healing becomes applicable in every life situation as it appears to be pivotal to culture and tradition within the Zimbabwean Ndebele context of dealing with or countering supernatural powers. Traditional healing also focuses on psychosocial aspects of life which include treatment of illnesses and counselling and addresses the spiritual needs within a culture in a traditional manner (Mathole, Lindmark & Ahlberg 2005: 946; Awoyinka et al 2006:209).

Four (4) themes emerged from the data that were obtained from the individual open-ended in-depth interviews with the *sangomas* namely:

- Being a *sangoma*
- On unnatural birthing
- Traditional practices
- Art of traditional healing in relation to birthing

These themes and main categories are presented graphically in figure 4.3.

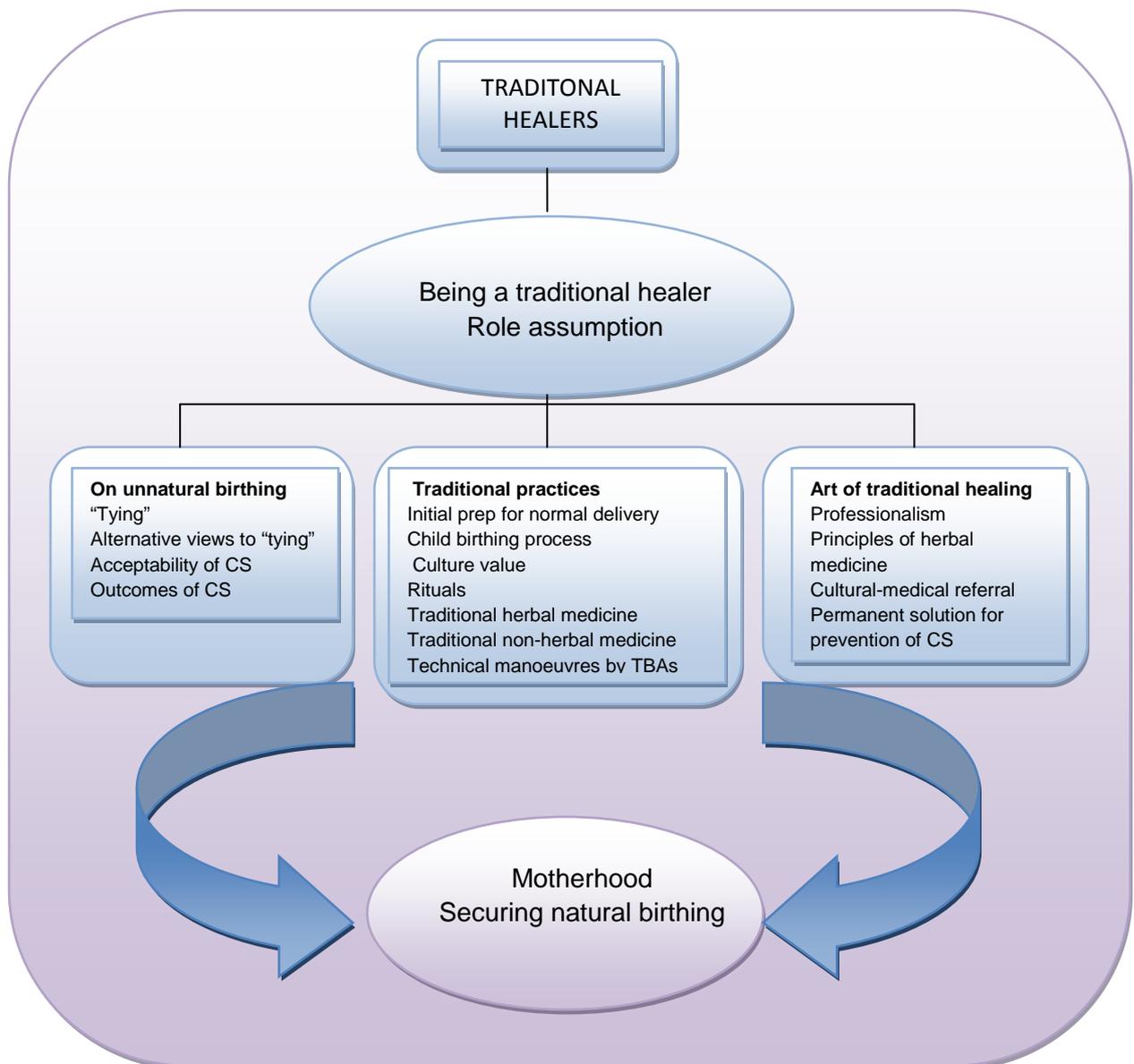


Figure 4.3: Sangomas' perception on unnatural birthing

4.5.1 THEME 1: Being a *Sangoma*

Theme1 relates to being a *sangoma*. *Sangomas* have been playing a major role as providers of primary health care to the majority of people in Africa for thousands of years and as such, *sangomas* are an important, highly respected group in the Zimbabwean Ndebele community for the knowledge, leadership and mystical powers that they possess. *Sangomas* perform different functions according to their expertise. The process of being a *sangoma* also takes various forms, but once qualified *sangomas* assume other societal roles which include being a counselor, educator and advisor to the community (Mathole et al 2005:945; Nyika 2006:25; Truter 2007:57).

An overview of theme 1: being a traditional healer is given in Data display 40.

DATA DISPLAY 40
THEME 1: Being a traditional healer
Overview

Qualifying to be a traditional healer
Role assumption

4.5.1.1 Category 1.1: “Qualifying” to be a traditional healer

In the Zimbabwean Ndebele tradition, religion centres around worshipping ancestral spirits and thus religious beliefs are guided by *sangomas* who house spirit mediums within their human persons (Nyika 2006:26; Mathole et al 2005:943; Truter 2007:57). Data display 41 contains evidence given by informants in this regard.

DATA DISPLAY 41
THEME 1: Being a traditional healer
CATEGORY 1.1: “Qualification” to be a traditional healer

Training

- The apprenticeship is another ... I was trained by a senior traditional healer (Data: 966.1) (A3S/TH).

Healing through the spirit mediums

- I am possessed with spirits (Data: 1054). I have the **powers** to see that if a person is like this, I should use that herb and do this and that (Data: 1056 (B3S/TH)).
 - Each spirit medium wants to use its own herbs. Each one knows their own herbs Data: (1128) (C3S/TH).
 - ..., we just talk to the ancestors and even mention the herbs that we give and say ‘receive these herbs’. It is as if we are not giving her
-

(woman) as we say 'may these herbs be received' (Data: 982) (A3S/TH).

- I can pick the problem from the woman's eyes. The woman's eyes would be having some kind of membrane going across the white part of the eye. I can just pick it that this child will not be able to give birth properly. If the woman's eyes are clean, one can be assured that she will have a complication free delivery. We are guided by her eyes and her body (Data: 1058) (B3S/TH).

Spiritual guidance/communication

- My spirit mediums do not assist during delivery, I am shown in a dream and I am also shown through the water and then it keeps coming that ... (Data: 966). Now we are talking about our religion; where it stands, when we rebuke and say this and that or we frankly ask the spirits 'why is she tied' (use of herbs and/or magic to cause labour complications)? (Data: 976.2) (A3S/TH).

African religion

- Could it be the issue of the spirits from which our religion arises? We ask those questions because we as society tell ourselves that the spirits are capable of obstructing the labour (Data: 976.2.1) (A3S/TH).

Rebuking bad spirits

- The spirit mediums from the woman's side of the family and spirit mediums from those people who may be bearing the grudge are a hindrance or obstruction (Data: 978). We (*sangomas*) rebuke those spirit mediums from the woman's side and the people bearing the grudge. We continue to rebuke them. Even if one thinks they are on the right track; there will always be something of theirs, because, for as long as one is on this earth, the journey is tough ... (Data: 980.1). We shout and shout according to our culture; since we have spirit mediums in us. Maybe there is something the ancestors of the baby are not happy about (Data: 978.1). We then rebuke the people to whom the foetus belongs again and also ask that she (woman) be guided and protected by the spirits while in hospital (Data: 984.2) (A3S/TH).

Limits to healers' abilities

- They (ancestors) would be disgruntled. Sometimes there are some disgruntlements by the ancestors about the pregnancy or the family; anything, some of them (disgruntlements) we cannot contain (Data: 980 (A3TS/H)).

Ancestral spirits as medium to the husband

- For them (*sangomas*) to inform the ancestors, they will be telling the ancestors of the husband, because they would not be able to tell the husband directly that 'your wife here is failing to give birth because she committed adultery with so and so' (Data: 1120). They (*sangomas*) will tell the husband's ancestors that 'yes, there is this woman, she committed adultery, and the baby does not belong to you' (Data: 1112.2). They will be hiding from the ancestors that "No, to the Ncube and the Moyo clans (not real surnames) we are informing you that your daughter-in-law committed adultery somewhere with someone from such and such a clan, please be free and allow the separation (delivery of the baby) of two bodies (mother and baby)" (Data: 1120.1.1) (C3S/TH).

Evidence given by the informants reveals different ways of training and operations of *sangomas*. Truter (2007:57) categorises African traditional healers in three different components; each with a different kind of training:

- *Diviners*

These operate within traditional, religious, supernatural contexts understood by the specific community. They become diviners through ancestral calling and not by choice. For one to become a qualified diviner, one has to go through a period of six to ten years of apprenticeship. The diviners are the ones who get possessed by a spirit; referred as a spirit medium, through which they can communicate on behalf of clients.

Nyika (2006:26) explains the phenomenon of being possessed by saying that traditional medicine is based on both spiritual and physical components of personhood with the spiritual aspect being the basis of the supernatural dimension of the traditional medicine. In view of Nyika's (2006:28) explanation of being spiritually possessed it becomes difficult for people to understand what goes on in traditional medicine.

- *Inyanga* (traditional doctor or herbalist)

These have a wealth of knowledge of curative herbs and medicinal mixtures of animal origins. This group chooses to become traditional healers and have no calling and no divine powers and their training is by apprenticeship for a couple of years.

Data display 54 contains evidence of the use of traditional medicinal mixtures of animal origins; for example, the donkey's placenta, elephant's placenta and the hare's nest.

- *Umporofiti* or *Umthandazi* (faith healer)

This type of traditional healer is a professed Christian who is prayed for and goes through purification rites. Faith healers heal mostly through prayer, laying hands on

clients or using what is believed to be holy water and/or ash. They profess that their healing power comes from God and can have a trance-contact with *umoya* (a spirit) characterised by vigorous physical body movements. There is no training that Faith healers undergo after being prayed for and going through purification rites, they only have to work in close contact with a healer.

The scenario discussed in the preceding paragraph is typical of most African countries; Zimbabwe included. Faith healers “place high priority on the power of the ‘word’”. The belief is that use of the word in the healing process is an appeal to summon the supernatural being to the aid of the patient and that supernatural force is believed to be “God” or the traditional magical powers believed to be in control of human existence. Faith healers sometimes use a combination of both the Holy Spirit and ancestral spirits; the whole practice is so complex and not easy for the ordinary human being to comprehend. It would appear that in the whole of Africa, traditional healers use curative herbs, animal medicinal mixtures in combination with utterances to the spirits or ancestors for "word" efficacy to effect healing and cures (Ganyi & Ogar 2012:31).

A study done by Mathole et al (2005:943) in Zimbabwe also describes similar categories of African traditional healers with almost the same kind of training with a slight variation in that each category of healers includes TBAs.

All three groups of African traditional healers described in the preceding paragraphs have one objective, namely that of healing; it is just the training and the way in which each one operates that differ. The researcher did not have the opportunity of interviewing *umporofiti* (faith healer) when conducting the study. It is therefore not clear to the researcher how *umporofiti* (faith healers) could manage to work with both the Holy Spirit and with the ancestral spirits at the same time.

Giving evidence on healing through the spirit mediums, informants testified being possessed by the spirit mediums which they said was what gave them individual magical powers to be able to see what problems a client could be having and the type of herbs they could use to solve the problem (Data: 1056) (B3S/TH). Informants also indicated some remote communication with the spirit mediums through dreams,

visions or through the water giving guidance on how to assist a client. The informants were not willing to give details of what form the communication took, but the researcher understood them to be magical (Data: 966) (A3S/TH) (Truter 2007:59).

Evidence given indicate that *sangomas* communicate with spirit mediums of the birthing woman and those of the spouse to resolve grudges, disgruntlements or request for permission for the birthing woman to be protected or guided should there be a need for her to go to hospital (Data: 980.1) (A3S/TH). Informants also pointed out that they had the power to rebuke the ancestors to which the foetus belongs in order to beckon them to come to their people's rescue, guide and protect them (Data: 984.2) (A3S/TH). It also came to light that *sangomas* persuaded and begged the spirits to release the woman and allow her to give birth naturally (Data: 982) (A3S/TH).

It appears that the communication that is supposed to go on between the spirit mediums and the ancestors is magical; as such even the clients and their spouses would not be privy to what would be going on at that level of spiritual consultation (Ganyi & Ogar 2012:31; Nyika 2006:26).

4.5.1.2 Category 1.2: Role assumption

By virtue of being in a powerful, respectful position and because of the therapeutic powers that the *sangomas* have, they find themselves assuming other roles besides that of healing. Counselling is part of the healing activity which the *sangomas* perform. Other roles include the advisory and protective roles (Mathole et al 2005:945). Data display 42 contains evidence in this regard.

DATA DISPLAY 42**THEME 1: Being a traditional healer****CATEGORY 1.2: Role assumption**

Role of counsellor

- We as elders then counsel the woman once they are pregnant 'do not do that', do this'. The other thing about our children is that now they do not listen to us (Data: 1074.1) (B3S/TH).

Role of advisor

- So when one has a pregnant daughter, one needs to keep a close eye and tell her all the 'dos and don'ts' because at delivery the foetus will also imitate what the mother was doing when they were pregnant (Data: 1078.2) (B3S/TH).

Protective role

- It (telling the husband that the wife committed adultery) would be too difficult a task for them (sangomas-traditional healers) to undertake because they do not want the woman to be sent back to her home for having committed adultery. They sangomas try and protect the woman's marriage (Data: 1120.1). They (sangomas-traditional healers) will be hiding from the ancestors that 'No, to the Ncube and the Moyo clans (not real surnames) we are informing you that your daughter-in-law committed adultery somewhere with someone from such and such a clan; please, be free and allow the separation (delivery of the baby) of two bodies (mother and baby)' (Data: 1120.1.1) (C3S/TH).
-

In this section, informants gave evidence that pertain to other forms of cultural and therapeutic interventions that complement traditional healing. Counselling, although more inclined to being restrictive, particularly on cultural issues relating to pregnancy and birthing, is one of the roles that *sangomas* perform (Data: 1074.1) (B3S/TH). The advisory and protective roles that informants said they perform are equally important to society (Data: 1078.2) (B3S/TH); (Data: 1120.1) (C3S/TH). What seems to emerge is that sangomas provide an important holistic service to society (Mathole et al 2005:945).

4.5.2 THEME 2: On unnatural birthing

In the Zimbabwean Ndebele culture, unnatural birth is linked to the supernatural power of witchcraft. Infidelity is also viewed as a reason for CS (Mathole et al 2005:952; Aziken et al (2007:46). Data display 43 gives an overview in this regard.

DATA DISPLAY 43
THEME 2: On unnatural birthing
Overview

Tying
Alternative view to tying
Acceptability of CS
Outcomes of CS

4.5.2.1 Category 2.1: “Tying”

The concept of “tying” appears repeatedly in the data in relation to women being unable to give birth naturally. With the influence that *sangomas* have over the general public, and the weight that their views bear on societal issues, “tying” is discussed in detail at this point with a view to understand the part played by *sangomas* with reference to “tying”. Tying is also the “glasses” through which the traditional healers view unnatural birthing, especially obstructed labour. In midwifery, obstructed labour that results in CS, relate to causes such as cephalo-pelvic disproportion, prolonged labour and maternal distress on the mother’s side while cord prolapse, foetal distress and macrosomia are foetal reasons for CS (Sellers 2009:1569-1570; Frazer et al 2010: 614).

Data display 44 gives evidence on “tying” (use of magic/herbs to cause labour complications)

DATA DISPLAY 44
THEME 2: On unnatural birthing
CATEGORY 2.1 “Tying”

Process of “tying” (use of herbs/magic to cause labour complications)

- What people do when they ‘tie’ (use of herbs and/or magic to cause labour complications) the woman is to collect the soil where there is the woman’s foot print or the soil where the woman would have urinated. They (people) then go and mix that soil with herbs that they use for ‘tying’ so that it becomes impossible for the baby to be born until the woman is taken to hospital ... and operated upon, because the foetus would now be having no power to come down and be able to go directly to the outlet and be delivered naturally (Data: 1090). It (‘tying’) is evil because now we people are wicked, fixing one another. Yes, maybe there would be enmity between the one giving birth and the traditional healer who is the person with the knowledge of herbs (Data: 1106). They would do the ‘tying’ (use of herbs and/or magic to cause labour complications) of the woman so that they could be paid for undoing the tying (Data: 1096). No, tying (use of herbs and/or magic to cause labour complications) someone was not a crime, they (someone who would have done the ‘tying’) have not committed a
-

crime because they would be trying to earn a living (Data: 1100) (C3S/TH).

Process of “untying”

- What other people do is that if they know the person who would have ‘tied’ (use of herbs and/or magic to cause labour complications) the woman, the people go and collect the one who would have ‘tied’ (use of herbs/magic to cause labour complications) the woman and when the person comes, the woman delivers just as they (the one who would have ‘tied’ the woman) arrive because they would have already mixed some herbs to undo the ‘tying’ before they come. The person just comes and asks as they arrive ‘what is the problem?’ stamping their foot down and the baby is suddenly delivered (Data: 1092.1). The woman would have been ‘tied’ (use of herbs and/or magic to cause labour complications) that is why they should be given the herbs to drink to reverse the effect and make it possible for them to give birth naturally (Data: 1084.1). If I am the one who had done the ‘tying’ (use of herbs and/or magic to cause labour complications) to fix the woman, when I am approached I will be embarrassed and give you the herbs to go and give the woman to drink so she can deliver. I know that she will pay me with whatever she has. I will not leave one to suffer and say ‘no that one leave her like that it is her fault’ (Data: 1162.2) (C3S/TH).
- To undo the ‘tying’ (use of herbs and/or magic to cause labour complications), we (sangomas-traditional healers) then tell the woman to collect some soil from the foot print of the person who has made them angry. When we come we ask for the soil from the foot print and we then take some herbs and mix with the soil, and then take the water from that mixture and give the woman to drink. The woman will give birth and that is the end of it, it will never happen again (Data: 1066.2) (B3S/TH).
- With that *ibaso* (some herb that a person burns and says their wish), one can also burn it and talk and say that she must deliver even if she is ‘tied’ ‘whatever has been done to her (woman), she must deliver’(Data: 986.1) (A3S/TH).

Giving evidence on the process of “tying” (use of herbs and/or magic to cause labour complications) informants described what seemed magical (Data: 1090) (C3S/TH). The process of ‘tying’ as described by the informants sounded mythical “... which tends to make it a taboo to question or attempt to fathom the intricacies of TM” (Nyika 2007:26).

The process of “untying” was also discussed by the informants (Data: 1100.1) (C3S/TH). Evidence revealed that there is the “tying”, and also the “untying” processes. Informants described three possible methods of untying. It emerged from the study that it is possible to have the untying done before labour actually commences (Data: 1066.2) (B3S/TH). It is reportedly also possible for the woman to have the process of untying effected through the use of herbs (Data: 986.1)

(A3S/TH); (Data: 1084.1) (C3S/TH). The informants revealed that besides tying women to “fix” them or merely for being evil, *sangomas* or whoever would have done the tying would do it as a lucrative business. This is the case as they would be paid for the “untying” since the same people who do the tying have the power to do the “untying: (Data: 1096) (C3S/TH); (Data: 1100) (C3S/TH); (Data:1162.2) (C3S/TH); (Data: 1092.1) (C3S/TH).

The researcher found the “tying” and “untying” of pregnant women a very curious issue to understand. It is similar to what was discussed earlier on CS rates increasing as doctors perform CS for personal reasons of lucrative business and for gaining clinical experience at the expense of the client; the woman who will later suffer emotional, psychological, physical and socio-cultural ill effects as a result of CS(Data: 1066.2) (B3S/TH) (Black et al 2001 cited in Pairman et al 2006:788; Reid 2007: 33).

4.5.2.2 Category 2.2: Alternative views to tying

The traditional healers showed a certain degree of anatomical and midwifery knowledge and understanding of birthing complications mixed with traditional perspectives. In addition to “tying” as a major reason for women being unable to give birth naturally, the Zimbabwean Ndebele society also understands issues that may complicate labour, such as the presentation of the foetus. However, popular cultural beliefs also permeate some of these understandings. Data display 45 contains evidence in this regard.

DATA DISPLAY 45
THEME 2: On unnatural birthing
CATEGORY 2.2 Alternative views to “tying”

Obstruction (Caesarean section)

- At times it could just be that she has never given birth before and thus would have a CS. because the outlet would not yet be well developed (Data: 1140.2). At times someone may even labour for two days and the foetus ends up dying inside the mother’s womb (Data: 1108).Someone could deliver naturally, the first two children and then be fixed (by ‘tying’ - use of herbs and/or magic to cause labour complications) by someone with the third or fourth baby and fail to give birth until a CS is done (Data: 1140.3) (C3S/TH).
 - ... when a woman has to have an operation, it must be clear that everything else has been tried, but when it (CS) can be prevented it must be prevented (Data: 970.1) (A3S/TH),
-

Malpresentation: breech

- ... at times baby may present as a breech (Data: 1018). If baby presents as a breech, Is it not that there are some babies who are born feet first? (Data: 1026). Yes. The baby would be presenting feet first and we instruct the TBAs to guide the baby, guide and guide and bring the baby down with those feet. Baby comes down well, with the feet until the head comes and tears the mother on the pelvic floor (Data: 1030) (B3S/TH).
- we also do not encourage breech delivery; this is why they (TBAs) use the hand to turn the foetus inside the womb because if it is a breech presentation ... foetus is supposed to present with the head first, but then it presents with the feet first (Data: 990.1). When it is a breech presentation one hears them (pregnant women) saying “my hip has dislocated, my hip this, my hip that, my hip ...” (Data: 992) (A3S/TH).
- That (foetus presenting as a breech) may pose a problem to the mother who may be injured on the outlet (Data: 990.2) (A3S/TH).

Malpresentation: transverse lie

- The baby will not be having a way neither this side nor this side and the feet will be this side (indicating across the abdomen), baby will be in the transverse position (Data: 1022) (B3S/TH).
- When it is a transverse lie there is no dislocation. In some pregnancies one may see them (women) spotting some blood vaginally. That (spotting blood) alone shows that there is something forcing its way out, because the baby would be squatting like this (demonstrated) (Data: 992.1) (A3S/TH).

Although some of the evidence given by the informants appears to be scientific reasons for CS, it seems as though they would be more coincidental and more inclined to be cultural reasons suggesting some guess work (Data: 992) (A3S/TH); 992.1) (A3S/TH). Cultural reasons for CS have also been given as “fixing” (“tying” by another person with the intent of causing suffering) (Data: 1140) (C3S/TH). Foetal malpresentation, such as breech presentations, transverse lie as well as other eventualities that may occur when a woman is giving birth for the first time as well as labour that takes too long were also given as reasons for CS (Data: 1018) (B3S/TH); (Data: 1022) (B3S/TH); (Data: 1108) (C3S/TH). The preceding reasons given by the informants are congruent with scientific ones. See section. 4.5.2.1. However, informants were not comfortable with breech deliveries as they indicated that these presentations sometimes causes problems (Data: 990.2) (A3S/TH). The information on breech delivery causing problems is in line with the medical situation where the mother may sustain pelvic floor trauma and the baby sustain superficial tissue damage on the part that would be presenting due to repeated vaginal examinations in an effort to confirm the presenting part. The baby can also have

fractures of the humerus, clavicle or femur or Erb's palsy when the brachial plexus is damaged and intracranial damage from rapid delivery of the head (Sellers 2009:1454; Fraser et al 2010:595-596). It appeared that most informants were more concerned about the mother than about the infant concerning the outcomes of birthing. What seems to be of importance to the informants in as far as the baby is concerned is whether the baby belongs to the clan or not; hence the fuss about infidelity (Awoyinka 2006:209).

4.5.2.3 Category 2.3: Acceptability of CS

In this category informants gave evidence of their views on the acceptability of CS. The informants freely expressed their perceptions on issues surrounding alternative modes of childbirth. Data display 46 exhibits informants' views in this regard.

DATA DISPLAY 46

THEME 2: On unnatural birthing

CATEGORY 2.3: Acceptability of CS

None acceptability

- we also do not encourage breech delivery; this is why they (TBAs) use the hand to turn the foetus inside the womb because if it is a breech presentation... foetus is supposed to present with the head first, but then it presents with the feet first (Data: 990.1) (A3S/TH).
- Culturally, it (CS) is not acceptable... (Data: 1044). No, we do not want it (Data: 1072) (B3S/TH).
- There is no such a thing as CS culturally... (Data: 1092). ...as for me, I just do not want it (CS) (Data: 1142) (C3S/TH).

Conditional acceptability of CS

- We (society) do not encourage the operation such that when we see someone going for an operation, let us agree that; 'no, we tried everything, every corner and failed; we the spirits, we tried those herbs that we burn, we tried all other' (Data: 984). We (sangomas-traditional healers) then finally get to a consensus to say 'no she (woman) can be free to go to hospital and have whatever she wants done to herself' (Data: 984.1) (A3S/TH).
- When things really get very complicated it is also advisable to seek medical advice... (Data: 1162.1) (C3S/TH).

Understanding reasons for inability to give birth naturally

- I would say that (not being able to give birth naturally) is how she was made naturally (Data: 1050). These bones (indicating the hips) would be fused together under the joint; the outlet would be small (Data: 1052) (B3S/TH).

Acceptability of health care services

- Women go to deliver in hospital because people now do not like using herbs that much. People now like modern things from Europeans (Data: 1148) C3S/TH).
-

Evidence given by informants in Data display 46 suggests some irregularity on the acceptance and non-acceptance of alternative modes of birthing; CS in particular. At one point, informants firmly rejected CS (Data: 1072) (B3S/TH); (Data: 1142) (C3S/TH); (Data: 1146) (C3S/TH), but it appears that in some situations informants communicated with the spirit mediums so that they reached a compromise and conditionally accepted CS while informants condoned the acceptance of CS or cleared their consciences by saying that they did all they could culturally do to prevent CS (Data; 984) (A3S/TH). The conditional acceptance of CS and other alternative modes of birthing, as well as the utilisation of health care services, appeared to be a realisation and understanding of the need, and scientific reasons, for alternative modes of birthing (Data: 1050) (B3S/TH). However, some of the cultural reasons given for CS by the informants were the same as the scientific ones (Data: 1052) (B3S/TH). These included malpresentation such as transverse lie, breech, prolonged labour and a small pelvis (Data: 1018; 1022 & 1108) (Sellers 2009:1569-1570; Frazer et al 2010:614) see section 4.5.2.2.

4.5.2.4 Category 2.4: Outcomes of CS

The *sangomas* expressed their perceptions on how the women are affected by CS. Data display 47 contains evidence in this regard.

DATA DISPLAY 47

THEME 2: On unnatural birthing CATEGORY 2.4: Outcomes of CS

Physical effects

- We as sangomas have realised that following an operation a lot of women have complications. One may have certain complications that may lead to permanent disability this is why we try and prevent the operation (Data: 962). It does not become healthy when a person has a scar which they did not have since birth...when the ground is wet they (women) complain that they feel that the inside is open (Data: 962.1) (A3S/TH).
 - All the same this person would have been damaged because now they will have a scar after CS (Data; 1132.1). ...one really suffers a lot of pain from it (CS) and it makes the body weak because they (woman who had CS) are always ill (Data: 1142.1). When it is cold, the woman complains of pain on the operation site and if they stay in the rural areas they cannot even carry a bucket of water on their head because a person gets strength from their stomach (Data: 1142.2). I mean household work or work where the woman has to pull something or cultivating like this (demonstrated cultivating) lifting the hands up and down; that she cannot do. The woman is unable to work properly, because they now have a scar (Data: 1144 (C3S/TH)).
-

Womanhood

- No, it (CS) means that the woman is not a complete woman. Her outlet would be closed, because sometimes, with these hips of ours one could have small bones (Data: 1040) (B3S/TH).
- She (woman) is no longer a complete woman because it is possible for the woman to pick another pregnancy, she will then have another CS, and it means that she will always be operated each time she is giving birth (Data: 1134.1) (C3S/TH).

Motherhood

- The woman is just as respectable as any other woman, we the elderly, can see that this woman did not deliver normally as expected culturally, but gave birth by CS, as such she is a mother (Data: 1074) (B3S/TH).

Naming the child

- Yes, it (*Fulatha*) becomes a name; *Fulatha* means one who was born feet first (Data: 996). Others are born like that; they become the *Fulathas*; (babies born feet first) (Data: 994) (A3S/TH).
 - Someone in that family would have been born presenting as a breech. what we call '*Fulathelwa*' in isiNdebele (Data: 1028) (B3S/TH).
-

Evidence given by the informants revealed concerns about physical health, permanent disabilities and sustained ill health of the women after CS (Data: 962) (A3S/TH); (Data: 962.1) (A3S/TH). The concern was about the woman having a scar that would be failing to heal and thus affecting the woman's performance of household chores as well as sexual relations with her husband. The stigma attached to being sick all the time was also raised by the informants as a concern (Data: 1132.1) (C3S/TH). All these concerns could incapacitate the woman physically, psychologically and emotionally. It appears that the belief was that the woman became an invalid who could not even help herself in any way, and could not perform any household chores following CS.(Data: 1144) (C3S/TH). The above mentioned sentiments were also shared by the spouses who expressed that it was for the same reasons that they as spouses had to take over their wives' duties; a situation they found to be compromising to their manhood (see data: display 32).

Informants' information suggested that the Zimbabwean Ndebele society does not accept alternative modes of childbirth. However, it acknowledges motherhood despite the an unnatural birthing process. While the Zimbabwean Ndebele society stigmatise women unable to give birth naturally, as long as a woman has a child, this woman makes gains on motherhood status despite the loss of womanhood status (Data: 1074) (B3S/TH). This being the case then, the question arises as to

why the fuss about natural birthing if motherhood is given the same respect whether or not the woman gives birth naturally.

Culturally, the question to be asked is: “what question should the name given to a baby answer?” The name given to a baby should answer the question; “what’s in a name?” because in the Zimbabwean Ndebele culture it appears that names are given according to what is happening during the birthing process, how the baby was born or the appearance of the baby and even what was happening to the family or socially. Evidence contained in Data display 47 confirms this premise. Child naming is also a ritual in which important people in the family, including the grandmother and the father take charge. Evidence given by the informants also shows that naming of a child is indeed influenced by the way in which the baby was born (Data: 994) (A3S/TH). Another observation was that name giving could be from precedence or according to family history (Data: 1028) (B3S/TH).

4.5.3 THEME 3: Traditional practices

There is a plethora of concepts that revolve around tradition and culture as well as religion during child birth. It should be noted that traditional medicine has remained the first port of call and seems to be the major solution of most socio-cultural issues of individual families and communities in most developing countries and indeed in the Zimbabwean Ndebele nation as is the case in most African societies based on culture and tradition. During the birthing process complications may sometimes arise and the belief is that the complications can only be solved through the administration of traditional herbal medicines to precipitate labour in an attempt to prevent unnatural birthing. Sometimes certain rituals are performed to facilitate natural birthing; for example the process of “untying” (Mathole et al 2005:943; Nyika 2006:26).

Traditional practices of birthing comprise several sub-categories. Data display 48 gives an overview and summary of the main categories on traditional practices.

DATA DISPLAY 48
THEME 3: Traditional practices
Overview

Initial preparation for normal delivery
Child birthing process
Culture value
Rituals
Traditional herbal medicine
Traditional non-herbal medicine
Technical manoeuvres by TBA's
Payment for services rendered

4.5.3.1 Category 3.1: Initial preparation for normal delivery

In the Zimbabwean Ndebele culture, preparation for normal birthing is in the form of herbal medicine that the pregnant woman is given to protect her from witchcraft and to stabilise the pregnancy and prevent miscarriage. Some herbs are used to ease birthing. The preparation for normal birthing is also an attempt to build a strong fort for the woman to protect her against “tying” particularly during pregnancy when she is more vulnerable. The practice can be equated to what is done in ANC by the midwives and obstetricians when the woman is given care to screen for potential risks during pregnancy and labour and by starting treatment early (Mathole et al 2005:946; Mathole 2005:23; Sellers 2009:166) see section 1.2.3.22 on GOANC.

Sub-category 1 (Data display 49) contains evidence on the initial preparation for normal delivery.

DATA DISPLAY 49
THEME 3 Traditional practices
Category 3. 1: Initial preparation for normal delivery

- A long time ago when a person fell pregnant, they would be given herbs to drink. They would start when the pregnancy is two months old ...so that the pregnancy anchors properly without giving the woman problems (Data: 1148.1). They (TBAs) will be talking to her (woman) there in the hut and asking her, ‘tell us if you committed adultery and tell us who you did it (adultery) with so that you can deliver normally’ (Data: 1114.1) (C3S/TH).
 - By so doing (giving the woman herbs to drink) we (sangomas-traditional healers) will be preparing for the foetus to have space, because there are times where it (foetus) fails to have a proper place in the womb ...we could give her (woman) that (mixture) which helps hasten the process (Data: 958.2) (A3S/TH)
-

According to evidence given by the informants, it is apparent that traditional practices are engrained in culture. However, most of the traditional practices are never explained but perpetuated through generations with neither rationale nor logic as in the case of the administration of herbal medicine. Once a woman conceives, she is given herbal medicine in preparation for embryonic embedment in the uterus (Data: 958) (A3S/TH). During the physiological changes, embryonic embedment in the uterus takes place following conception. However, nidation, which is embedding of the fertilised ovum in the endometrium of the uterus, is a natural process which does not need enhancement as purported by the informants (Mathole 2005:946; Tiran & Sullivan; 2008:163).

The informants also raised the issue of questioning of the woman by the TBAs about adultery. Adultery, also referred to as infidelity, is defined as “participation in sexual intercourse with a person other than one’s partner” (Piercy, Hertlein & Wetchler 2005:6).

According to what the informants related, the rationale for raising the issue of adultery at this initial stage is that, should there be a possibility of infidelity it could be attended to through some herbal treatment or specific rituals prior to commencement of labour since infidelity is believed to cause ‘tying’. This is the case because ‘tying’ is regarded as a sign of ancestral refusal to have a child whose paternity is questionable born into the clan. Obstructed labour is therefore accepted as ancestral punishment for marital infidelity (Bullock 1913:11; Awoyinka et al 2006:209) (see sections 2.9 and 2.8.1.2).

The reader should note that in the Zimbabwean culture and indeed in other African tribes, young girls are initiated into womanhood through puberty rites of passage by performing prescribed ceremonies. Virginity is also highly valued by the Zimbabwean Ndebele society to the extent that breaking it would be a shame to the family particularly to the people handing over the girl to her husband when she gets married. The aunties escorting the girl to her marital home should apologise to the man’s family by giving them a new blanket with a hole to symbolise her loss of

virginity. The girl's family should then pay some retribution, usually in the form of cattle, for the girl to be accepted as she is by the husband's family.

4.5.3.2 Category 3.2: Birthing process

During the birthing process *sangomas* are able to monitor and assess labour of clients referred to them by TBAs for complicated labour. *Sangomas* use traditional and magico-religious methods which include consultation with the spirit mediums even if the client is not present (Nyika 2007:26). Data display 50 contains evidence on *sangomas'* involvement in the birthing process as corroborated by Truter (2007:58).

DATA DISPLAY 50

THEME 3 Traditional practices

CATEGORY 3.2 Child birthing process

General indicator for labour progress

- ... when the waters break; it means that the baby is coming the right way (Data: 1032.1) (B3S/TH).

Assessment of labour

- When we (*sangomas*-traditional healers) attend to a complicated delivery, what we do is that we check through spirit mediums to see if the woman has been 'tied' (use of herbs and/magic to cause labour complications) (Data: 1004). We do not rush for the operation; we do not rush to take her to the doctors, we first of all wait to see if the baby can be delivered naturally (Data: 1012.4) (B3S/TH).

Monitoring labour progress

- Yes, we give the woman the medical mixture of the hare's nest, and then count the minutes within which baby would be born to monitor the duration and assess labour progress (Data: 1012). We then wait to see; if the contractions become stronger and stronger we just wait and monitor labour and then see how the baby will come out (Data: 1012.2). Then we (*sangomas*-traditional healers) see that the woman is about to give birth because the foetus descends down and comes here (indicating above the symphysis pubis) and tears the membranes (Data: 1012.2.1) (B3S/TH).

Management of the 3rd stage of labour

- If the membranes are retained, we take a wooden spoon and place it here (demonstrating placing wooden spoon at back of mouth) (Data: 1012.5). We (prick the mother's epiglottis with it, when she (woman) vomits, the membranes get expelled (Data: 1014). If that (pricking the mother's epiglottis) fails we ask her to blow into a bottle since the baby would have been born; so that when the woman tries to blow, she blows into the bottle then the membranes drop out (Data: 1014.1) B3S/TH).
-

Evidence given by the informants reveals that over and above the mystical procedures of consulting with the spirit mediums on labour progress, the traditional process of monitoring the labour progress is congruent with the scientific one where labour is augmented with uterotonic drugs if there is slow progress (Data: 1012) (B3S/TH). Evidence given shows some similarities between the traditional ways and the scientific procedures in as far as assessment and monitoring of labour are concerned and where a vaginal examination is done to assess cervical dilatation and foetal head descent.

In the practice of midwifery, the active management of the third stage of labour is very important for the prevention of post-partum haemorrhage which is one of the major causes of maternal mortality and posing a major hurdle in achieving the MDG 5 (NHS for Zimbabwean 1997-2007: xi; Fraser et al 2010:528, 1013).

Although there is no evidence given by the informants about the active management of the third stage of labour, data display 48 indicates various traditional attempts to achieve the expulsion of the placenta and any possible retained products of conception (Data: 1012.5) (B3S/TH); (Data:1014.1) (B3S/TH).

4.5.3.3 Category 3.3: Culture value

Culture refers to the perspectives, practices and products of a social group comprising the repertoire of learned ideas, values, knowledge, aesthetic preferences, rules and customs, ceremonies and ways of life characteristic of a given group. Culture is perpetuated from generation to generation as it is a powerful component of society which holds inherent values (Cohen & Kennedy 2007:47; Truter 2007:57; Taylor 1871 cited in Fraser, Cooper & Nolte 2010:16). Data display 51 discusses the issue of culture value in detail.

Data display 51 discusses the issue of culture value in detail.

DATA DISPLAY 51
THEME 3 Traditional practices
CATEGORY 3.3 Culture value

- I very much like the fact that women should deliver naturally like it used to happen in yester years, because that is the rule that there is a way of giving birth that has always been there (Data: 1080) (B3S/TH)
 - What I would like to say is that when you (interviewer) go back to your colleagues; please tell them that people should learn to trust their own culture and try and stick to their culture (Data: 1162). ...but people must have respect for their culture. Let us hold on to our culture it really works (Data: 1162.1) (C3S/TH).
-

Evidence, given by the informants in data display 51, seems to suggest that society uses culture as a guide indicating how things should be done to maintain cultural values. (Data: 1080) (B3S/TH); 1162.1). The informants would appreciate collaboration of health care workers with *sangomas* in caring for women during pregnancy and the birthing period in order to perpetuate the culture which the informants valued. Such a move would be in accordance with the WHO stance which formally recognised the importance of collaborating with *sangomas*. This was formally realised where countries like South Africa, drafted the “Traditional Health Practitioners Act”, Act 35 of 2004 that came into operation on 13 January 2006. Zimbabwe also officially recognised *sangomas* through the Zimbabwe Traditional Healers Association (ZINATHA) in response to a study by Chavunduka in 1994 (Mukumbura cited in Mathole et al 2005:938; Truter 2007:58, 60).

Although some recognition exists of the importance of the services rendered by *sangomas*, there has not been any collaboration as would have been expected after the recognition of these services and formulation of the ZINATHA. It is therefore necessary to advocate for an approach that will incorporate local indigenous knowledge to which the community will contribute to as suggested by Mathole et al (2005:953). In spite of the efforts that have been made to regularise the practice of traditional medicine by *sangomas*, a lot still needs to be done in terms of incorporating traditional medicine into the already existing primary health care systems, sensitising health care providers, policy makers, and the communities at large so that they can critically examine and address major ethical and regulatory

issues surrounding African traditional medicine which are often ignored in spite of their potential to compromise the welfare of the patients (Nyika 2006:27).

However, there is a major debate in as far as regulating of traditional medicine is concerned. Critics of comparing Western medicine with African traditional medicine postulate that there is no need for an invasion of traditional medicine to Western medicine as they believe that African traditional medicine is quite compatible with Western scientific medicine (Tangwa 2007:41). Tangwa argues that it is not ethically right to use “evaluation and terminology appropriate in one domain, namely, modern (Western) scientific medicine to apply in another domain, namely, traditional (African) medicine without considering whether this is possible or necessary” (Tangwa 2007:42). There are nationally and internationally recognised traditional medical practitioners’ associations which condemn malpractices and abuses of the profession by bogus healers. Thus African traditional medicine cannot be evaluated using regulations and guidelines emanating from “The Nuremberg Code because it was not part of the medical atrocities that resulted in the “Nuremberg Trials and the Nuremberg Code”. Tangwa’s argument is that traditional medicine is not historically connected with the Nuremberg Code experimentations on humans as it has no connection or meaning to traditional medicine. Nyika (2006:27), a proponent of application of ethical and regulatory guidelines, maintains that in traditional medical practice, it is the aspect of combining herbalism with supernatural processes, the magical branch characterised by sacredness and ritualism, which is beyond the comprehension of humans. This complicates the application of ethical and regulatory guidelines (Tangwa 2007:42; Nyika 2006:27) to traditional medicine.

The other argument raised by Tangwa (2007:42) is that since 80% of Africans’ health problems are attended to by use of African traditional medicine which has been practiced for centuries before the advent of the scientific medicine and believes that there really is no need for it being referred to as unconventional and unorthodox and mainstreamed into the scientific primary healthcare system which only caters for 20% of the population. (Tangwa 2007:43-44)

4.5.3.4 Category 3.4: Rituals

Van Gennep (1960 cited in Square 2009:220) states that rituals connect the changes in the individual human life cycle with change in the social hierarchy. As such, it has been seen to unite the physical and the social aspects of an individual's life. The author further explains that rites of passage have three stages that are culturally standard when passing from one developmental stage to another: rituals of separation, transition and incorporation. In many African societies, rituals play an important role as they aim to restore balance and harmony in terms of beliefs and values of that specific culture. The belief is that if the ancestors withdraw their protection and gift of fortune, the descendant is exposed to vulnerability to all sorts of diseases and illnesses. In essence, performing rituals is believed to reduce anxiety and serve to relieve guilt and often produces a calming effect (Nyika 2007:27; Truter 2007:59).

Data display 52 discusses the different rituals performed in the Zimbabwean Ndebele society to mystically clear unacceptable issues surrounding the birth of a child or accepting the baby into the family.

DATA DISPLAY 52
THEME 3 Traditional practices
CATEGORY 3.4 Rituals

General indicator

- It (ritual) also goes according to people's tribes; this tribe does this, that tribe does that (Data: 1156.2) (C3S/TH).

The issues of infidelity

- Yes, with that confession of the woman's **infidelity**, it will then be decided what ritual to perform to address that situation (Data: 1112.1) (C3S/TH).

Home coming rituals

- I will distance myself so that I am not anyway near because my shadow should not be around the baby because if my shadow is around, the baby will have a sunken fontanel (Data: 1154.1). We perform the rituals when the woman comes back home from the hospital (Data: 1152). When my wife gives birth at the hospital, when she comes back home, I do not go inside the house before we perform the *bhathi umfula* (reunion ritual). There is a herb that we have to leak with my wife before we enter the house (Data: 1154). The woman will take the plate, from which I usually have meals and place it upside down on the threshold; the wife then goes inside the house with the baby, and then come out holding the baby and then we leak the herbs which would have been place on the plate that is upside down on the
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threshold. The wife also leaks the herbs, after which she hands over the baby to me. I then go inside the house and the mother goes out and then comes into the house after me. 'We are now re-united. But if I am not the father to the baby that baby will have a sunken fontanel and then I will just tell the mother that the baby is not mine (Data: 1154.2). We do the rituals with the mother, once she has leaked the herbs, she would be done. With me, that ritual of leaking herbs is to introduce me to the baby as the father and for the scent that I have naturally (Data: 1156). After leaking the herb, the mother will breast feed the baby and the herbs are now in the mother's blood and also in my blood; so when I hold the baby, baby does not cry. If someone who is not the father holds the baby, baby cries (Data: 1156.1) (C3S/TH).

Cord stump rituals

- It (cord stump) should never be allowed to fall off and rest on the baby while baby is sleeping and as such people should have a way of placing the baby in such a way that the cord does not rest on the baby when the cord stump falls off. This is why you hear that, Mrs so and so is no longer able to bear children anymore (Data: 1156.3). Some throw it (cord stump) under the maize barn. Other people throw away the cord stump by way of leaving it where two roads cross, some will throw it in the river for the fish to eat, others will throw the cord stump on top of a tree and do not mind where it lands and It (cord stump) then gets eaten by insects; it goes according to tribe (Data: 1158.1) (C3S/TH)..

It appears that in the Zimbabwean Ndebele culture there is a range of rituals that are performed following the birth of a child. These rituals pertain to rectifying issues of infidelity (Data: 1112.1) (C3S/TH), welcoming the baby into the family as well as testing for fraternity (Data: 1154.2) (C3STH). There are a number of rituals that are performed on the cord stump, from the way it falls off to the way it is disposed of (Data: 1156) (C3S/TH); (Data: 1158.1) (C3S/TH). Rituals are part of the African culture and not only in the Zimbabwean Ndebele society. An example of a ritual was described by a researcher from Swaziland presenting a research paper on *Socio-cultural issues in birthing practices* at the 29th International Congress, International Confederation of Midwives in Durban 19th – 23rd June; 2011. The Swati people perform a ritual at birth to change a trend of bearing children of one sex if the woman keeps bearing children of the same gender; female in particular as they do not perpetuate the family name and growth of the clan is not continued. The placenta has to be handled in a different way in order to influence the change of gender with subsequent babies in favour of the male gender. The placenta is turned inside out onto the maternal surface and then a knot is tied on the cord. Mathole et al (2005:948) also describe a similar procedure that is done in the Zimbabwean

Ndebele culture as a way of ensuring that the woman has a baby of a different gender the next time. The placenta has to be buried within the home, the ritual is meant to remind the child always to remember to come back home. The way the cord falls off also connotes some myths and misconceptions in the Zimbabwean Ndebele society. The mythical belief, as expressed by the informants, is that should the cord touch the baby when it falls off, the mother will not bear any further children (Data: 1156.3) (C3S/TH). Some women might opt not to give birth at a health care centre because the placenta is not given to the woman to go and perform these rituals at home. This might explain why some Zimbabwean Ndebele women rather give birth at home (Matua 2004:34; Mathole et al 2005: 948; Ziyane 2011:50).

4.5.3.5 Category 3.5: Traditional herbal medicine

Traditional healing in the Zimbabwean Ndebele context is about using both herbal and traditional medicine. "... herbalism is a branch of TM based on phytochemical components of herbs that have medicinal properties" (Nyika 2007:26). However , WHO defines traditional medicine as "health practices, approaches, knowledge and beliefs incorporating plant, animal and mineral based medicines, spiritual therapies, manual techniques and exercises, applied singularly or in combination to treat, diagnose and prevent illness or maintain well-being" (Nyika 2007:26). What should be of note in the above definitions is that herbal medicine does not have the supernatural component like the traditional medicine which is based on both the spiritual and the physical components of the person.

Although emphasised as natural, the birthing process in the Zimbabwean culture is one aspect of life that seems to be strongly supported by the use of medicines through cultural interventions from the beginning of the pregnancy through to the postnatal period (Mathole et al 2005:946).

Data display 53 contains evidence in this regard.

DATA DISPLAY 53**THEME 3 Traditional practices****CATEGORY 3.5: Traditional herbal medicine**

Rationale for giving herbal medicine

- She (woman) needs to be taken care of and given herbs to drink, because there is need to try whatever is possible to prevent an operative delivery (Data: 992.2). ... what we have is that the woman is given herbs to drink so that they can give birth naturally (Data: 1092). In those herbs we mix *mpofana* (leaves from some medicinal herb)) and in that *mpofana* we add *umchitazulu* (barks of some type of medicinal tree) for the woman to deliver natural (Data: 958.1) (A3S/TH).
- We do have herbs that we traditional healers use as Zimbabwean Ndebele people when a woman is giving birth (Data: 1004.1. ...those bones (hip bones) should be opened using herbs, so that the outlet opens up nicely (Data: 1052.1) (B3S/TH).

Post CS

- Following the operation, we then start giving her herbs again to reduce the swelling inside and to make the incision heal properly... (Data: 962.2) (A3S/TH).

Herbal medicines during birthing

- If we see that there is something creating a barrier – membrane, because there is that membrane that sometimes covers the baby's head, what we do is that we take *Umthunqiselo* (some herb for fumigating) while the mother is in the squatting position (Data: 1012.3). ... if it is not yet time for her (woman) to give birth, then we (*sangomas*-traditional healers) give her the herbs to speed up the delivery (Data: 1016.1) (B3S/TH).
- When there is no progress like that; we have two types of roots that we give to the women. One takes *umchitazulu*, boils it thoroughly, but it must be then cooled. When it is then warm, one then takes a measure of two tablespoons and then gives the woman to swallow everything at once and make sure it goes down to the stomach because when they are in that state they will be hungry then the medicine goes right inside (Data: 962.3). When we now use *igonde* (herbal medicine) we will have seen that the other one, *Umchitazulu* was ineffective and we then keep increasing the measure (Data: 964) (A3S/TH).

Different herbs different uses

- Yes, there are many different herbs and the way we use them is different depending on one's spirit medium. I use '*isikhukhukhu*' (some slippery herb) (Data: 1126). I use '*isikhukhukhu*' and '*inkunzane*' (some slippery herbs). '*Inkunzane*' is not for drinking but for washing the vulva to make it slippery so that the baby slips through and it really works. I give her (woman) '*isikhukhukhu*' to drink. I use the small coca-cola bottle as a measurement. I give the woman '*isikhukhukhu*' to drink and finish it. As she finishes drinking the foetus dislodges and the woman's muscles here (indicating where the baby comes out) loosen and they become soft (Data: 1128.1). The herbs are given at that point when the woman is ready to deliver, but when there is an obvious complication and we (traditional healer) see that she cannot make it, we would then give her the same herbs *isikhukhukhu* to drink (Data: 1130). The other herb that I use is *Impofu enduna* (a type of reddish herb)... which I dig from the ground and I would take the roots to give
-

to the mother to precipitate labour (Data: 1130.1.2) (C3S/TH).

Protection from being “tied”

- Other women may be given the herbs to drink during pregnancy so that even if someone tries to do something evil to them, even when they have collected the soil with the woman’s footprint, the woman can drink the herbs and wash her feet, hands or even her body, the ‘tying’ (use of herbs and/or magic to cause labour complications) will not work because the herbs make her slippery (Data: 1130.1). I also use *inkunzane* to protect the woman from being ‘tied’ (use of herbs and/or magic to cause labour complications) (Data: 1130.1.1) (C3S/TH).

Effects of herbal medicine

- ... then, we (*sangomas*-traditional healers) collect rubbish outside where paths cross and fumigate the woman’s outlet with it. Ah! After fumigation, the membrane covering the head rescinds and the baby comes out (Data: 1012.3.1). The head tears the pelvic floor because it (pelvic floor) is slippery because of the herbs that the mother would have been given (Data: 1030.1) (B3S/TH)
- Then when the woman is given herbs to drink, the foetus turns round and finds its way out (Data: 1086.1). After drinking the herbs, the baby comes down. The foetus then loosens the mother’s flesh and the hips open up and then the woman gives birth (Data: 1088). I give them (TBAs) some herbs to go and give the woman to drink. By the time I get back here, the woman would have given birth (Data: 1160.1) (C3S/TH).

Importance of dosage measures

- What we need to realise is that with some of these traditional medicines we sometimes make blunders because we do not consider measures. Some herbs act very fast and they harass the person who is taking them (Data: 986.2). We (*sangomas*-traditional healers) need to realise that sometimes this (not using measures when taking herbal medicines) is what destroys the person if they are given an overdose (Data: 986.2.2). We therefore need to be cautious about the measures, because these things (herbal medicines) are strong with some that are fast acting and can tear the woman (Data: 986.2.3) (A3S/TH).

Effects of herbal overdose

- If it (taking an overdose of herbal medicine) happens to someone who is in labour, it is very exhausting. She (labouring woman) really gets exhausted and the foetus gets distressed (Data: 988.1) (A3S/TH).

Evidence given by the informants seems to suggest that in the Zimbabwean Ndebele culture, whether there are complications or not, the way to manage pregnancy and the birthing process is by cultural intervention through the administration of herbs at different stages of pregnancy, labour and during the postnatal period. The major reason given for cultural intervention is to enhance natural birthing in order to prevent CS (Data: 958.1) (A3S/TH); (Data: 962.2) (A3S/TH). Some herbal medicines are used as protection against evils such as “tying” the woman (Data: 1130.1) (C3S/TH); (Data: 1130.1.1) (C3S/TH). Among the various uses of different herbs by

traditional healers, acceleration of labour was also mentioned (Data 962.3) (C3S/TH). In data display 53, the concept of acceleration of labour, as discussed by the informants, is similar to the way acceleration of labour is done in bio-medicine where oxytocin is increased according to how labour is progressing (Data: 964) (A3S/TH). Oxytocin is a powerful uterotonic agent synthesised in the hypothalamus. It is released periodically to act on the smooth muscle of the myometrium where there are many of its receptors that are sensitive to uterine oxytocin. Oxytocin infusion is used for augmentation of labour in management of hypotonic uterine dysfunction (Fraser et al 2010:558; Gibert, 2007; Simpson, 2008 cited in Hockenberry & Wilson 2010: 509).

Even when obvious mechanical complications would warrant CS during labour, herbal medicines were reportedly administered. The question arose as to whether the *sangomas* themselves understood the birthing process or merely believed in their magic and depended on their mystical spirit mediums to somehow find a solution (Data: 1012.3) (B3S/TH). In Data display 53, informants boasted about their knowledge of a range of different herbs and mixtures and how they (*sangomas*-traditional healers) used them at different stages of the labour process (Data: 962.2) (AC3S/TH) and after CS to aid the healing of the incision (Data; 1128.1) (C3S/TH); (Data: 1130.1.1) (C3S/TH); (Data; 1130.1.2) (C3S/TH).

Another aspect that emerged from the data was the issue of dosage measures as over doses could cause serious problems such as foetal distress (Data: 988.1) (A3S/TH). The informants seemed quite concerned about the issue of not having some kind of dosage measure as they felt that their herbs had a lot of strength which could have some adverse effects on the foetus (Data: 986.2.2) (A3S/TH). The fact that the indigenous knowledge about medicinal herbs is passed from one generation to another without documentation is what makes it difficult for *sangomas* to prescribe precise dosages. Nyika (2007:28) professed that medicinal herbs are used as crude mixtures without adequate information about dosages and side effects; a situation that risks patient's lives especially that some traditional medicines could have potentially harmful side effects even if they have good efficacy. Hence, the outcry for standardisation and regulation of the practices of *sangomas* with the hope that it would monitor both practice and drug administration in order to prevent overdosing

clients which could result in serious complications or even loss of lives (Nyika 2006 28).

The preceding discussion is somewhat similar the medical intervention where the uterus might rupture from an overdose or ill-monitored oxytocin dosage through an intravenous infusion (Data: 1012.3.1); (B3S/TH); (Data:1088) (C3S/TH) (Fraser 2010:558).

4.5.3.6 Category 3.6: Traditional non-herbal medicine

In the South African Traditional Practitioners' Act (Act 35 of 2004), traditional medicine is defined as ...”an object or substance used in traditional health practice for

- the diagnosis, treatment or prevention of physical or mental illness
- any curative or therapeutic purpose, including the maintenance or restoration of physical or mental health or well-being in human beings, but does not include a dependence-producing or dangerous substance or drug” (Truter 2007:56)

In line with the above definition, traditional medicine takes into account other traditional therapeutic substances that can be used in combination with herbs or as alternative medicines for optimum efficacy. Data display 54 contains evidence in this regard (see section 4.5.3.5).

DATA DISPLAY 54

THEME 3 Traditional practices

CATEGORY 3.6: Traditional non-herbal medicine

Non-herbal medicines

- We (*sangomas*-traditional healers) give her (woman) the donkey's placenta, we could also give her the elephant's placenta, and we also give her the placenta of ... no that thing, the hare's next for her to give birth naturally (Data: 1004.2). We make her drink the solution made after soaking the hare's nest in water for the woman to deliver naturally (Data: 1004.2.1). Sometimes when we think it is too late when we see that there was infidelity but the woman is not able to say; we take some *rapoko* (some kind of millet) and then give her (woman) to throw it (*rapoko*) in the fire and encourage her to say everything bad that she did so that she can deliver (Data: 1060.3). *Rapoko* is some kind of medicine to people; this is why we advise our children to carry
-

it wherever they go (Data: 1064.3) (B3S/TH).

Medicinal-herbal mixtures

- We (*sangomas*-traditional healers) collect the soil of the hare's nest and mix it with *isikhukhukhu* (slippery herb) and make a solution for the woman to drink. The result is that the baby will just jump out of the mother's womb like the hare jumping out of its nest. Labour does not take long even if the mother is 'tied' (use of herbs and/magic to cause labour complications) baby jumps out of the mother's womb suddenly (Data: 1008) (B3S/TH).

Ritualistic intervention

- When the woman drinks it (solution made after soaking the hare's nest in water), she should leave the cup to drop on its own so that baby can be delivered naturally without assistance (Data: 1004.2.2). Yes, the donkey's placenta is soaked in boiled water and given to the woman to drink the same way as the other herbs, leaving the cup to drop on its own so that the baby is delivered on its own without any assistance (Data: 1010) (B3S/TH).
-

Evidence given by informants in this section revealed that traditional medicines seem to have been used both to enhance herbal medicines or in place of herbal medicines. Of note is the donkey's placenta, the elephant's placenta and the hare's nest which the informants pointed out could be used to facilitate natural birthing (Data: 1004.2) (B3S/TH).

Ritualistic intervention seemed to accompany some non-herbal traditional medicine administration such as leaving the cup from which the woman was drinking the medicines to just drop as she finished drinking mixtures of herbal medicine and the donkey's placenta or the hare's nest (Data: 1004.2) (B3S/TH); (Data: 1010) (B3S/TH). The informants indicated that the donkey's placenta, and the hare's nest can each be mixed with *isikhukhukhu* (a slippery herb) for efficacy for "untying" or to resolve any kind of labour complication including unresolved grudges (Data: 1008) (B3S/TH); (Data: 1032) (B3S/TH), (Data: 1066) (B3S/TH) and (Data: 1066.2) (B3S/TH) (Nyika 2007:27).

Rapoko (some kind of millet believed to reverse labour complications) is used in cases of infidelity where it is thrown into fiery coal and the woman makes a confession as the *rapoko* pops (Data: 1060.3) (B3S/TH); (Data: 1064) (B3S/TH); (Data: 1064.2) (B3S/TH). The informants suggested some belief of some kind of medicinal effect linked to some magical powers of the beer brewing millet . An

extensive literature search on related literature on properties and effects of the traditional beer brewing millet “rapoko” when thrown onto fiery coals to pop did not yield any results.

4.5.3.7 Category 3.7: Technical manoeuvres

Sangomas have over the years attained some skills through experience that they use in an emergency to attempt some internal version of the infant in a malpresentation to facilitate normal birth; a skill defined by WHO as part of traditional healing. See section 4.5.3.5. Data display 55 contains information in this respect.

DATA DISPLAY 55
THEME 3 Traditional practices
CATEGORY 3.7: Technical manoeuvres

- Then when baby is in that position (transverse) we (*sangomas*-traditional healers) hold the mother upside down. (Data: 1022.1). While holding the mother upside down, we take a chair or a bucket and then stand on top. I take one leg up, another one up then I put my hand inside the woman and I then turn the foetus to face the right way (indicating in between the thighs) (Data: 1024). If we, whilst assisting TBAs think that calling an ambulance is ‘too late’, one can put a hand inside the mother vaginally; then the foetus can be turned (internal version) and the mother can deliver (1Data: 1036.1) (B3S/TH).

The informants indicated different versions of technical manoeuvres as an intervention in the event of obstructed labour. One described the procedure of an internal version in simplistic terms (Data: 1022.1) (B3S/TH0. No mention was made of any assistance from anybody during the attempted external version of the foetus. (Data: 1024) (B3S/TH). Evidence given by the informants on the technical manoeuvres seemed to be consistent. In medical practice a similar procedure is performed by doctors if there is a malpresentation particularly at the time of giving birth. It appears that the same procedure prevails within traditional healing where the traditional healer can be equated to the consultant obstetrician who performs the higher order or complex procedures on clients referred by TBAs.

4.5.3.8 Category 3.8: Payment for services rendered

In any situation people are expected to pay for services. The same principle applies in the Zimbabwean Ndebele culture. However, the difference is that payment for birthing services does not have to be in monetary terms. It can be in kind with whatever the person paying can afford; as is the case with all other traditional services. Data display 56 contains evidence in this regard.

DATA DISPLAY 56

THEME 3 Traditional practice

CATEGORY 3.8: Payment for services rendered

- Then they (people) give her (person undoing the tying) a chicken or ten dollars (by today's currency) and say 'here is something as payment for your herbs'; so that the day this person gives birth, they have a non complicated delivery with no effect of having been 'tied'(use of herbs and/or magic to cause labour complications) or anything at all (Data: 1100.2). The husband pays to the TBAs for what the wife was doing and what the TBAs went through during delivery as a result of her (woman) being 'tied' (use of herbs and/or magic to cause labour complications); he (husband) pays them (TBAs) money called '*Amehlo ezalukazi*' (meaning the eyes of old women). We (society) pay money to cover up for the cultural aspects (Data: 1114.2.1). One would be paying the TBAs who delivered their (husband's) wife so that the TBAs do not go blind that is what is called '*Amehlo ezalukazi*' (Data: 1118.1). One pays the TBAs because they saw the private parts of their (husband's) wife and even now some people still do it (paying the TBAs for seeing the private parts of their wife). (Data: 1118.1.1). Yes it (the paying done culturally) is the same as that which is done at the hospital; it is like paying for services rendered (Data: 1116). Culturally, in the olden days people would pay although there was no money involved, at times one would give a goat or a chicken for payment for services because those were important things to pay with (Data: 1118) (C3S/TH).
-

Although there is no specific charge of what one should pay for services rendered in the traditional practice, it appears that something must be paid to the person who manages the delivery. Evidence given by the informants suggested that payment for services is made in kind "a chicken or a goat" (Data: 1118) (C3S/TH) (Nyazema et al 1992 cited in Mathole 2006:18).

Evidence given by the informants indicated that payment for services rendered was not for offsetting costs or making any profit but rather as a ritual to prevent blindness (*Amehlo ezalukazi*) of whoever delivered the baby from seeing the private parts of

the birthing woman (Data: 1118.1) (C3S/TH); (Data: 1118.1.1) (C3S/TH). Culturally, the blindness caused by seeing someone's private parts is a general mythical belief in the Zimbabwean Ndebele society that applies to anybody even if one sees another person's private parts accidentally. Therefore, in the case of delivering a baby, the blindness is believed to be certain should the ritual payment not be made.

The reasons for payment of maternity fees at health care centres are totally different from the cultural ones as women pay for services rendered in the form of material things such as the doctor's expertise, intravenous infusions if used, drugs, linen, food and cotton wool. The payments in health care centres were referred to by one informant as 'huge bills' especially following CS. It is possible that these costs might deter women from giving birth at health institutions. Studies done in Bangladesh show that one of the reasons for women avoiding giving birth in hospitals was economic (Mathole et al 2005:952, Aziken et al 2007:46).

4.5.4 THEME 4: The art and profession of traditional healing

"African traditional healing is ... intertwined with cultural and religious beliefs, and is holistic in nature. It does not focus on only the physical condition, but also on the psychological, spiritual and social aspects of individuals, families and communities" (Truter 2007:56). Traditional healing, as a profession, has a three pronged concept. There is the aspect of training through apprenticeship which is observation and experience, the spiritual aspect of being possessed by some spirit medium at an initiation ceremony and the faith healing where there is no training but a purification rite through being prayed for (Truter 2007:56; Nyika 2006:26).

Data display 57 gives an overview of the main categories and subcategories of traditional healing.

DATA DISPLAY 57**THEME 4: The art and profession of traditional healing****Overview**

Professionalism
Principles of herbal medicine
Cultural-medical referral
Permanent solution for prevention of CS

4.5.4.1 Category 4.1: Professionalism

Traditional healers are professionals in their own right and like in any other profession function under some regulations and guidelines (Truter 2007:60). Data display 58 contains evidence in relation to professionalism.

DATA DISPLAY 58**THEME 4: The art and profession of traditional healing****CATEGORY 4.1: Professionalism**

Scope of practice

- ... but here I am talking about my spirit mediums. I am told about my pregnant client wherever they are. She (pregnant client) is far away right now; those who are far away I have a way of handling them, but those who are near I know that the TBAs will say *gogo* (meaning grandmother) we are now going to give her (woman) this medicine. That is what the TBAs tell me (Data: 966.2). ... for the one (labouring woman) who is far away, I have ways of doing it (cultural intervention). I release her (woman) while she is in South Africa) (Data: 968.1). Yes, they (TBAs) come and collect the herbs from me and I then give instructions on what to go and do (Data: 968) (A3S/TH).
- Even myself if anybody comes to me when someone has been 'tied' (use of herbs and/or magic to cause labour complications) and I have the herbs for undoing the 'tying'. I give them and say 'go and give the woman to drink' so that she can give birth naturally (Data: 1102). If there are complications during labour the (TBAs) should quickly tell me 'Ah Mr (name supplied) there is a woman labouring and there are complications. She cannot deliver' (Data: 1160) (C3S/TH).

Desire for traditional – medical networking

- Yes, I would like to hear from you who use medical interventions. Why is it that you acknowledge us as healers ... but you do not refer ill people to us so that we could use cultural interventions? (Data: 1164) (C3S/TH).

Cultural – medical divide

- It is different culturally, because the herbs used are not the same as those used in hospital Data: (1148.1.2). It is only now that there is talk that *sangomas* should work with the doctors, but it has not yet been concluded ... (Data: 1148.1.3) (C3S/TH).
-

Evidence given by informants indicates that traditional healing is a profession whereby the individual has to undergo some training to qualify as a traditional healer (Data: 966.1) (A3S/TH). It appears that the scope of practice for traditional healers is unlimited because the spirit mediums' involvements and treatments can be effected from anywhere, including places that are abroad as long as there is communication and instructions from the spirit mediums (Data: 996.2) (A3S/TH); (Data: 968.1) (A3S/TH). What seems to emerge from the evidence given by the informants is that *sangomas* work as consultants to the TBAs (Data: 1102) (C3S/TH). Informants expressed a wish to network with the medical fraternity in the form of cross referrals between the two fraternities: biomedical and traditional healing (Data: 1164) (C3S/TH); (Data: 1148) (C3S/TH). Collaboration and networking with health institutions could beome possible (see section 4.4.3.3).

4.5.4.2 Category 4.2: Principles of herbal medicine

As discussed in the preceding section (4.5.4.1), in every profession there are rules and regulations as well as principles that are there as a guide to the professional practice. Data: display 59 contains evidence in this regard.

DATA DISPLAY 59

THEME 4 :The art and profession of traditional healing

CATEGORY 4 .2: Principles of herbal medicine

Dosage measurement

- ...the draw back with our herbs is that we have no dosage measurement and the herbs have not been inspected (Data: 1148.2)...when I dispense the herbs I know that the dosage measurement is two teaspoons. This one (showing the measure) I use to measure the dosage for someone who is very ill and this one (showing the measure) is used for small babies like this (indicating height with a hand). That is what I use for dosage measurement for a very ill person. Then for the person who is ill but looking a bit stronger, I give them a full teaspoon. I do not hip the teaspoon like this (indicating) I level the teaspoon a little bit (Data: 1148.2.3) (C3S/TH).

Herbal medicine processing

- The process is that I go and dig for the herbs in the bush, I come and pound the roots and sieve them. I have a sieve that I use for the ones that are for drinking and for those that are mixed with the porridge. I then do the bottling and the labelling to indicate on each bottle the use of each herb (Data: 1148.2.2) (C3S/TH).
-

According to evidence given by the informants it appears that there is no specific herbal dosage measurement that the *sangomas* go by when administering treatment, but one informant seems to have designed her own dosage measures (Data: 1148.2.3) (C3S/TH). This is an important aspect in the practice of medicine; whether in herbal medicine, traditional medicine or scientific medicine because overdose has in other medical practices caused serious adverse outcomes and/or loss of lives. One traditional healer explained drug processing quite elaborately in the cultural perspective (Data: 1148.2.2) (C3S/TH). *Sangomas* appeared to be pharmacists in their own right because each spirit medium “,,has their own field of expertise, with their own method of diagnosis and their own particular medicine” (Truter 2007:57).

4.5.4.3 Category 4.3: Cultural-medical referrals

When the informants eventually accepted the fact that the labour could be complicated and decided to take their client to the hospital or to the doctor, they did not mention referral or the need to consult, but seemingly wanted to get rid of the client. Data display 60 presents evidence in this regard.

DATA DISPLAY 60

THEME 4 : The art of traditional healing

CATEGORY 4 .3: Cultural-medical referral

- If the woman cannot deliver in spite of our advice, we call an ambulance... because then we realise that there is no progress (Data: 1036). ...sometimes when the woman gets to the doctors, if they (doctors) also have the knowledge they can also do an internal version (Data: 1038.1) (B3S/TH).

The CS is done at the hospital, we (*sangomas*-traditional healers and the TBAs) send the mother there if we are not succeeding with our cultural herbs (Data: 1132). ...the problem is that people rush to hospital once they there is no labour progress they (TBAs) phone the ambulance and take the woman to hospital. When the woman gets to hospital, a CS is done meanwhile this could have been a simple thing that could have been solved right here in the house (Data: 1160.2). ...when things really get very complicated it is also advisable to seek medical advice, but people must have respect for their culture. Let us hold on to our culture it really works (Data: 1162.1) (C3S/TH).

Social support for TBAs

- Ah! We just ask any office so that one can phone. Like those days when there were no phones in homes. One would ask anyone to say ‘ah! My child; please could you ring for the ambulance’. (Data: 1038) (B3S/TH).
-

There was no apparent organised referral system from the traditional healers to health care institutions once informants could not manage a client referred to them by TBAs. The traditional healers referred clients to health care institutions not because they needed to seek second opinions, but as a last resort (Data: 1036) (B3S/TH); (Data: 1162.1) (C3S/TH). The informants felt that even if a CS was done, the situation could have been handled as a home delivery, indicating a possible lack of understanding issues relating to CS (Data; 1160.2) (C3S/TH) and complications. The informants also expressed a lack of confidence in the doctors (Data: 1138.1) (C3S/TH).

4.5.4.4 Category 4.4 Permanent solution for preventing caesarian sections

The art of traditional healing is perceived as being dynamic and versatile; hence such issues as prevention of CS can be attended to by using herbal medicines. Scientifically, sterilisation is used to prevent pregnancy and ultimately avoid CS. However, sterilisation is a surgical procedure which, like CS, may also be culturally unacceptable to the Zimbabwean Ndebele society particularly as it will be stopping the women from having any further children. Despite the cultural emphasis on having children it is interesting that there seems to be traditional medicine, herbal or non-herbal that could serve as a contraceptive.

Data display 61 contains evince relating to permanent solution for prevention of CS.

DATA DISPLAY 61

THEME 4 The art and profession of traditional healing

CATEGORY 4.4: Permanent solution for prevention of CS

- At times one may end up having to be sterilised following CS so that she never falls pregnant again such that it would be necessary for the woman to be given herbs to drink in order to prevent her getting pregnant. We do have such herbs culturally (Data: 1134.2). No, she (woman) ends up being sterilised so that she does not always have to have a CS (Data: 1136) (C3S/TH).

Metaphor

- One can liken this (CS) to a clay pot that is broken on one side. One cannot fill such a pot with water because if they do the water would spill through the broken side (Data: 1144.1) (C3S/TH).
-

Informants gave evidence that culturally there is some provision for permanently solving the problem of repeated CS by using herbs that prevent the woman from conceiving; an indication of the diversity of the art of traditional healing (Data: 1134.2) (C3S/TH). The metaphorical explanation is in line with the ruptured uterus that can be caused by repeated CS (Data: 1144.1) (C3STH).

4.5.5 Conclusion

The discussion on *sangomas* and their views relating to pregnancy, child bearing and birthing confirms what Truter (2007:60) postulates, namely that in many African societies *sangomas* hold multi-faceted highly esteemed powerful positions within communities. Besides the traditional healing *sangomas* have other roles in society which include counselling, and dealing with psycho-socio-cultural and religious issues.

There is a need to seriously consider the contribution of traditional healers to the health system in Zimbabwe. In Zimbabwe *sangomas* have a very valuable role of providing health care to society in a holistic manner since a large part of their practice includes psychosocial counselling.

The issue of regulations and ethical guidelines of traditional medicine is very desirable, but the question is that who is the rightful person or authority to implement it since there is so much sacredness, complexity and mystification in the supernaturalism of the practice which advocates of the regularisation and ethical authorities do not understand? (Ganyi & Ogar 2012:32; Nyika 2007:26-27; Truter 2007:58-59; Mathole et al 2005:945).

4.6 DATA ON PERCEPTIONS OF TRADITIONAL BIRTH ATTENDANTS (TBAs)

This section on traditional birth attendants' perceptions on unnatural birthing is closely related to that of the section on sangomas. Traditional birth attendants (*ababelethisi*) are usually elderly women who had no special training in midwifery and have been practising midwifery for many years. They might have learned their craft from other traditional midwives and from practical experience. TBAs are highly respected for their experience and ritual expertise (Nickodem 2007:205; Truter 2007:58; Saravanan 2010:95). The literature search reveals that there are two kinds of TBAs; "community TBAs" women who practice midwifery by assisting pregnant women who request their services during delivery; and the "family TBA" who only delivers babies of relatives and friends (Saravanan et al 2010:94). However a study in Zimbabwe by Chavunduka (1994 cited in Mathole 2007:942-943) indicates that 92% of TBAs also provide herbs and practice other forms of traditional health care. TBAs are classified as a diverse group which includes:

- TBAs who are ordinary women who acquired midwifery skills through assisting other TBAs for a period of time until they are able to practice independently.
- TBAs who are traditional healers/diviners with supernatural powers to protect pregnant women against witchcraft.
- TBAs, known as prophets, who are associated with the church and practise faith healing through prayer and holy water (Mathole et al 2007:943; Truter 2007:58; Saravanan 2010:94).

In line with the above categorisation of TBAs, a study by Galaa (2006:124), in Ghana also reveals a more or less similar form of categorisation of TBAs.

- TBAs who acquired spiritual powers to support them in their midwifery care,
- TBAs who inherited midwifery practice and administration of herbal medicine from their mothers-in-law
- TBAs who were socialised into midwifery practice through apprenticeship.

Galaa further claims that the TBAs who use spiritual powers and those who inherit midwifery practice from their mothers-in-law have a wealth of knowledge as compared to those who were initiated through apprenticeship.

Truter (2007:56) discusses TBAs under the umbrella topic of “African traditional healers: cultural and religious beliefs intertwined in a holistic way” an indication that TBAs practise as healers and subscribe to the religious aspect of practice. In Zimbabwe, TBAs are officially recognised by the government as they deliver 30% of the babies born outside the formal health system and TBAs are part of the Zimbabwe Traditional Healers Association (ZINATHA)

Focus group interviews conducted with a group of TBAs were lively and enlightening. Most of the information was congruent with that of the community elders and the *sangomas* (traditional healers). What differed from the other groups was that the TBAs gave evidence of what took place in their world of practice during the delivery of the babies and what roles they played; while *sangomas* (traditional healers) and community elders related mostly what TBAs did when caring for women during ANC, parturition and post natally. Three themes emerged from the data obtained through the focus group interviews (FGIs) that were held with the TBAs. The emergent themes include:

- Cultural perspectives on unnatural child bearing
- The practice of TBA's
- Acceptability of unnatural child bearing

Figure 4.4 gives a diagrammatic representation of these themes and related categories.

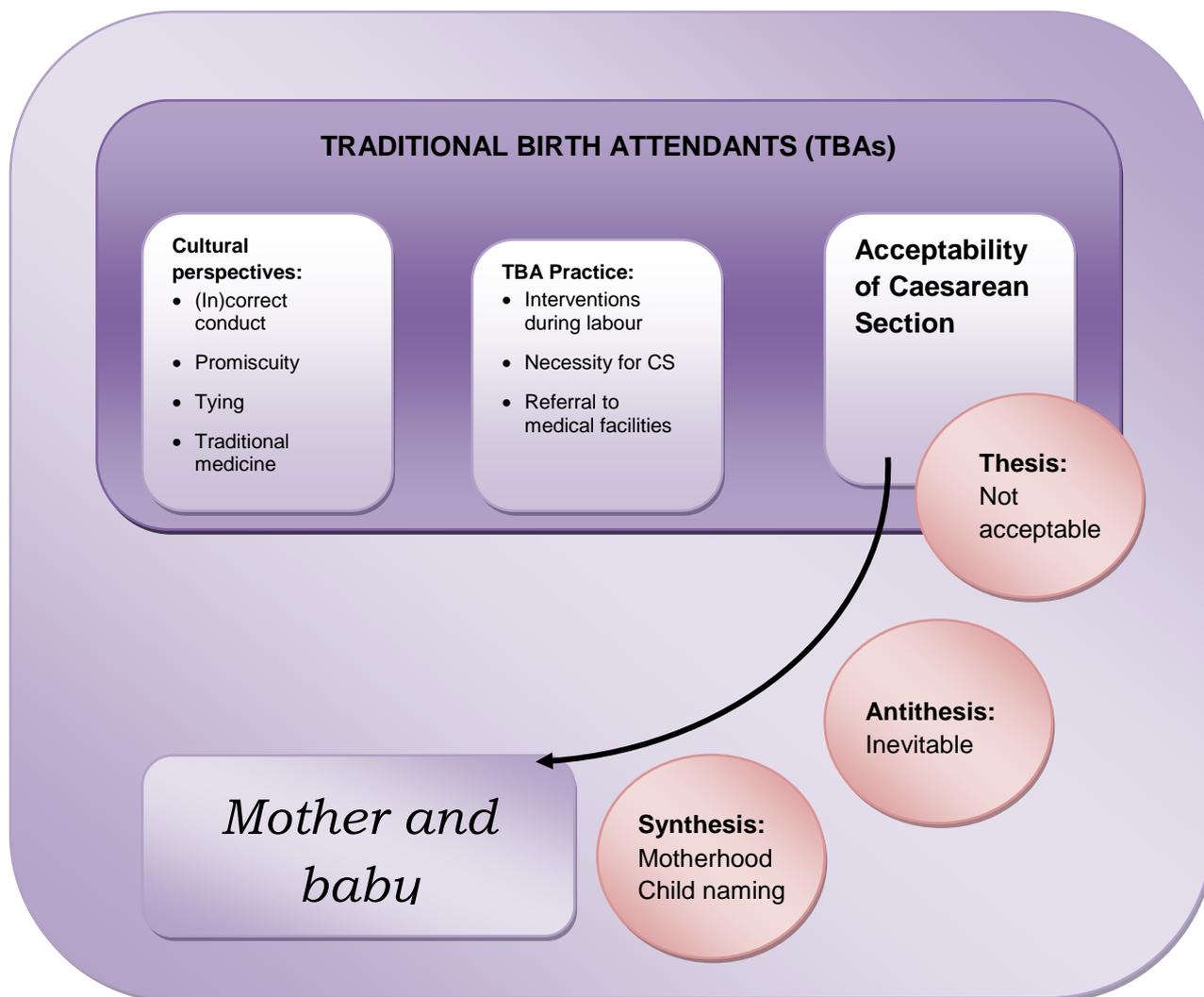


Figure 4.4: Traditional birth attendants (TBAs)

4.6.1 THEME 1: Birthing within the traditional domain

This theme focuses on cultural and traditional issues of pregnancy and birthing in the Zimbabwean Ndebele society. Data display 62 gives an overview and summary of the main categories constituting Theme 1.

DATA DISPLAY 62
THEME 1: Birthing within the traditional domain
Overview

Socio-cultural (in)correct conduct
 Promiscuity
 Tying
 Traditional medicine

4.6.1.1 Category 1.1: Socio-cultural (in)correct conduct

Data display 61 contains evidence of cultural habits surrounding pregnancy and birthing important to TBAs. Habits in this instance refer to social conduct and behaviour people are accustomed to in relation to pregnant women and pregnancy. These habits are based on certain beliefs and convictions, and both the execution and omission to act in a certain way have (believed) consequences. Data display 63 also contains evidence of TBAs' concern about the erosion of cultural habits and appropriate social conduct where pregnant women and pregnancy are involved.

DATA DISPLAY 63

THEME 1: Birthing within the traditional domain

CATEGORY 1.1: Socio-cultural (in)correct conduct

Pregnancy related beliefs and practices important to TBA's

- ... one was not allowed to peep into the hut at the door with the head in and the rest of the body remaining outside (Data: 1238)(TBA4).
- When we grew up, one would never take someone halfway when they were pregnant because the two would then stand on the road chatting; baby will also do the same the day one is in labour, baby will imitate the mother (and the birthing will be prolonged) (Data:1240) (TBA3) .
- When one is pregnant they would not be accompanied, if at all - there was need for accompaniment, when people then part the pregnant one were given a leaf from a tree to take with her. If they are not given a leaf; their labour would be complicated. Yes (Data:1240.1) (TBA3)
- When one was pregnant they would eat seated down and not eat while standing. If one came into the hut to say something to the people who are inside, one should come in, seat themselves down and say what they need to say then stand up and go (Data: 1236.1.3) (TBA2)..
- Even if one is just about getting inside the house and they are at the door, if someone calls them from outside they should not turn and go back, they should get inside the house first, then turn and go out (Data: 1236.1.4)(TBA2).

Erosion of cultural beliefs and practices.

- One may just walk in and out of the hut as they wish, time and again. One may disagree with all the rules and yet in the olden days all the rules were observed (Data: 1236.1.2) (TBA2).
 - We (society) no longer observe what used to be observed by a pregnant woman in the olden days. We (society) get cautioned to say 'do not drink water while you are standing' and the response would be, 'Ah! What is wrong with that?' (Data: 1236.1) (TBA2).
 - At times somebody may just be standing amongst seated elders when cautioned the response is 'ah what is wrong with that?' (Data: 1236.1.1) (TBA2).
 - In the olden days, the operation (CS) was unheard of culturally, because people observed traditional practices and culture was valued. Now there is confusion (Data: 1236.3) (TBA2).
-

-
- **Outcome of cultural erosion**
 - That, (not following rules) is what results in one ending up being operated (CS) upon (Data: 1236.2) (TBA2).
-

It is apparent from the evidence in data display 63 that TBAs experienced a loss of some culture value as they indicated that during the “olden days” the “operation” (CS) was unheard of (Data: 1236.3) (TBA2). Substantiation of this statement with literature was impossible since no documented records were available to show that CS was unheard of. CS might have been unheard of because of cultural interventions or because of the unavailability of appropriate technology or because of a combination of both these factors. Seemingly, the informants attributed the occurrence of alternative modes of birthing to a breach of cultural restrictions and socially acceptable conduct during pregnancy (Data: 1236.2) (TBA2). Several reasons for CS are given in data display 63; one example is (Data: 1240) (TBA3) where the foetus would imitate the lingering associated with taking someone half way on a journey, stand on the way and chat; thus taking long to be delivered. It appears some of the cultural restrictions would be nullified by doing some simple rituals in the form of social conduct (Data: 1240.1) (TBA3). This information is discussed under this category, but it seems to fit into a number of other categories within the same theme and across other themes from other groups that were interviewed; such as traditional practice, traditional beliefs and ritualistic interventions (Boyle & Andrew 1999:88).

4.6.1.2 Category 1.2: TBA’s beliefs relating to promiscuity and bearing of grudges

In addition to the culturally held customs discussed in the previous section, TBAs also held certain opinions as to the origin of a need for CS. A traditional belief is not something that one can change as it appears to be inherent in the culture of a society although, in some instances, it can be changed by a more scientifically founded understanding. As it becomes evident later in this section, the latter type of knowledge often appeared to be “second best” to culturally inspired suspicion. Some issues of the traditional beliefs of the Zimbabwean Ndebele society are discussed in Data display 64.

DATA DISPLAY 64**THEME 1: Birthing within the traditional domain****CATEGORY 1.2:TBA beliefs relating to promiscuity and bearing of grudges**

General indicator

- All attempts to do an internal version will be unsuccessful because this young mother would be promiscuous (Data: 1201) (TBA2).

Tradition and belief

- She (woman) would be having multiple sexual partners. If the pregnancy does not belong to her husband, those manoeuvres done by the TBAs do not work (Data: 1204). The solution is to put some *rapoko* (some kind of millet believed to reverse labour complications) on hot coal and the mother should stand with feet astride over that(Data: 1204.1). Yes, she should have liquor and show dribbling over that hot coal with the *rapoko* (some kind of millet) popping (Data:1204.1.1) (TBA3)
 - The addition is that during the ritual where *rapoko* (some kind of millet believed to reverse labour complications) is put on hot coal, if it starts popping it confirms the infidelity which the young mother was not able to admit in front of the elders (Data: 1224). That popping of the *rapoko* confirms that the young mother had a number of issues or she could have kept some grudges. The popping of the *rapoko* reveals that even if the woman denied everything on questioning, there definitely is something that she did (being unfaithful) (Data: 1224.1) (TBA4). I meant exactly what these other informants were saying that the woman would have to reveal the man to whom the pregnancy belongs, only then can she deliver (Data:1230) (TBA2).
-

The informants generally believed that some of the traditional medicines given to the women during complicated labour are believed to confirm infidelity as the cause of the labour complications (Data: 1224.1) (TBA4). Informants gave evidence suggesting that they believed that infidelity and nurses were the major causes of inability to give birth naturally (Data: 1204) (TBA3); (Data: 1224) (TBA4). The other belief expressed by the informants was that promiscuity made attempts of internal version unsuccessful (Data: 1201) (TBA3). Informants also indicated that they believed in cultural interventions such as burning of *rapoko* (some kind of millet believed to reverse labour complications) in order to prevent unnatural birthing. The belief, as explained by the informants, is that when the *rapoko* pops while the woman is standing astride over the burning coal and the *rapoko*; it confirms infidelity to which the woman should confess and reveal the man to whom the pregnancy belongs for her to be able to deliver the baby (Data: 1230) (TBA4). These traditional

interventions would not be considering that the cause of labour complications are scientific rather than cultural or traditional.

4.6.1.3 Category 1.3: Issues relating to “tying”

Historically the Ndebele culture was centred on religious rituals and on worshipping ancestral spirits. In this context religion also refers to witchcraft as any illness or labour complication is believed to be a result of witchcraft or some supernatural powers which also relates to “tying” as a complication of labour (Mathole 2005:946; Awoyinka 2006:29; Nyika 2007:27) Data display 65 contains evidence in this regard from the point of view of the TBAs.

DATA DISPLAY 65

THEME 1 Birthing within the traditional domain

CATEGORY 1.3: The issue of “tying”

Process of “tying” (use of herbs/magic to cause labour complications)

- When they (women) are bewitched, their foot prints are taken with the soil and mixed with herbs. They (people) will be envying one’s life and one’s comfort grandchild (Data: 1208). They (people who do the tying) put that soil with the foot prints on a piece of material with herbs and then tie it up thoroughly with the soil inside. That is how they ‘tie’ (use of herbs and/or magic to cause complicated labour) one (Data: 1210) (TBA3).

Process of “untying”

- If that soil and herbs with the foot print is not untied, my child, one never gives birth. Not until one drinks that traditional medicine *nyeluka* (type of fish) or donkey’s placenta that unties the soil with foot print tied in a piece of material with herbs does one give birth. (Data: 1210.1). That *Nyeluka*, donkey’s placenta and/or *rapoko* is the traditional medicine used to ‘untie’ the woman (Data: 1212) (TBA3).
-

Informants explained the process of “tying” as using herbs/magic to cause labour complications (Data: 1208) (TBA3); (Data: 1210) (TBA3). The reverse process of “untying” was also described as including traditional medicines that are used to effect “untying” (Data:1212) (TBA3). The evidence indicated that the “tying” (use of herbs/magic to cause labour complication) is a deliberate act which can either be a result of witchcraft or infidelity and can be reversed through confession to the midwives in the Zimbabwean Ndebele culture or to the priest in other cultures so that the woman could have an easy delivery. See (Data: 1230) in Data display 64. (Bullock 1913:11; King 2003:125). Also see section 2.8.1.2).

Although the TBAs usually consult with *sangomas* (traditional healers) so that they can be given herbs used for “untying”, TBAs also have the power and skill to do the “untying” depending on the type of TBA they are; whether they are TBA/*Sangoma* (traditional healer) or TBA/faith healer. If they are the ordinary TBA who has no divine or ancestral powers they do not do the untying (Truter 2007:58).

4.6.1.4 Category 1.4: Traditional medicine

Despite the evidence of a culturally based “scientific” procedural approach to delivering the baby, in line with the professed cultural norms, practices and beliefs surrounding pregnancy, natural birthing and unnatural birthing; in the Zimbabwean Ndebele culture, society believes in traditional medicine more so because it is part of their religion. In this study the definition of traditional medicine as given by Truter (2007:56) in section 4.5.3.6 refers to both herbal and other medicinal substances used on their own or in combination with each other but distinct from western medical practices. Similarly, the WHO defines traditional medicine as; “health practices, approaches, knowledge and beliefs incorporating plant, animal and mineral based medicines, spiritual therapies, manual techniques and exercises applied singularly or in combination to treat, diagnose and prevent illness or maintain well-being” (Nyika 2007:26). These two definitions describe the TBAs’ practice with the guidance of their “consultants” the *sangomas* (traditional healers) with the inclusion of the technical manoeuvres in situations where the need arises during the birthing process (see Data display 68).

TBAs may use traditional medicine in their own capacity as TBAs who are also healers or in consultation with *sangomas* (traditional healers) and/or other herbalists. Data display 66 exhibits some of the traditional medicine used.

DATA DISPLAY 66**THEME 1: Birthing within the traditional domain****CATEGORY 1.4: Traditional medicine**

Pre-natal care**Nyeluka**

- ... when the woman goes into labour she is given *nyeluka* (a type of fish which has some medicinal effect) (Data: 1179.1). It (*nyeluka*, some water snake) is dried and then stored like that so that when the woman goes into labour, it is soaked in water and warmed up then the woman drinks it from a cup and she just leaves the cup to drop at the threshold (some ritual) (Data: 1185). She drinks the *nyeluka* (a type of fish which has some medicinal effect) when she goes into labour, so that she has a normal delivery with no complications (Data: 1187). Then the woman delivers after drinking *Nyeluka*, everything is expelled; the placenta and the membranes; everything ... (Data: 1187.1) (TBA3).

Donkey's placenta

- The donkey's placenta is also given to the labouring woman in the form of a drink (Data: 1193.1). The donkey's placenta is also capable of causing the foetus to turn (internal version) and change position in the uterus if it was a transverse lie. It (foetus) then gets delivered normally with the head coming first (Data: 1193.1.1) (TBA4).

Rapoko

- She (woman) would be having multiple sexual partners. If the pregnancy does not belong to her husband, those versions do not work ... the solution is to put some *rapoko* on hot coal and the mother should stand with feet astride over that ... with the *rapoko* popping (Data: 1204) (TBA3).

Effects of traditional medicine

- When the woman delivers after drinking *Nyeluka*, everything is expelled; the placenta and the membranes; everything ... (Data: 1187.1). We (TBAs) give her (woman) some herbal mixtures to drink as well, so that nothing is retained inside the uterus (Data: 1181). Yes after drinking *nyeluka* the delivery is the one that happens very fast with nothing remaining in the womb (Data: 1189) (TBA3).
- The donkey's placenta is also capable of causing the foetus to turn (internal version) and change position in the uterus if it was a transverse lie. It (foetus) then gets delivered normally with the head coming first (Data: 1193.1.1) (TBA4).
- The donkey's placenta which the other informant mentioned, when administered, can cause the baby to turn and change position to also effects internal version present with the head first (Data: 1195.2) (TBA2).
- The smoke from the *rapoko* (some kind of millet) burning on hot coal will cause baby to turn and change position (1204.). That (smoke of *rapoko* – some kind of millet, causing baby to change position) alone shows that the young woman is promiscuous; this baby does not belong to this person (husband) (Data: 1204.1.1). That (woman being promiscuous) is the reason why use of traditional medicine to cause version will not work if the woman is promiscuous (Data: 1206) (TBA3).

Post natal care

- We (TBAs) understand that in hospital they suture the mother's perineum with stitch, but at home they (elder woman) look for *umganu*
-

(marula tree barks) and place them outside the house then early in the morning they wake the mother up and sit her in a warm *umganu* (marula tree barks) bath so that the pelvic muscles return to their pre-pregnant state (Data: 1177). This (umganu bath on the perineum) is done daily every morning until the pre-pregnant state of the pelvic flow muscles has been achieved (Data: 1177.1) (TBA2).

- Hot compresses will be done all over the body but not the operation site. We (TBAs) apply hot compresses all over the body because the mother would be having aches and pains because of the physical strain she would have gone through during labour and operative delivery (Data: 1242.1) (TBA1).
-

Evidence given by the informants in Data display 66 indicates that giving traditional medicine to a pregnant woman is culture bound. With or without labour complications, the woman is given some traditional medicines in preparation for natural birth (Data: 1179.1) (TBA3). Evidence given for enhancing natural, complication free birthing includes the use of *nyeluka* (a type of fish believed to have some medicinal effect), donkey's placenta, *rapoko* (some kind of millet believed to reverse labour complication) (Data: 1195.2) (TBA2); (Data: 1193.1.1) (TBA4); (Data: 1204) (TBA3). Preceding evidence revealed that desired effects of traditional medicine were normally achieved. (Informants also gave evidence relating to the burning of *rapokoto* solve the issue of complicated labour and that if the *rapoko* pops on the fiery coals, that is believed to be proof that there was promiscuity in the case of the birthing woman (Data: 1204.1) (TBA3). Credibility, proof of the effects of traditional medicine is, however, not possible. Further to discussing the effects of traditional medicine during the birthing process, informants also gave evidence of how they managed post natal care and how they attended to perineal tears in particular using traditional medicines in comparison with scientific methods of perineal repairs (Data: 1177, 11771.1) (TBA2); (Data: 1242.1) (TBA1).

4.6.2 THEME 2: The practice of TBAs

The practice of TBAs involves provision of maternal and infant health care services in assisting women and their families and giving them support during birthing. Traditional beliefs and birthing behaviours unique to a society usually shape the characteristics, health and social roles of TBAs. Becoming a TBA is either by apprenticeship or observation and experience in most countries where TBAs practise. The situation in Zimbabwe is different by the inclusion of *sangomas*

(traditional healers) and faith healers. In both situations, the practice of TBAs might be complemented by formal training provided by governments to enhance the clinical skills of the TBAs (Saravanan 2010:94; Mathole et al 2005: 939).

DATA DISPLAY 67**THEME 2: The practice of TBAs****Overview**

Interventions during delivery

Non-traditional conditions necessitating CS

Referral to medical facilities

6.4.2.1 Category 2.1: Interventions during delivery

Despite the cultural beliefs surrounding pregnancy and issues relating to unnatural child bearing, TBAs endeavour to uphold, the actual practice of known scientific (obstetric) procedures. It takes experience from a seasoned TBA or professionally trained individual to describe the steps involved in delivering a baby, considering the fact that the birthing process often proceeds quite fast and needs special attention to specific issues to bring about life and still have alive mother. The major objective is zero loss of life during a delivery and to reduce maternal and neonatal mortality by 75% and by 66.6% respectively; in order to achieve the reproductive health objective and the MGDs of “Achieving universal access to reproductive health by 2015 ...”(World Summit Outcome 2005).

Data display 68 provides evidence of the TBAs’ practice and the sequence of the delivery procedure obtained during an FGI.

DATA DISPLAY 68**THEME 2: The practice of TBA’s****CATEGORY 2.1: Interventions during delivery**

General indicator

- Baby should present with the head first. This is why they (TBAs) will attempt an internal version at delivery (Data: 1195.1)(TBA2).

Monitoring of labour progress

- When the head has engaged, I stay with the woman to monitor her closely. I will stay there and do a vaginal examination with my fingers so that I can feel whether the head is coming down. If the head is not engaged, I do not allow the woman to push because she will be exhausted (Data: 1169.2) (TBA1).
-

Delivery procedure

- When the head has engaged, if she (woman) wants, I seat her up and instruct her not push with her mouth open, she should close her mouth so that she can push properly (Data: 1169.3). ...what we know is that when the head is stuck, is to take a razor blade and make a small cut (Data: 1214.1). When baby is completely delivered that is when I cut the cord and tie it on the baby's side and also on the part that is still attached to the mother so that it (cord) does not slide back into the mother since the placenta would still be in the womb. I then ask the mother to push in order to expel the placenta (Data: 1169.4). During the delivery I want her to sit facing up and deliver properly, so that I can receive the baby (Data: 1169.4.1). If it is the head presenting first, I check if the shoulders are coming and check if there is no cord around the neck or arm. When I want to remove the cord, I will be careful when pulling to see which side I am pulling, is it from the baby or from the mother (Data: 1169.4.2). Then I pull from the mother bit by bit while she continues to push, I continue to receive the baby until the baby is born then I quickly remove the cord from wherever it is around sometimes even when the placenta has been expelled some membranes may remain inside the womb, and one sees some threads sort of hanging (Data: 1169.4.3) (TBA1).
- After cutting the cord the mother should sit up, and then the placenta and membranes are expelled (Data: 1193.2) (TBA4).

Management of the 3rd Stage of labour

- I will then insert my fingers and try and remove the threads slowly, slowly bit by bit while the woman is pushing until they all come out (Data: 1169.4.4). The placenta would have been removed, but at times some membranes remain; those are the ones that I remove manually with my fingers: elders call them *imichilo* (meaning whips). They (membranes) are very dangerous if they are left inside the mother's womb because the membranes quickly get septic when retained and the woman may die (Data: 1171) (TBA1).
- ...when the delivery has been done and all is over, if there are any retained products of conception which these other grandmothers were talking about, we (TBAs) usually ask the woman to blow into a bottle. (Data: 1181.2) (TBA3).
- ...sometimes the mother gets tears on the perineum during delivery (Data: 1175.1) (TBA2).

Technical manoeuvres by TBAs

- In case baby presents as a breech, they (TBAs) do an internal version and turn the baby inside the womb by pushing their hands inside the womb and turn the baby, the woman will then give birth naturally (Data: 1173.2). They (TBAs) push in those fingers, turn the baby until the baby turns and the head comes down and then the mother gives birth (Data: 1175). If they (TBAs) realise that this baby is presenting with feet first, they attend to it by way of attempting an internal version (Data: 1197.1). Yes, the TBA's fingers pushed into the mother vaginally end up turning the baby and the result is that in baby ends up being born normally, the natural way (Data: 1199) (TBA2).
- We (TBAs) cut on the mother's perineum, just a little bit so that baby's head can pass through this young mother's small outlet (Data: 1216). Yes, just cutting the perineum a little bit with a razor blade (Data: 1218) (TBA1)..

Procedure for breech delivery

- ... one will be waiting to receive the baby until the head comes down
-

and gets stuck. I then pushed in my thumb and felt for the chin and pushed it down like this (demonstrating) (Data: 1262.1). . then pick both of the baby's feet and throw baby's body on top of mother's abdomen and then deliver the head (Data: 1264) (TBA1).

Post natal care

See data display 66

Scientifically, monitoring of labour progress is accomplished through the use of technology. One informant gave a vivid account of how labour progress is monitored using appropriate technology in carrying out examinations during labour, doing observations as well as giving instructions to the woman of what to do and what not to do during delivery (Data: 1169.2) (TBA1). Apparently, this is plausible evidence as it resembles the scientific way of monitoring labour progress although not with the same detail. Vaginal examinations are carried out to assess cervical dilatation, percentage of cervical effacement, foetal membrane status, foetal presentation, position, station, degree of foetal head flexion and presence of foetal swelling on whatever presenting part or the presence of moulding (Page & McCandlish 2006:343; Ricci 2009:362).

It appeared that the particular informant had a wealth of experience in attending to births in a traditional setting. The evidence suggested that the particular informant could have been one of the TBAs who benefitted from the formal training provided by the MOHCW in Zimbabwe in 1997. This TBA training was criticised as being inappropriate for the elderly and illiterate; particularly because it was based on the international generalised guidelines using midwifery training manuals (Mathole et al 2005:939).

Evidence given by the informants in Data Display 67 indicates the experience that the TBAs had in attending to a delivery within the traditional domain. In fact, evidence pertains to the proceedings of both the second and the third stages of labour which is from full dilatation of the cervix to the delivery of the baby. Informants also gave evidence pertaining to the management of the third stage of labour giving detailed information from the delivery of the baby to the expulsion of the placenta (Data: 1193.2) (TBA4) to examination of the mother post-delivery (Data: 1171) (TBA1); (Data: 1181.2) (TBA3). The description of the delivery procedure given in

Data display 65 appears to be congruent with the scientific delivery procedure (Ricci 2009:354-355).

In situations where the baby presented as a breech, the TBAs used their skills to do specific manipulations on the foetus with their fingers in an effort to make the baby present with the head first in order to achieve natural birthing (Data1195.1). Evidence suggested that TBAs had experience of getting to the foetus in the womb and turn it using their fingers (Data: 1173.2) (TBA2). Informants also shared their own experiences of delivering a baby presenting as a breech (Data: 1262.1) (TBA1). There appears to be a similarity of manoeuvres used by the TBAs to those used by the doctors.

Despite the laudable experience and knowledge that the informants believe traditional birth attendants have, there are debated issues concerning the impact of TBAs, services as to whether TBAs are good for improving the maternal and perinatal health or not. Both positive and negative views on the outcome of the traditional practices in home births are shared.

Available evidence indicates that “strategies incorporating TBAs may be a practical and complimentary solution for many women in developing countries particularly in rural areas .It is apparent that consensus in the debate seems to support training of TBA as a crucial need in the management of pregnancy and parturition although it may not be very possible in Africa where most of the TBAs are elderly, apprenticed and illiterate (Are traditional birth attendants good ... 2011).

Evidently, TBAs have gained their support from communities, because, they are accessible at all times, day and night, live within the community and understand the traditions, cultures and languages of the women that they attend to and because they are trusted by the by the communities, they deliver more babies than the skilled midwives who later loose their skills from non practise. Available studies applause the social role of TBAs in society their physical closeness to their clientele, their acceptability and availability as well as the affordability of their services and the attention to personal needs of the families, households and communities which are used to explain the women’s continued quest for homebirths. Studies done in India

reveal that sixty one percent (61%) of births still occur at home and less than half of total births, forty six point six percent (46.6%) receive skilled attendance at birth. WHO in its suggestions still insists on training TBAs to recognise danger signs during pregnancy and labour considering that in spite of it being a natural process, birthing is fraught with risks for both mother and baby, and as such training of TBAs is critical as a strategy of reducing maternal mortality and morbidity. Several studies have indicated that training of TBAs and their inclusion in health care service provision have the potential to improve maternal and perinatal health (Leedman 1982; Kamal 1992; UNFPA1997; Kamal 1998 cited in Izugbara et al 2008:36).

The ideas and thoughts expressed in the preceding discussion that TBAs have the potential to improve maternal and perinatal health are disputed by other schools of thought who point out that initiatives that exclude traditional birth attendants have been shown to improve maternal health and the belief is that traditional birth attendants have no place in the future of management of pregnancy and birth. Literature view shows that the use of traditional attendants in improving maternal and perinatal health has generated a lot of heated debate among health professionals and yet facts indicate strong support of their use, because of the fact that shortage of skilled workers always creates a void into which TBAs will fit. However, the debate goes on to say they do more harm than good; such as the unhygienic practices which can introduce infection to mothers and babies during their conduct of deliveries. (Guha 1998; OHCHR 2006; WHO 1999 cited in Saravanan 2010:94; BMJ 2011:342).

6.4.2.2 Category 2.2: Non-traditional conditions necessitating CS

Despite the general culturally held expectation that birthing must be natural and spontaneous and that it should take place in an environment that allows for the practising of accompanying rituals (Awoyinka et al 2006:209; Aziken et al2007:46), some TBAs mentioned medical and scientific reasons why CS might be necessary. Data display 69 contains evidence of knowledge on anatomical, foetal and obstetric issues relating to birthing provided by TBAs.

DATA DISPLAY 69**THEME 2 The practice of TBA's****CATEGORY 2.2: Non-traditional conditions necessitating CS**

Malpresentation

- ...sometimes the foetus lies in a transverse position or at times presents with the feet first; so, what we (society) used to hear the elders say is that ah! This one is *Fulatha*; baby will be coming with feet first. This is why it is said *Fulatha* because it is the back coming first (Data: 1195) (TBA2).

Inadequate pelvis

- The other reason for (CS) is that some people say, the woman would be having no outlet. Even if we (TBAs) give her all the herbal treatment if she has no outlet she will not deliver even if she is not promiscuous (Data: 1252). There are some women who naturally do not have an adequate outlet ... this is why the woman would have a CS done even if she is innocent (Data: 1252.1). Another one may have children through CS up to three until they (doctors) sterilise her because of not having an adequate outlet (Data: 1252.2). ... she (woman) would not be having a way through which the babies can come out (Data: 1252.4) (TBA3).

Macrosomia

- At times it would be a big baby. This is why they (woman) would end up with CS because it would not be possible for them to push the baby out and then they (woman) would end up having been operated because the baby would be too big, just that and nothing bad (Data: 1252.4.1) (TBA3).
-

In data display 69 informants gave plausible evidence of the reasons of CS. Malpresentation (Data: 1195) (TBA2) was pointed out by the informants as one of the reasons for CS.

In summary, malpresentation, an inadequate pelvis and macrosomia were the major reasons for CS highlighted by the informants. The reasons for CS given by the informants are in line with the scientific ones (Sellers 2009:1569; Fraser et al 2010:614)

6.4.2.3 Category 2.3: Referral to medical facilities

There seems to be a divide between traditional medicine and practice and western medicine and practice, and the acknowledgement of the latter, within the Zimbabwean Ndebele culture, when it comes to pregnancy and both natural and unnatural birthing. This is further evidenced by the fact that there does not seem to

be a structured referral system between traditional healers and TBAs of pregnant women or women in labour. The movement of women from cultural and traditional care to health care centres is by chance or happens under duress only when there is a life-threatening problem or labour complication on which traditional medicine seems to have no effect. Data display 70 contains evidence in this regard.

DATA DISPLAY 70

THEME 2: The practice of TBAs

CATEGORY 2.3: Cultural medical referral

- ..if that (taking traditional medicines) fails, Ah! We (TBAs) refer to the whites for further management, because we (TBAs) cannot manage to open the woman up. We do not know anything about that; what we know is that when the head is stuck, is to take a razor blade and make a small cut (Data: 1214.1). Then it is better to call for transport to take the mother to the clinic or to hospital if all efforts of making baby turn fail (Data: 1220) (TBA1).
 - We (TBAs) take the woman to hospital because she might die and what would happen to the baby; because the baby will not come out. The doctors will do a CS. Yes, the woman should be operated upon (Data: 1222) (TBA4).
-

With regard to seeking health care from health care institutions or from doctors, it appears that this was not done regularly. In most instances TBAs would refer women in labour to get rid of the risk of a maternal or neonatal death when a serious problem arises (Data: 1222) (TBA4). What seems to emerge from the evidence given by the informants is that; given a choice; there would never be a woman who seeks health care from a health care centre, but fear of loss of the woman and/or her baby is what pressurises TBAs to refer the mother to a health care centre.

In the preceding discussion it is apparent that cultural interventions do not have provision for a clear and transparent referral system to medical facilities when labour complications occur during a delivery. Referral of clients appears to be done for personal protection of TBAs and not for the welfare of the client as evidence in Data display 70. Other studies done also reveal that although traditional medicine has widely been accepted as an African bioscience (although not understood) an apparent limitation of traditional medicine is that it has no definite referral system; for example, TBAs who may be able to identify a labour complication refer their clients to *sangomas* (traditional healers) for cultural interventions. Evidence given by the

informants indicates that there is no definite referral system used by the *sangomas* (traditional healers) and TBAs to refer women who develop complications during pregnancy and birthing other than referring clients with complications among each other; between *sangomas* (traditional healers) and TBAs.

In a study done by Mathole et al in Zimbabwe, a TBA from the apostolic faith described a referral system within the faith healing system as quoted below:

“Ah, for us who do not have spiritual gifts, if we are told that a woman has a complication, I tell her to go to other TBAs who have the powers, who can prophesy or are spiritually gifted to deal with that specific type of complication (TBAG4)” (Mathole et al 2005:944).

It is apparent that the type of referral system that the TBAs use interferes with the referral that the TBAs are supposed to make to health care centres (Janowitz et al 1985:745; Benrgstrom 1990 cited in Chalo, Salihu, Nabukera & Zirabamuzaale 2005:554; Mathole et al 2005:943-944).

Studies done reveal that appropriate management of pregnancies and deliveries as well as referral to competent health care centres is key in reducing the high burden of maternal mortality in the resource limited nations of Africa; a component which has been found missing in the practice of traditional medicine. Chalo, Salihu, Nabureka and Zirabamuzaale (2005:554) profess that a critical factor in reducing maternal mortality is access to a first referral level of care (referral to health care institutions). Kwast 1996 cited in Chalo et al (2005; 554), points out that for a variety of reasons in most settings of rural Africa, the TBA is the first level of care for pregnant women. Since most studies have focused on the rather poor and inadequate skills of the TBA efforts, efforts need to be made to equip TBAs with life-saving skills through training programmes (Chalo et al 2005:554).

The literature review also reveals that women do not seek health care services from health care centres for fear of CS being performed on them which culminates to fear of dying during CS. Another factor that affects referral is the willingness of clients including their relatives to be referred as some refuse referral and accept whatever

outcome of the pregnancy and the birthing process as divine as long as they are attended to by TBAs (Mathole et al 2005:950; Azikeni et al 2007:46; Chigbu & Iloabachie 2007:1263; Abodunrin, Akande, Musa & Aderibigbe 2010:79; Saravanan 2010:94; Mathole et al 2005: 939; Janowitz et al 1985:748).

While addressing issues that hamper referral of mothers with complicated labour by TBAs it should be noted that in most countries in Africa; Zimbabwe included, most TBAs are the older women in the community who are illiterate. Thus the level of education of TBAs needs to be enhanced for them to be able to handle issues of effective communication centres and computing maternal and perinatal mortality rates which is often very difficult because of insufficient data available as TBAs are not capable of recording statistics. Studies done reveal that younger TBAs and those with higher educational level are more likely to refer clients with high risk and complicated pregnancies as they are likely to have some education which could help them to better understand the risk factors during pregnancy and complications of labour particularly where training of TBAs has been done considering that being literate is an obvious determining factor of understanding instructions and cultivating a more positive perception of possible complications (Chalo et al 2005:554; Abodunrin et al 2010:79).

However, it is important to note that the fact that the TBAs are trained does not mean that their practise is without challenges. A study done in Uganda in Buikwe County, Mukono District revealed lack of transport and long distance presents a major challenge to both the trained TBAs and the referral process in transferring difficult obstetric cases to a higher level of care. Nonetheless; in this case, issues of lack of transport can be addressed through provision of other modes of transport such as motorcycles, bicycles and sometimes wheel barrows and scotch carts in the remotest of areas of Africa (Chalo et al 2005:554, 556).

However, as has been pointed out earlier in this study, the services of the TBAs do face some challenges; a particularly challenge is that of formal training on matters of pregnancy and birthing and lack of capacity to recognise danger signs during pregnancy and birthing. WHO 1997; Sibley et al 2004 cited in (Izugbara, Ezeh & Fotso 2008:36) in a study carried out in Kenya revealed that 53 million women South

Kenya give birth at home annually assisted by TBAs most of whom do not even have the skills to recognise, manage and prevent related complications a situation which could compromise birth outcomes and contributes to increased mortality and morbidity rates of mothers and their newborns. Another challenge expressed in the same study is lack of critical knowledge about pregnancy and related matters. Trained TBAs expressed facing challenges of humiliation and being called names by nurses and doctors while escorting their clients to hospitals. TBAS have suffered disrespect and non-cooperation from health care providers who were responsible for the demonising of TBAs in the eyes of the public as well as for putting their good work to disrepute (Izugbaraet 2008:38, 42).

Considering the above discussion it calls for some intervention to relieve the TBAs of the frustration they get from the challenges they face. Training programmes should be initiated and/or accelerated in those African countries that have already initiated them, Zimbabwe included. The objective of the training is to enhance and strengthen the knowledge and skills (indigenous or formal) that the TBAs have on pregnancy, childbirth and for them to be able to identify the risk factors and complications that may arise and refer their clients using the appropriate criteria that they would have been taught. Health care providers need to be oriented on the services of the TBAs and be encouraged to appreciate them as stakeholders in the provision of maternity services in a social organisation (NACD& ORC Macro cited in Izugbara 2008:38).

4.6.3 THEME 3: Acceptability of CS

Evidence given by informants in this section show that there has been some variation in as far as acceptability or non-acceptability of CS is concerned, and these are dependent on the achievability of a natural childbirth (Azikeni et al 2007:46). Data display 71 contains evidence in this regard.

DATA DISPLAY 71
THEME 3: Acceptability of CS

Thesis

- Culturally, it (alternative modes of birthing) is not acceptable, (Data: 1234) (TBA2).

Anti thesis

- Having a (CS) done is sometimes not good because at times one might die. It could be the mother dying or the foetus if the delivery delays. Baby can die inside the mother's womb (Data: 1250.1) (TBA3).
- ... but if the woman is not operated upon, she would die and the baby also would die and two souls would be lost. This is why we end up taking the woman to hospital maybe the mother might die, but baby may survive or vice-versa (Data: 1234.1). ... because they (doctors) have many alternative ways of getting the woman to deliver (Data: 1234.2) (TBA2).

Synthesis

- The only important thing is that the woman would be a child bearing woman, but ... (Data: 1252.3) (TBA3).
 - Yes, it (*Fulatha*) becomes the name of that baby. All the other children will call this one *Fulatha*; it (the name) would have started at the time of birth. Maybe the (TBAs) will not have noticed that this baby is presenting with feet first, but ... (Data: 1197) (TBA2).
-

What seems to emerge from the evidence given by the informants is that it appears that if the Zimbabwean Ndebele society had a choice there would be no CS performed on women whatsoever. Evidence given by the informants again suggested that CS was culturally unacceptable (Data: 1234) (TBA2). However; the fear of losing the mother and/or baby seemed to lead TBAs and society to accept CS (Data: 1234.1) (TBA2).

4.6.4 Conclusion

TBAs interviewed were able to demonstrate their knowledge, experience and skills that related to the role they played in society as TBAs. They worked hand in hand with the *Sangomas* (traditional healers) in the use and administration of herbal and traditional medicines to enhance natural birthing and prevent CS.

CHAPTER 5

RELATING THE FINDINGS TO EXISTING THEORY PARSE'S THEORY OF HUMANBECOMING

5.1 INTRODUCTION

In addition to the thematic analysis and presentation of data in the previous chapter the current chapter serves as a follow-up on that analysis – a further interpretation of the data. In the current chapter, the analysis and interpretation of the data are presented at a more theoretical level. Whereas in the previous chapter it was not the general idea, in line with Jackson and Mazzei (2012:Loc124), the current chapter aims at the “inclusion of previously unthought-of [sic] data” (Jackson & Mazzei 2012:Loc124). In the same vein, it is the researcher’s intention to also “get out of the representational trap of trying to figure out what the participants in our [my] study “mean,” and helps us [me] avoid being seduced by the desire to create a coherent and interesting narrative that is bound by themes and patterns” (Jackson & Mazzei 2012:Loc124). Despite the almost “apparentness” of the findings presented in the previous chapter, the researcher also realised that that exercise, in addition to what the researcher have disclosed in her reflexivity report (see chapter 3), greatly assisted her in arriving at the current point in her research.

The themes and categories arrived at during the previous phase of data analysis, although a necessary process for her to have gone through, did not yield much “new” information. As Jackson and Mazzei (2012:Loc662) indicate, “Coding takes us back to what is known, not only to the experiences of our participants, but also to our own experience ...” Naturally, had the researcher been *au fait* with the theory presented in this chapter prior to thematic analysis was done and reported on in chapter 4, that knowledge might also have slipped into her thematic analysis.

Jackson and Mazzei’s (2012) general approach of “thinking with theory” put the researcher on her way. The analysis and presentation of data that follows might be

considered a hybrid between the work of these authors and that of using a framework approach (Smith & Firth 2011) for qualitative data gathering and analysis. The researcher's analysis is in between the *macro* arrived at via thematic analysis and the *micro* produced by the approach suggested by Jackson and Mazzei (2012:Loc680). By not merely relating the findings from the thematic analysis to existing literature, but interpreting these findings in terms of theoretical constructs the researcher tried to fold the texts (data and theory) onto one another as proposed by Jackson and Mazzei (2012:Loc680). With regard to the latter, as far as the researcher's insight allowed her, in the presentation of each of the principles of the Theory of Humanbecoming (THB), she reflected on paradoxes she had encountered during the research as well as paradoxes, as defined by Parse.

It is however not possible to mention or discuss all the possible incidences in the data that can be related to, or discussed in terms of Parse's Theory of Humanbecoming. This chapter focuses mostly on the mothers, however, where the situation warrants it, reference to TBAs, sangomas, spouses and elders is made. Quotations from the evidence (data) in chapter 4 are also sparingly used to avoid unnecessary repetition of information. The researcher also needs to point out that in her understanding and interpretation of the paradoxes contained in the THB, these are lived all at once relating to different issues composing an individual's existence at any moment in time. This is most intricate and more is probably concealed than revealed as far as these paradoxes are concerned. Consequently, due to the intricate nature of an all-at-once living of paradoxes and the fact that not all can be revealed, instead of looking at one of the major findings in chapter 4 and interpreting it in terms of the whole of the THB, the researcher opted for fragmentation, of illustrating different paradoxes by different "categories" from chapter 4.

5.2 PARSE'S THEORY OF HUMANBECOMING (THB)¹

The researcher is aware of the research methodology pertinent to Parse's theory. However, at the onset of the current research it was not the intention to actually work

¹ The simultaneity paradigm from which Parse's later work stems requires that certain nouns and verbs end with "*-ing*" indicating the present continuous tense and the continuity captured by these words. In addition her coining of the single word terminology *humanbecoming* and *humanuniverse* characterises the concept of "indivisibility" which is also fundamental to the Theory of Human Becoming (Parse 2010:Loc5389). The word *humanbecoming* is used throughout this chapter regardless of syntax except for the name of the theory: *Theory of Human Becoming*.

according to Parse's 'humanbecoming, school of thought. The qualitative design and methods used during the current study is in the researchers' opinion compatible with those proposed by Parse as it is also reflective of an existential phenomenological and hermeneutic phenomenological underpinning (see chapter 3).

5.2.1 Reasons for having chosen the THB

It is the paradoxical "life space" (the researcher's interpretation) accompanying each of the principles of the THB that initially drew the researcher to Parse's theory. Parse (Parse in Parker & Smith 2010:Loc5404) defines the concept of paradox and paradoxical by pointing out that it does not imply opposites or problems to be solved, but rather the ways humans live their lives – rhythms lived all-at-once. Having analysed the data in chapter 4 (as the researcher did) the "paradox" created by western medicine coming into contact with traditional medicine (and vice versa) became more apparent to her. Each on its own seems "solid" however becoming aware of both could create a paradoxical space one has to live in. The researcher can only corroborate what Alligood and Marriner Tomey (2006:436) state; that the theory at first glance appeared familiar, simplistic and clear; all perceptions the researcher held at the very beginning. However, on deeper study and in relating the research findings to this theory it became, at that time at least, unfamiliar, complex and obscure. So even in this the researcher experienced a shifting *paradox* of hope-despair, simplicity-complexity, and understanding-confusion – what Alligood and Marriner Tomey (2006:436) refer to as "familiar-yet-unfamiliar, simplistic-yet-complex, and clear-yet-obscure".

In addition to the paradox created by the confluence of two cultural knowledge systems, that fits the paradoxical nature of humanbecoming proposed by the theory, it is also its move away from the medical model proposed by the THB, that attracted the researcher's attention. The complete *unlikeness* of the theory in comparison to the medical model (and other nursing theories) also intrigued the researcher and the THB seemed a good way in which to explore this further. As one of the fundamental tenets of the THB points out, "health is a synthesis of values and a personal commitment to be the person one wants to be. Persons are free to choose meaning and significance of events ... to choose their attitude, their concerns ... their hopes

and dreams ... Human dignity links up with choice and with having one's value priorities respected by others" (Alligood & Marriner Tomey 2006:437). This leaves the researcher with the distinct appreciation of cultural values other than the medical model; however, the paradoxical counterpoint is that it leaves the researcher with great concern about the value choices open to, and the freedom of choice available to indigenously oriented individuals, especially women, coming into contact with western medicine and the accompanying medical model. The researcher's position in this regard became further intricate by realising that according to the THB, "health cannot be given or taken, controlled or manipulated, judged, or diagnosed. Health is the way persons live their values in ways consistent with their desires, hopes, and dreams" (Alligood & Marriner Tomey 2006:437), and Parse's further statement that "Personal health may be changed as commitment is changed, which "include[s] creative imaging, affirming self, and spontaneous glimpsing of the paradoxical" (Parse 1990:138 cited in Alligood & Marriner Tomey 2010:154). So, the researcher refrain from judging although the researcher's compassion and sympathy for the traditionally oriented Ndebele woman might be considered as such.

5.2.2 Brief overview of the THB

"Humanbecoming emanates from the simultaneity paradigm and is a basic human science that has co-created human experiences as a central focus" (Parse Parse in Parker & Smith 2010:Loc5381). The theory consists of three overarching themes namely: meaning, rhythmicity, and transcendence (Cody 2012:8; Fawcett 2001:126; Alligood & Marriner Tomey 2010:507-510). These overarching themes are each defined by three specific principles, each containing accompanying paradoxical processes. Table 5.1 exhibits a schematic overview of the structure of the THB as applied in the current research.

TABLE 5.1: LAYOUT OF THE MAIN MOMENTS IN PARSE'S THEORY OF HUMANBECOMING			
Principles and overarching concepts	Overarching themes	Concepts	Paradoxical processes
1) "Structuring meaning multidimensionally is cocreating reality through the languaging of valuing and imaging"	Meaning	Imagining	Explicit-tacit Reflective-pre-reflective
		Valuing	Confirming-non-confirming
		Languaging	Speaking-being silent Moving- being still
2 "Cocreating rhythmical patterns of relating and living the paradoxical unity of revealing-concealing and enabling-limiting while connecting separating"	Rhythmicity	Disclosure	Revealing-concealing
		Choice	Enabling-limiting
		Being connected	Connecting-separating
3 "Cotranscending with the possible is powering unique ways of originating in the process of transforming"	Transcendence	Powering	Pushing-resisting
		Originating	Conformity-nonconformity
		Transforming	Familiar-unfamiliar

(Adapted from Alligood & Marriner Tomey 2006, 2010; Cody 2012)

5.2.3 Assumptions underlying humanbecoming

With the development and evolvement of the THB, Parse condensed the original nine (9) assumptions to three assumptions pertinent to humanbecoming (Hickman 2002:432; Parse 2012:81). These, to the researcher, clearly reflect the existential phenomenological and simultaneity grounding of the THB. These assumptions also form the principles of the THB as indicated in table 5.1

5.2.4 The principles of the THB

The paradoxical processes inherent in living human life as expounded by the THB, are unique to the THB (Alligood & Marriner Tomey 2006:438; Parse in Parse in Parker & Smith 2010:Loc5404) among nursing theories. Three principles which are value-based illustrate rhythmicity through paradoxical processes allowing for such rhythmicity. It is also these principles and paradoxes that initially drew the researcher towards acquainting myself further with the THB. Rhythmicity refers to human beings creating patterns during day-to-day living reflecting personal meanings and values.

In these, both freedom and choice are available to the complex engagements and disengagement among people and between people, things, ideas and preferences. It is the researcher's understanding that, the Ndebele culture's interface with western medicine creates a paradox allowing exactly for infinite options regarding engagement and disengagement with ideas, preferences, prescriptions and the like.

5.2.4.1 Principle 1: “Structuring meaning multidimensionally is cocreating reality through the languaging of valuing and imaging”

Alligood and Marriner Tomey (2010:507) rephrase this principle as persons choosing the meaning their realities have for them. Meaning is either explicit or tacit. The image one has of reality one co-creates with others. This is evident from the current research as many categories arrived at in chapter 4, relating to the Ndebele's perception on alternative birthing and cultural values and mores surrounding pregnancy and child birth, surfaced in the analysis of interviews with mothers, spouses, sangomas, TBAs and elders. Although the realities that can be created are boundless or unlimited, it sometimes appears that sangomas, elders and TBAs would want to limit these realities of pregnancy and childbearing to the options allowed for by the indigenous Ndebele culture and not that of western medicine. The way in which people “language” (to imagine, talk about, communicate and express in terms of language or other symbolic actions with the same interpretive value among people), their realities also indicate their values regarding that specific reality or part of reality. Attributing meaning and deriving meaning are central to this principle and “structuring meaning multidimensionally” and are what humans do (Alligood & Marriner Tomey 2006:439). Such meaning attribution and derivation is an evolving process (a rhythm) that encompasses both the explicit and the tacit (Alligood & Marriner Tomey 2006:329; Parse 2012:82); that which has been reflected upon and that which is a pre-reflective presence in the individual's perceptual and awareness field.

The three concepts of imaging, valuing and languaging, contained in this principle were the entry point for interpreting the findings in terms of the THB. In the discussion, the researcher sometimes returns to these concepts to explain concepts related to the other two principles of the theory (THB).

5.2.4.1.1 *Imaging*

Imaging represents individuals' views of reality. Such views imply knowledge and knowing which can be overt or reflective, blended in one's mind and awareness, or it can be tacit or pre-reflective in which instance it resides in the unconscious (Alligood & Marriner Tomey 2010:507). The latter is "not yet thought of however lurking" in one's awareness or understanding. To know "why" some things are the way they are is sometimes not possible as the lives we live hold mystery to ourselves. "We cannot everything" so to speak, and least of all, "all-at-once". Nonetheless, all of the paradoxes and their associated concepts as identified by the THB might occur in an all-at-once fashion. Imaging is brought about by persons accepting and rejecting values, beliefs and practices congruent with their dominant world view. This comes about through "questioning, speaking about what things mean, exploring personal views, picturing cherished possibilities and comparing options and alternative views" (Alligood & Marriner Tomey 2006:439).

- **Imaging as reflected in the data and findings**

From the analyses of data in chapter 4 it is apparent that all the different population subgroups – mothers, elders, sangomas and TBA's – contributed to structuring meaning multidimensionally and they co-created a reality around birthing through languaging reflecting different imagings. An explicit or reflective image of unnatural birthing as well as what should and should not be done during pregnancy and childbearing was given. In the event of "imaging" unnatural childbirth as acceptable, an alternative value was placed upon birthing. However, this was done with certain reservations indicating that there are other values related to birthing, namely natural birthing, and contexts, such as at home where cultural practices can be performed, values are more esteemed. Even mothers, who had given birth alternatively or abnormally, imagined this as they "language" that they did not meet with the standards or values set by the Ndebele society in this regard. For instance, one woman said:

“It is embarrassing for an adult woman to fail to push the baby out. It was embarrassing because I wondered what people were saying” (Data: 325.2.1) (F1WFD)

Some sangomas indicated pertinently that unnatural birthing is totally unacceptable to them (Data display 46). Elders, as the protectors of tradition (see summary in figure 4.5) also “imagined” a reflective or explicit cultural view on birthing and pregnancy; reflectively and explicitly imagined and languaged, as cultural do’s and don’ts, stemming from superstition, traditional medicine and traditional birthing practices. Natural birthing, to them too is the only truly acceptable (reflected/explicit) imaging of the reality of birthing. The analysis of data, as indicated in figure 4.4, also implies a shift in the reflective and explicit imaging of birthing, a shift toward the tacit and pre-reflective. Changing circumstances might inevitably require CS. With regard to an individual pregnant women, CS could be seen as up to the moment that the TBA realises that medical assistance is needed, as tacit or pre-reflective imaging. When the tacit and pre-reflective reality of unnatural birthing become reflective and explicit for mothers, a new paradox is created, namely that of having to choose (reflecting and making explicit) the possibilities of motherhood or womanhood and no longer the original expectation of motherhood and womanhood. The previously unimagined “not womanhood” (as tacit and pre-reflective at the most) now becomes a true possibility and in the end an eventuality.

In the research findings, mothers have an image of themselves as having achieved motherhood through alternative (CS) modes of birthing, however have failed in gaining womanhood a cherished value in the Zimbabwean Ndebele culture. The paradoxical process is that the mothers accept motherhood through alternative modes of child birth, and have to live with the loss of womanhood. As one mother (woman) said:

“I also wanted to go through that experience so that I know what it is like to push a baby being a woman, because you also want to be a perfect woman” (Data: 272) (E1WCS).

5.2.4.1.2 Valuing

Valuing refers to choosing and embracing what is important. It reflects choices and help shape unique patterns of humanbecoming, living and being. New values are blended in with existing values. The paradox of valuing is confirming-nonconfirming. According to Allgood and Marriner Tomey (2010:507), this concept relates to how the individual sanctions or do not sanction beliefs, including cultural beliefs, in the light of one's own perspective or worldview. Negotiating the paradoxical opportunities of confirming-nonconfirming is a continuous process of choosing among and rejecting some beliefs or traditions relating to how one should think, feel, act and the like. In this process one might be either stable or one might suddenly make radically different choices, either of confirming or nonconfirming (rejecting) beliefs and traditions – as is the case with CS.

- **Valuing as reflected by the data and findings**

What is apparent from the findings of the research is that all spheres of the Ndebele society, mothers, spouses, sangomas, TBAs and elders, valued natural birthing, with some variation in the motive for their valuing. Women value motherhood through natural birthing which would also bestow upon them womanhood. Apart from carrying on certain traditional values and beliefs, sangomas and TBAs seem to value traditional birthing both from a magico-religious worldview and from a financial gain point of view. Elders appeared to be more, authentic in their promoting of natural birthing as, together with pregnancy, an event of immense cultural significance. The only person that seems to transgress (nonconforming to) the value of natural birthing is the woman undergoing a CS (whether by free choice or by necessity) or the one giving birth in some other unnatural way.

With regard to valuing and conforming-nonconforming as these relate to pregnancy and child birth, another *paradox* of ironic proportion that struck the researcher is that of “dictating values” and “living out values”. In the Ndebele society, as is the case with most African societies characterised by male dominance, “dictating” values and guarding tradition are mostly done by men (and in some cases woman such as TBAs and female traditional healers). The value of natural birthing is traditionally

“enforced” by loading it with additional values that can, in the case of failing the first value (natural birthing) be used to sanction woman who fails to give birth naturally. These are motherhood and womanhood; both highly appreciated traditional values. The irony is that these values are forced, and thereby conforming, mostly by men who will never fall pregnant themselves and who cannot imagine being in a situation to have to choose between, life, social sanctioning and death; death whether socially or physically. Non-conforming as far as natural birthing is concerned seems still to be severely sanctioned in the Ndebele traditional society.

- **Valuing of the researcher**

By virtue of the researcher belonging to the Zimbabwean Ndebele society, the researcher was oriented to the same cultural and traditional beliefs as the participants, but her westernised nurse training changed the researcher’s worldview as she now see things differently because she is now enlightened by the scientific knowledge of the nursing profession and her Christian conviction. This value laden realisation dawned on the researcher only once she started analysing the data. This realisation was strengthened while reflecting on Parse’s theory and the presentation of findings in terms of the THB. This in turn kindled the researcher’s reflection as required by qualitative research for researchers as the main instrument. Because the THB defines that which is paradoxical not as opposites or problems to be solved, but rather ways in which humans live their lives, the researcher had to be pertinently on guard not to view that which no longer appealed to her as opposing her convictions and values, or as becoming a problem that she has to solve via her research. This, during the analysis of data as presented in chapter 4 compelled her to place limits on her “interpretation” and categorisation of the data.

5.2.4.1.3 Languaging

Languaging involves the ways in which persons are in the world in relationships with self and others (Alligood & Mariner Tomey 2006:439). Languaging is founded on the paradoxical processes of speaking- being-silent and moving-being-still.

Alligood and Marriner Tomey (2010:507-8) further point out that “Languaging is a concept that relates to how humans symbolize and express their imaged realities and their value priorities”. Languaging is reflected by what we say, even in our silences. Lanuaging, like communication, is an ever-present human action as we “disclose something about ourselves even when we are silent and remain still”. While we can observe the languaging of others, we still cannot know exactly the meaning of that languaging. One needs to ask people about what their words and gestures means. This is especially true where different cultures come into contact with one another as well as in conducting qualitative research.

- **Languaging as reflected by the data and findings**

Languaging as reflected by the data is not so much a current research finding as a well-documented issue in the literature. Furthermore, it should be noted that cultural and traditional practices in most African countries, Zimbabwe included, are generally rooted in cultural discrimination against women; a typical example is that of child birth where serious discriminatory and oppressive cultural restrictive practices are performed (WHO 2008 cited in Mubangizi 2012:34; Culture vs. Human rights ... 2010).

The mothers verbalised their humanbecoming by languaging as they shared their lived experiences with the researcher , what it means to them to give birth through alternative modes of child birth. In their dialogue, they expressed their image of womanhood, motherhood and how they view themselves in society after having given birth unnaturally. One woman expressed this concern about themselves:

“I feel as if I have lost dignity as a woman who is not able to bear children at the time of pushing” (Data: 327.1) (F1WFD).

The meaning of their lived experiences was expressed in language through dialogue during the interviews and sometimes body language was observed in the form of laughter, crying or shrugging shoulders or approving nods. Through language, the mothers expressed, their values, their knowledge both explicit and tacit as they moved towards humanbecoming.

- **Languaging of the researcher**

In dialoguing with the participants the researcher used the local language “isiNdebele” so that the words would be understood to mean what they were intended to mean. The researcher spent a lot of time with participant so that she could have the opportunity to probe, explain and clarify issues and reflect, as these were in-depth face-to-face interviews to extract detailed information. Dialogue with the mothers was the mode of extracting data from the participants, observations for non-verbal information was also a mode of communication to accommodate the “speaking-being silent (Parse 2012:83).

5.2.4.2 Principle 2: “[Co]creating rhythmical patterns of relating and living the paradoxical unity of revealing-concealing and enabling-limiting while connecting-separating”

The paradoxical processes for this principle are: revealing-concealing, enabling-limiting and connecting-separating. Whereas the theme for the first principle was meaning, the theme of this second principle is rhythm and rhythmicity. A view of rhythmicity prevents one from viewing these paradoxes as mutually exclusive as they allow free movement and choice with the process, a degree of both ever present in the process of human becoming. This also involves persons expressing opposing viewpoints about situations; like contradicting themselves to an observer.

5.2.4.2.1 Revealing-concealing

This paradox involves a way in which persons disclose or do not disclose meaning, thoughts, feelings, values, concerns, hope and the like. Revealing and concealing occur all at once in what persons say, their actions and choices. What is revealed and concealed depends on context and circumstance. This implies that persons are not ever fully revealed – there is always more to be said than said. Revealing-concealing is the way people disclose and keep hidden (all-at-once) the person they are becoming. There is always more to tell and more to know about ourselves and others. It is not always possible to convey messages very clear and often one says what one did not intend to say. Some aspects of reality and experience remain

concealed. The way in which we disclose or not-disclose also depend on the people we are with or towards whom we disclose/not-disclose. (Allgood & Marriner Tomey 2010:508). The issue of revealing-concealing is of the utmost importance in data collection and data analysis in qualitative research as nothing can ever be fully understood.

- **Revealing-concealing as reflected by the data and findings**

The way in which mothers/women “reveal-conceal” or “disclose or not-disclose to TBAs and sangomas the allegedly committed infidelity or adultery, the reason for complicated birthing creates a double paradox. Culture dictates conviction of the fact that infidelity occurred in the case of obstructed or complicated birthing. In revealing concealing or disclosing not-disclosing infidelity when it did not actually occurred the outcome is the same: guilt.

- **Revealing-concealing of the researcher**

The research setting allowed interviewees to reveal their lived experiences and what the experiences mean to them. Interviews were conducted privately in the mothers’ usual settings at a venue of their choice to encourage the participants to reveal most of their views and talk freely of their experiences although revealing-concealing is the process in languaging as people only reveal that which they want to reveal. Although the interviews were conducted in privacy and the ethical issues of confidentiality considered, the fact that the interviews were audio-taped could have caused some suspicions with the participants revealing information selectively and concealing what they did not wish the researcher to know about in their lived experiences including their encounters with the *sangomas* (traditional healers), community elders and the TBAs. In her research the paradox of revealing-concealing was evidenced by the fact that during data collection some mothers were not comfortable with the fact that their interviews were going to be audio-taped, which resulted in the construction of a semi-structured interview schedule (see appendix B).

It took a guided interview (see chapter 3) with the supervisor, prompting the researcher about certain aspects relating to her becoming to reveal what she has previously concealed. One of the main revelations to her was her openness about having adopted a Western oriented stance towards health and illness (see chapter 3), an openness that also allowed her to propose recommendations in line with that orientation; with the caution from Parse “that health cannot be taken or given to any person”. In addition, revealing her previous concealed pride taken in being Ndebele, allowed the researcher to acknowledge that despite her Westernisation, she is still proudly Ndebele. This experience lifted a feeling of “burden” and set her free to turn from the felt “objective” representation of data and findings and to stay with these (chapter 4) to a more involved and interpretive and interpreted presentation in terms of Parse’s THB. This created the researcher’s own paradoxical rhythm,

5.2.4.2.2 Enabling-limiting

Enabling-limiting relates to the inherent opportunities and limitations or restrictions created by personal choices; it relates to consequence and discovery (Parse in Parse in Parker & Smith 2010:Loc5412). These come about with our everyday living, our choices all have potential and restrictions (Alligood & Marriner Tomey 2010:508). All choices and decisions have a myriad of possibilities of consequences which are not all revealed to the individual at the time of making a choice. Alligood and Marriner Tomey (2010:508) point out the ambiguity of reality in this regard - ambiguity that primarily resides in the paradoxical life space in which we find ourselves in; the very “thing” that allows and demands choices and at the same time offers further ambiguity. Although each choice offers certain enabling potential it also holds restricting limitations (Alligood & Marriner Tomey 2010:509).

- **Enabling-limiting as reflected by the data and findings**

To take up on the example in the previous section, disclosing/not-disclosing and revealing/concealing infidelity create yet a new paradox, namely that of enabling-limiting. Should the woman decide not to disclose, it might enable her to maintain her self-worth and self-respect. However, it might also limit her future role in society resulting from sanctioning on the part of society at large for her “infidelity”. Analysing

and interpreting the situation of a woman bound for CS according to the data available and the guidance of the THB, really opens up a deeper involvement, consideration and understanding of these women's experiences. Enabling-limiting relates to the inherent opportunities and limitations created by personal choices; to consequence and discovery (Alligood & Marriner Tomey 2006:440).

Many cultural beliefs restrict Zimbabwean Ndebele women particularly during pregnancy and preparation for birthing under the pretext of promoting natural birthing (see section 4.7.1.1 Data display 86 on "Dos and Don'ts" of cultural restrictions). The cultural belief is that the restrictions enable uncomplicated natural birthing and yet the perspective of the medical model of care (in which the researcher, believes) is that cultural restrictions limit the power of women's health seeking behaviours. The findings of the research also reveal that although the cultural belief in the Zimbabwean Ndebele society is that CS enables motherhood it limits womanhood.

5.2.4.2.3 Connecting-separating

The main theme in this paradox is the way in which persons can be with others while at the same time being separated from them or being together without being in the same location. This connecting-separating also relates to the ways people are with projects and ideas. The principle of being connected links to the paradoxes of connecting-separating and attending-distancing. It patterns the way in which people relate to others, whether in communion or keeping to ourselves. In this regard Alligood and Marriner Tomey (2010:509) indicate that the way in which we connect or separate ourselves from others, things, ideas and the like is indicative of certain value priorities. Alligood and Marriner Tomey (2010:509) cite Bourne (2000) who states that "sometimes there is connecting when people are separated because people can dwell with an absence of presence with great intimacy, such as when grieving for others". The way in which the Ndebele treats stillbirth and women who died during complicated birthing is exemplar hereof.

In the researcher's interpretation, as a westernised Ndebele, connecting fully to the Ndebele community at large can only happen once the community at large has structured meaning around complicated and obstructed birth from a western science

(anatomical and pathophysiological) point of view. Imaging inspired by an understanding of anatomy, and valuing of the human body and medical intervention as well as being able to “language” these seem the only way within the THB that society or next of kin will be able to explicitly reflect on, confirming and speaking about, revealing, enabling and connecting, thus accepting medical reasons, for CS; thereby creating a “new” rhythm and rhythmicity.

- **Connecting-separating as reflected by the data and findings**

As a researcher, who is Ndebele; the researcher is connected to the culture and traditional beliefs of the Zimbabwean Ndebele society but her Western training, knowledge and Christian beliefs have separated her from what the Zimbabwean Ndebele believe in relation to pregnancy and child birth and her worldview is now different which is the paradox she has experienced in her ‘human becoming’.

5.2.4.3 Principle 3: “[Co]transcending with the possible is powering unique ways of originating in the process of transforming”

The principle brings forth ideas of change, struggle and transcendence. “It focuses on how human beings create themselves while moving with their hopes and dreams” (Alligood & Marriner Tomey 2006:441). The theme of this principle is transcendence and has the related concept of transformation (Alligood & Marriner Tomey 2006:441).

The overarching theme in this instance is transcendence which is also a cooperative human endeavour – cotranscendence. The associated principles are: powering, originating and transforming. Transcendence in terms of the THB refers to the “continuous change and unfolding in the lives of individuals as they engage with and choose from infinite possibilities of how to be, whom to relate to and what interests and concern to explore” (Alligood & Marriner Tomey 2010:509). Choices indicate the way in which a person is becoming through powering, originating and transforming.

5.2.4.3.1 *Powering*

Powering is central to the paradoxical process of pushing-resisting that propels persons through life – their becoming. To “power” implies risks. During the process of powering, conflict is imminent (Alligood & Marriner Tomey 2010:507), whether with others or in the privacy of one’s own thoughts in the way of conflicting ideas and opinions effecting change and growth in constant flux of pushing-resisting. As persons clarify their value priorities, they move on through powering.

Powering, as a concept, conveys meaning about struggle and life and the will to go on despite hardship and threat. Life in terms of powering entails, in addition to pushing-resisting, affirming-not affirming and being-nonbeing. According to Alligood and Marriner Tomey (2010:509), the paradoxes involved in powering are pushing-resisting, affirming-not affirming and being-non being. In terms of the THB, the individual constantly engages being and nonbeing. Whereas being indicates the assertion of self, nonbeing is about loss and the risk of death and rejection. Alligood and Marriner Tomey (2010:509) clearly define powering as “the force exerted, the pushing to act and live with purpose amid possibilities for affirming and hold what is cherished, while simultaneously living with loss and thread of nonbeing”. As all people power and push, there is ample likelihood for conflict. Such conflict, in the researcher’s understanding and interpretation, is in and of itself; within the sphere of human becoming; subjected to the principles contained in the THB; that is, open to meaning attribution, rhythmicity and an opportunity towards (co)transcendence, involving all the paradoxical processes contained in the THB. It is the researcher’s understanding that the substance of the THB as summarised in table 5.1, permeates each and every incident, moment and occurrence of one’s life whether reflectively or pre-reflectively.

- **Powering as reflected by the data and findings**

The mothers wanted to achieve motherhood and together with society were pushing for natural birthing, even taking the risks of using herbal prescriptions and cultural interventions to try and enhance natural birthing. It is in their valued beliefs that child birth should be natural. In this regard mothers/women indicated:

“You take the donkey’s placenta, and then you take that “quality” of giving birth fast from the donkey and transfer it to the person” (Data: 675) (A5CE).

“When she (woman) takes that placenta, as traditional medicine, she will also give birth fast” (Data: 675) (A5CE).

“It (*nyeluka*, some water snake) is dried and then stored like that so that when the woman goes into labour, it is soaked in water and warmed up then the woman drinks it from a cup and she just leaves the cup to drop at the threshold” (some ritual) (Data: 1185) (TBA3).

By so doing the cultural practices would be resisting alternative modes of child birth. This shows that both the mothers and society were in conflict between cherished values of natural birthing and resisting alternative modes of childbirth; a process that eventually moved the mothers through multidimensional experiences to achieving their hopes of motherhood (Hickman 2000:435).

- **Powering of the researcher**

My view of the paradoxical process of pushing-resisting is that while the Zimbabwean Ndebele society is pushing for power, for mothers to give birth naturally resisting the reality that sometimes complication of labour occurs and natural child birth is not possible.

5.2.4.3.2 *Originating*

Originating refers to the unique ways persons create their own becoming (Alligood & Marriner Tomey 2006:441). The paradoxical process of conformity-nonconformity is central to originating. While people strive to be like others they also strive to be unique and different from others. In this persons face both certainty and uncertainty as they move beyond the “now” (Alligood & Marriner Tomey 2006:441). “Originating is the unique choice a person makes when facing alternatives, and the consequences of choosing among alternatives. The concept of originating relates to human uniqueness as this is suspended by the paradoxes of conforming-not conforming and certainty-uncertainty. For some, there is greater danger to be too much like others; some may say the danger is in being different. Each person defines and lives originating in light of his or her worldview and values (Parse 1981

cited by Alligood & Marriner Tomey 2010:509). Humans craft their unique patterns of originating as they engage in possibilities of everyday life.

- **Originating as reflected by the data and findings**

Traditionally it is of utmost importance from women (mothers) to be like other mothers, having given birth naturally, and thereby having attained motherhood and womanhood. However, in the case of complicated labour, it would be dangerous to insist on being like other mothers; being rather than nonbeing. For those who, for whatever reason, have to have a CS, the choice to not be like others, can indeed lead to nonbeing, both socially, and in extreme case of death, nonbeing.

- **Originating of the researcher**

In the researcher's opinion, the cultural mix, a mix of Ndebele, Shona and Western culture has left individuals in Zimbabwe as a whole, even of cultural orientation, conforming to some cultural values while rejecting others. Individuals in such a mixed culture indeed find themselves at any moment in time both as being and nonbeing, even if only from the perception of others.

5.2.4.3.3 Transforming

This concept represents a process of "deliberately shifting one's patterns of health". This may include changing either or both one's attitude and one's everyday life habits. The paradoxical process involved is that of familiar-unfamiliar and is central to transforming. Transforming as such is about integrating unfamiliar ideas or activities into one's life where the unfamiliar is woven into the familiar becoming a coherent and lived experience.

The concept of transforming is explicated with the paradox of familiar-unfamiliar. It involves the continuous changing and shifting of views that people have about their lives. People always struggle to integrate the unfamiliar with the familiar. As new discoveries are made, people change their understanding and sometimes life

patterns and world views can shift with insights that illuminate a familiar situation in a new light. Transforming is the ongoing change reflective of human ingenuity as people find ways to change the direction of their cherished hopes and dreams (Parse 1981 cited in Alligood and Marriner Tome 2010:509).

- **Transform in relating to mother and the Ndebele society**

Transforming in the current traditional Ndebele culture reflects an urge to return to old conventions, traditional cultures, fundamental values and familiar, secure sense of identity in order to move away from the multicultural confusion and conflict in the process of adjusting to cultural pluralism (Ayton-Shenker Online. [s.a.]; Culture vs. Human rights ... 2010). This, in the light of the current research findings, probably holds little good for pregnant women and women who have to undergo CS. The transforming that the researcher as woman and westernised Ndebele would like to see is that of her people understanding complicated and obstructed birthing, not a superstitious “tying”, but for what it is scientifically; for ways to accommodate certain non-harmful traditional practices around CS.

5.3 CULTURAL RIGHTS VERSUS HUMAN RIGHTS

Within the general scope of the research topic and the research finding as explicated up to this point, a previously “tacit” gnawing additional paradox has become “explicit” to the researcher ; that of human rights versus cultural rights.

Human rights are defined as the natural-born rights for every human being, universally. The emphasis is that, human rights are not privileges. The United Nations Charter states that human rights are “for all without distinction” (Ayton-Shenker Online. [s.a.]; United Nations 1996 - preamble cited in Reichert 2006:24; Reichert 2006:27).

The concept of culture is defined in chapter 1. Every human being has a right to culture, including the right to enjoy and develop cultural life and identity. However, the right to culture is limited at the point at which it infringes on another human rights.

According to international law, no right can be used at the expense or destruction of another rights (Ayton-Shenker Online. [s.a.]; Culture vs. Human rights ... 2010).

5.3.1 Universalism vs cultural relativism

The two main concepts pertinent to human rights are universalism and cultural relativism.

- **Universalism**

The Universal Declaration of Human Rights stipulates that human rights include freedom of speech and religion, freedom of movement and assembly, guarantees against discrimination, slavery and torture. The Vienna Declaration affirms that “the universal nature of these rights and freedoms is beyond question” and that “all human rights are universal ...” (Vienna Declaration 1993 cited in Reichert 2006:28; United Nations 1948 cited in Reichert 2006:25).

- **Cultural relativism**

Cultural relativism refers to a view that all cultures are equal and universal values, such as human rights, become secondary when considering cultural norms. In cultural relativism all points of view are valid and any truth is relative to a specific culture. “Cultural relativism maintains that there is an irreducible diversity among cultures because each culture is a unique whole with parts so intertwined that none of them can be understood or evaluated without reference to other parts and to the cultural as a whole” (Lawson 1998 cited in Reichert 2006:29; Culture vs. Human rights ... 2010). However, as indicated previously, the right to culture and the emphasis on cultural relativism are limited at the point at which it infringes on another human right. According to the international law, no right can be used at the expense or destruction of another rights (Ayton-Shenker Online. [s.a.]; Culture vs. Human rights ... 2010). This statement is of importance as cultural relativism is often used as an excuse to violate or to deny human rights and to abuse culture rights. With regard to the latter, cultural rights do not justify torture, murder, genocide,

discrimination on grounds of sex race, language or religion or any of the universal human rights (Ayton-Shenker Online. [s.a.]; Culture vs. Human rights ... 2010). Regrettably, cultural and traditional practices in most African countries, Zimbabwe included, foster several forms of discrimination, especially against women; a typical example is that of child birth where serious discriminatory and oppressive cultural restrictive practices are performed (WHO 2008 cited in Mubangizi 2012:34; Culture vs. Human rights ... 2010). This is also echoed by the current research findings.

- **Human rights vs cultural rights**

Cultural relativists argue that cultural relativism more often than not includes or asserts that traditional culture is sufficient to protect human rights and as such deems human rights unnecessary. Human rights and cultural right thus become a “paradox”. Interestingly, both cultural rights and human rights seem to have the same principles of human dignity, indivisibility, interdependence at heart and both apparently do not allow “discrimination” (Cultural rights ... 2007; Reichert 2006:33-34). However, some cultural and traditional practices do violate human rights. In a situation of violation of human rights the violations are covered up as cultural rights or norms (Human rights vs Cultural rights ... 2009). On the other hand, no matter what our intention is, the rights that we say all humans are entitled to, are often being forced on one culture by another (Human rights vs cultural rights... 2009; Culture vs Human rights ... 2010).

- **Human right and the research data and findings**

As reflected by the findings in chapter 4, for instance, cultural herbal intervention in the Zimbabwean Ndebele culture and all that goes on during pregnancy and child birth, have been passed on from generation to generation despite the violation of human rights. For example, a woman who is having very severe labour pains from an obstructed labour has to be subjected to a number of rituals such as having their labia pinched by the attending TBA. The belief that complicated labour is due to the woman having been unfaithful to her husband and the accompanying practice of the woman having to stand feet apart over burning rapoko, are, to say the least,

dehumanising from a human rights perspective. This is confirmed by the quotations below:

“She (woman) would be having multiple sexual partners. If the pregnancy does not belong to her husband, those manoeuvres done by the TBAs do not work” (Data: 1204) (TBA3).

“The addition is that during the ritual where *rapoko*, believed to reverse labour complications is put on hot coal, if it starts popping it confirms the infidelity which the young mother was not able to admit in front of the elders” (Data: 1224) (TBA4).

“... the woman would have to reveal the man to whom the pregnancy belongs, only then can she deliver” (Data:1230) (TBA2).

These kinds of treatment sum up to physical and psychological abuse which violate human right under the pretext of cultural norm and infringe on human rights under the cover of cultural norms (Culture vs. Human rights ... 2010).

The main focus concerning the mothers in the current research was to achieve both motherhood naturally so as to move towards the humanbecoming of womanhood as expected by culture; hence the focus on cultural rights. The human rights aspect is violated through the fact that women were not able to make their own choices concerning the preparation of birth from the time they became pregnant up to birth. Their human rights are also violated through the way they are treated by society (sangomas, community elders and TBAs) who subject them to cultural rites of passage and rituals in the name of cultural and traditional norms and values. Although the mothers/women moved through the paradox of human rights-cultural rights, they managed to transcend and realise alternative possibilities to human becoming as they manage to give birth and become mothers fulfilling.

5.4 CONCLUSION

In this chapter an attempt was made to illustrate, thinking about, and interpreting, the researcher’s research findings as explicated in chapter 4 in terms of Parse’s Theory of Humanbecoming. This exercise alerted the researcher to many previously “not thought of” implications of her research findings. The researcher found the application of Parse’s theory opening up many possibilities – too many to even contemplate. This is clearly reflective of a revealing-concealing paradox. With this the researcher acknowledges that the interpretation of the findings is all but complete. In the next chapter, conclusions are drawn and recommendations are made.

CHAPTER 6

SUMMARY, CONCLUSION AND RECOMMENDATIONS

6.1 INTRODUCTION

In this chapter a summary of study is given, conclusions are drawn and recommendations for practice and further research are made.

6.2 OVERVIEW OF THE STUDY

Most African cultures in the Sub-Saharan region have traditional beliefs and practices, rituals and ceremonies which they value among which are those that relate to birthing. African culture in general opposes any “unnaturalness” surrounding pregnancy and childbirth and links it with adultery and witchcraft. The Zimbabwe Ndebele society is no exception to this (Van Roosmalen & Van der Does 1995:22; King 2003:189; Mathole et al 2004:943; Awoyinka et al 2006:209; Aziken et al 2007:46). The problem is that alternative modes of birthing are not acceptable to the Zimbabwe Ndebele culture. Women who give birth through alternative modes of birthing, which include caesarean section (CS), instrument delivery (ID) and any other unnatural procedure are stigmatised (Matua 2004:334; Aziken et al 2007:46).

The research question that needed to be addressed was: “What are the Zimbabwean Ndebele perspectives on alternative modes of childbirth?” The aim of the current researcher was to obtain in-depth rich information so as to gain deep understanding of this phenomenon.

The research design was a combination of pointers from phenomenology and a generic qualitative approach used to elicit data gathered through unstructured individual in-depth interviews, structured interviews and focus group discussions.

The study purposively selected participants samples from five populations including women who had given birth through alternative modes of birthing, spouses, community elders and *Sangomas* (traditional healers) and TBAs from whom data were collected using individual in-depth interviews.

Data that showed a thread of evidence of the belief that the cultural reasons attributed to the need for alternative modes of childbirth are “tying” a result of infidelity and of harbouring grudges. Witchcraft was also another of the reasons given for alternative modes of childbirth. These reasons were mentioned throughout the five participant populations. Interestingly, some of the informants’ views are congruent with most of those found in literature relating to cultural issues of most African societies. Other views shared by the informants were in line with the scientific views and procedures used in midwifery practice and in obstetrics. For example, some informants believed that one of the reasons for CS was malpresentation such as breech presentation, a small outlet, transverse lie as well as other eventualities that may occur when a woman gives birth for the first time and labour that takes too long were also given as reasons for CS (Data: 1018; 1022; 1108).

6.3 TYING

Tying appeared during the current research as the main reason why alternative modes of giving birth may become necessary. Tying, which is the cultural equivalent obstetric term of “complicated or obstructed labour” by its very nature appears “unnatural” taking into consideration the vast array of measure taken culturally, from spiritual to traditional medicine, to secure a natural smooth birth. Culture and tradition are the forces that drive acceptability or unacceptability of alternative modes of childbirth as it emerged from each group of informants that were interviewed. The Zimbabwean Ndebele society believes in traditional medicine rather than in biomedical interventions when it comes to solving the issue of “tying”. This is illustrated by figure 6.1.

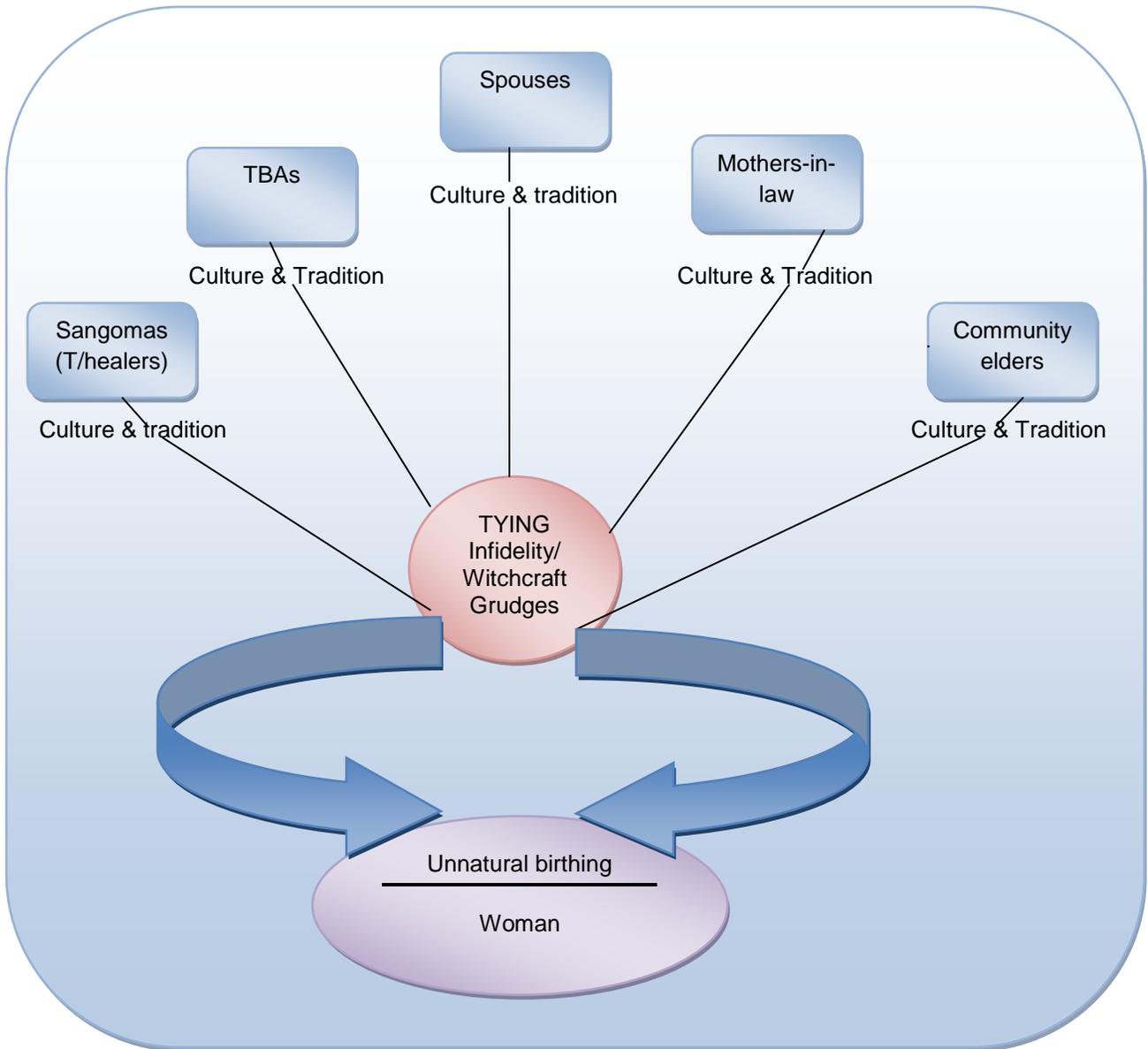


Figure 6.1: Cultural impact on alternative modes of birthing – tying

Society as represented in figure 6.1 is in control of the birthing process and its “unnaturally” through “tying” the main emergent theme which is born of infidelity, witchcraft and begrudging. The cultural philosophy of tying is a socio-cultural destabiliser in terms of acceptability of alternative modes of childbirth and needs urgent addressing as it impacts negatively on the achievements of the two MGs, 4 and 5.

6.3.1 Discussion and conclusion

The evidence given by the community elders with regard to “tying” relates to what they would like to promote traditionally; of keeping tradition surrounding pregnancy and childbirth pure traditional. *Sangomas* (traditional healers) related what they knew to both what the actual cultural practices are during child birth as well as the rituals that relate to pregnancy, those that precede the birthing process and those involved during birthing, including medicinal, herbal and spiritual customs. TBAs shared information on what they actually do and what happens in real practice during the birthing period as far as their profession and responsibilities are concerned; while the mothers told their stories of being caught up in the midst of a situation where neither western medicine nor cultural medicine can assist, but self-repudiation; acknowledging infidelity which whether true or not is what is considered the main cure for labour complications.

The Zimbabwean Ndebele society perceives the need for alternative modes of child birthing as a result of super natural magico-religious practice of “tying” which also happens as a result of ancestral punishment meted for infidelity (Awoyinka et al 2006:209). “Tying” also featured as a weapon among society to fight for a husband. Cultural reasons for CS have also been given as “fixing” (tying) by another person (Data: 1140) for petty jealousies or to prevent someone from having siblings because culturally, the more siblings one has, the more the economic power over the rest of the community. In this regard, it can be said that societal focus in as far as birthing is concerned has been directed to natural birthing, womanhood, motherhood and the socio-cultural issues that surround the birthing process (Donkor 2008:22).

With regards culture and tradition, it can be said that childbirth is a major focus of the Ndebele culture and beliefs and rituals surrounding this cannot be unlearned easily as it is intentionally perpetuated throughout generations. From the study findings, it can be concluded that behaviour change does not automatically follow change in knowledge; or that culturally embedded and deep-seated beliefs and practices are not easily replaced by alternative perceptions and knowledge. This is especially evidenced by the fact the

accounts from community elders and *sangomas* (traditional healers) as well as from TBA's. It is however, traditional healers and sangomas that perpetuate culture in general. Nonetheless, all three these groups' views on the issues override evident benefits of CS up to the point where referral becomes inevitable to save the life of the mother and child. The traditional belief of "tying" it seems, continues to be upheld by the Zimbabwean Ndebele society despite an understanding among some members of reason other than bewitchment; such as anatomical ones, causing complicated labour. What the Zimbabwean Ndebele society seems not to realise is that much as every culture has its rituals and traditional beliefs that relate to child birthing, some traditional beliefs that employ unhygienic practices and procedures can be harmful to mothers and the babies as these may compromise their health. Examples are the cultural interventions using both herbal and traditional medicine and ritualistic procedures as well as the unhygienic process of "untying" described earlier on in this report (OHCH 2006; WHO 1999 cited in Saravanan 2010:94).

Since unnatural birthing is believed to be a result of cultural works ("*tying*"), the belief is that it can only be prevented or reversed through cultural interventions. From the evidence given by the informants it appears that culturally it is general knowledge that a woman with a small outlet (inadequate pelvis) cannot deliver naturally; the question that remains after subjecting the woman to making confessions for infidelity (which she probably never even committed), and holding grudges:

- When do the TBAs make a cut-off point to say "now we give up" and then make decisions for referral to a health care centre for biomedical management?
- What are the reasons for referral to a health care centre for possible CS?

The above questions may remain unanswered in the current study, but one may be persuaded to conclude that the motivation for referral could be for personal reasons rather than for the benefit of the client. This leads to a further question, namely, why, if the benefits of CS is realised as saving the life of the mother and that of the new-born, does the Zimbabwean Ndebele society still hold on to unacceptability of alternative

modes of childbirth. All the above questions do not seem to have answers within the scope of the current research and as such further research on the specific questions is recommended.

6.3.2 Recommendations

The Zimbabwean Ndebele society needs to be empowered through education about the reproductive system's anatomical structure, particularly the female pelvis and its proportion/disproportion with the foetal skull in terms of the size of the baby – *macrosomia* which was alluded to in by the informants as one of the reasons for CS. Once the concepts of the basic anatomy of the female pelvis are understood it could help in terms of what happens at delivery as the baby negotiates the maternal pelvic outlet. In this regard it may also be to the benefit of all involved to:

- Target the essential role player in the event of pregnancy and birthing namely the elders, sangomas and TBAs with the necessary education and training in this regard. Video-animation of the birth process showing different types of medical accounts for “tying” should be made available to these persons as well as imprinting upon them the unnecessary pain and suffering caused the mother in an already traumatic experience. The latter recommendation is done with due regard of the cultural importance of the pain that a woman has to endure to pass the rite of womanhood.
- In addition, uplifting the general education of the Ndebele community in terms of western scientific knowledge might also help. School biology curricula and lifestyle curricula must emphasise the role of socio-demographic variable and anatomical variable as these relate to complicated labour.

The issue one encounters at this point is how to form a workable dialectic between the call for Africanisation and Westernisation. The researcher does not have an answer to this but for the “strive” to rectify the situation at this point in time. It would, however, be appropriate at this point to suggest further research into such dialectic. The researcher

therefore suggests research into ways in which Leininger's (George 2005:378) concepts of cultural care preservation/maintenance, culture care accommodation/negotiation and culture care repatterning/restructuring can be implemented within the Zimbabwean Ndebele culture. It is further recommended that with regard to "tying" an in-depth study is conducted into the following aspects relating to Leininger's "Sunrise Model": religious and philosophical factors, kingship and social factors, cultural values and life-ways, economic factors (who benefit from this), and educational factors (George 2005:378).

From a nursing epistemological point of view, it is suggested that the belief in "tying" be approached from the point of view of the different patterns of knowing as currently promoted by Chin and Kramer (2011). Admittedly, such an investigation will be biased from a western scientific and ethics point of view, however, the aim should be to arrive at an emancipatory pattern of knowing; a pattern of knowing women in the Ndebele culture deserve to acquire, to liberate themselves, a liberation in line with current women's rights movement and feminist thought.

6.4 CULTURAL INTERVENTIONS

6.4.1 Herbal and non-herbal medicine

The current study revealed that use of herbal and traditional medicines such as the donkey's placenta, *nyeluka* (water snake/fish/eel), the hare's nest, elephant's placenta, burning of *rapoko*, *inkunzane* and *isikhukhukhu* (some slippery herbs) to bath the outlet with are used in an effort to try and make natural birth possible; to prevent alternative or unnatural modes of childbirth as well as to protect the woman from evil spirits or witchcraft. It is clear that all traditional medicines relating to pregnancy and childbirth are aimed at "speeding up" what is seen culturally as a normal (non-pathological or non-sickness) event. The importance of children to demonstrate manhood, womanhood and motherhood, the child as future security and to escape from the scorn of barrenness, all imply the importance of the birthing process that is as event free as possible. The cultural belief in traditional medicine and the application hereof during pregnancy and

labour, necessitate that labour takes place in a non-medical and more traditional setting, such as the home of the mother to be or her mother's home. Literature search revealed that *sangomas* (traditional healers) and TBAs administer the herbal and traditional medicines as preparation for natural birthing and for prevention of unnatural birthing as well as protection from witchcraft (Mathole et al 2005:946) (see section 4.6).

However, should all the efforts of "untying" be unsuccessful, it appears that it is then that the woman is referred to a health care centre for whatever alternative mode of delivery the doctors decide on, more often than not a CS. It appears that the outcome of alternative modes of child birth is then used as proof for infidelity, and it would then not be surprising that in the Zimbabwean Ndebele culture alternative modes of childbirth carry a stigma and thus are not acceptable; neither to the community at large nor for the individual mother to be.

6.4.1.1 Discussion and conclusion

The Zimbabwean Ndebele society use herbs and traditional medicine to undo or reverse labour complications which probably by chance or coincidence seem to work for them at times. For this reason it appears that the Zimbabwean Ndebele society are encouraged to continue using traditional herbs and medicines as a way of "untying", protection from evil spirits and facilitating easy delivery despite the fact that more often than not they end up referring the woman to hospital, an indication that they believe in culture and traditional practices.

Based on the researcher's background in western medicine and midwifery, the researcher conclude that it might be possible that dried placenta, whether from donkey or elephant, could have medicinal value, however, the activity or potency of dried oxytocin needs to be established scientifically (pharmaceutically). The hygienic aspect of drying and keeping placentas also troubles the researcher. The alleged protection that certain traditional medicine, rites and rituals provide to both the mother and the

unborn foetus, in the opinion of the researcher could contribute greatly to the psychological peace of mind of the “believer”.

It is understandable that formal medical facilities might not appreciate the interference of traditional healers and TBA's and the application of their traditional medicine and remedies combined with those administered in such a facility. For this reason it is also understandable the tradition-bound individuals might not want to visit medical facilities or that they might be discouraged by traditional healers and TBS's to do so.

6.4.1.2 Recommendation

The main recommendation cuts to the bone of the profession of sangomas and TBAs namely that in some way the plant materials as well as the animal products that they use should become known to the scientific fraternity. This is easier said than done as secrecy in a sense secures these professions. Nonetheless, active substances need to be isolated and identified and documented so that, in an emergency, medical staff would know what the possible pharmacokinetic and pharmacodynamic implications they are up against.

In line with The Earth Charter (Earth Charter ... 2012) principle of “ecological integrity” it is also suggested that all plant and animal material utilised by sangomas (traditional healers) and TBS be cultivated to secure the availability of these materials for future use. The Zimbabwean Ndebele society need to be encouraged to grow the plants that they use in the management of labour as in botanic gardens; particularly the herbalists so that the knowledge and the trade can be passed down from generation to generation. It is also envisaged that, in an attempt to keep everything as natural as possible, that plants and herbs be cultivated in their natural habitat.

6.4.2 Rituals and traditional practices

6.4.2.1 Ritual for “untying”

The study revealed that the concept of tying can be reversed. Certain rituals combined with herbal and traditional medicines can be used to effect untying were described by the informants (see section 4.5.2.1). Literature search revealed that *sangomas* (traditional healers) and TBAs administer the herbal and traditional medicines as preparation for natural birthing and for prevention of unnatural birthing as well as protection from witchcraft (Mathole et al 2005:946) (see section 4.6).

Alternatively, rubbish gathered from cross-roads mixed with herbs would be given to the labouring woman to drink as it is believed that separation of the roads to different directions would be transferred to the woman to separate the two fleshies; that of the baby from the mother. Another ritual that was illuminated by the study is the confession that the women should make to TBAs and /or aunties for commission of infidelity which is also believed to release the woman and make it possible for her to deliver. In the process of making the confession, the woman should name her lover; who in turn should be brought into the delivery hut to make rituals for the woman to delivery and for the infant to live.

6.4.2.1.1 Discussion and conclusion

It is rather difficult for the researcher to maintain objectivity and to keep reminding herself that culture and tradition, and the practices and ritual that go with them go unquestioned by those that actively participate in them. Apart from the outsider view of the enigmatic relationship between infidelity and complicated labour, what most concern the researcher is the hygienic status of the practises surrounding traditional medicine, medication and treatment. Although this aspect does not relate directly to the research topic, the insistence that traditional potions do reverse complicated and obstructed labour does. It is apparently this insistence that results in either pregnant women not

visiting antenatal facilities or that complicated labour is being treated to the point where it becomes apparent that no confession or traditional medicine will “open the outlet”. Only then are patients referred to medical facilities; often too late. This gives an indication of the ingrained opposition to alternative modes of childbirth; of the non-institutional perspective on childbearing.

The data gathered also indicate humiliating and inhumane practices during obstructed labour (tying) and in an attempt to “clear the outlet” during “untying”. This, even though considered “cultural”, is denounced internationally. Such practices should not have any place in developing countries and one could only hope that part of the “development” would be leading women out of this type of cultural bondage.

6.4.2.1.2 Recommendations

The Zimbabwean Ndebele should realise that the issue of child birthing is very important and taking chances with the life of both the mother and the baby is not the best when a lot of time is wasted while trying to “untie” the mother. A previous recommendation is reiterated, namely for sangomas and TBAs to be formally educated in all aspects relating to obstetrics, especially the anatomy and physiology relating to complicated birthing and obstructed labour. For this to take place diffusely among sangomas and TBAs the following recommendations are made:

- A national role for registering traditional healer, sangomas and TBAs
- Closer cooperation between formal medical facilities and sangomas and TBAs
- Legislation on the integration of traditional healers (sangomas) and TBAs into the health system akin to the South African legislation in this regards
- Coordinated research into traditional knowledge systems, especially knowledge systems relating to health and childbearing

6.4.2.2 *Burial ritual for the mother*

The traditional practice involved in preparing a woman who died during birthing is opening the outlet wide so that the baby could be removed a concept that informants coined as separation of “two fleshs”; birth of some sort. This is done so that the mother would not be buried with the foetus in the womb. Van Dongen (2009:62) supports practice.

6.4.2.2.1 *Discussion and conclusion*

The issue at hand is that of possible necrophilia, should both the mother and the child be dead. With regard to the current research topic, the relationship of this finding to acceptability or unacceptability of alternative modes of childbirth, is again indirect, and relate to the traditional and cultural rituals that surround pregnancy and birthing. Nonetheless the finding does warrant consideration and recommendations

6.4.2.2.2 *Recommendations*

All previous recommendations apply as “prevention is better than cure”; referral of obstructed labour (tying) to a medical facility might prevent mother and infant mortality and morbidity. In addition, clear legislative stipulations need to be laid down with regard to handling the corps of women who died “at home” during delivery. Special arrangements via legislation should be made regarding the disposal of by-products of pregnancy with a special view on “muti” harvesting. At this point the implementation of a national traditional healers (sangomas) and TBA registration role and code of ethics as well as legal and illegal conduct needs to be established.

6.4.2.3 *Burial ritual for the baby*

The other burial ritual that the findings of the study revealed was the burial of the neonate who dies during delivery or is delivered as a stillborn. This also applies to

spontaneous abortion. When the baby is buried there should be a long stick that sticks out from the bottom of the grave such that when the burial is completed the stick is pulled out to leave a deep hole that gets down to the bottom of the grave. Informants explained the rationale of the ritual as assurance that the mother is not “closed”: not to be sterile and be able to bear more children following the stillborn if she did not die during the delivery herself.

6.4.2.3.1 Discussion and conclusion

The point at stake here is not so much what is done during the ritual, but the fact that the ritual bears immense cultural weight as it relates to fertility. Again, institutionalised birthing and death may not provide for adherers to the culture to perform these rites.

6.4.2.3.2 Recommendations

The recommendation on the legalisation of traditional medicine and legal stipulation of communication between health facilities and traditional birth attendants and sangomas, in fact all members of the clients family, are reiterated.

6.4.2.4 Managing by products of birthing

The study revealed that by products of birthing, especial the placenta, cord and stump bear great cultural importance and has to be treated and done away with in a special culturally acceptable way.

6.5 PROCEDURE SIMILARITIES

Findings reveal that there are similarities in the traditional ways and biomedical procedures in as far as assessment and monitoring of labour is concerned. This includes vaginal examination which is done to assess cervical dilatation and foetal head

descent. Some cultural reasons for CS that were given were similar to those found in midwifery and gynaecology.

6.5.1 Conclusion and discussion

It appears that tradition and culture depends a lot on experience and apprenticeship as a way of training and acquiring technical skills that are credible and acknowledged in societal circles. It is however not clear how such congruence with medical science could still accommodate a belief in “tying” and everything it involves.

6.5.2 Recommendations

There is need to introduce biomedical influence on traditional practices through training; hopefully that cultural and biomedical interface and collaboration of the two fraternities can inculcate a spirit of acknowledging and appreciating each other’s knowledge and skills and be able to work towards a common goal of Safe Motherhood.

6.6 CULTURAL HERITAGE

A major finding in this section is that historically and over the years, the Zimbabwean Ndebele society has tried to hold on to their tradition and culture since their arrival from Zululand in 1872. Findings of the study indicated that the cultural and traditional procedures and practices that are followed during the process of child birth are a heritage to the Zimbabwean Ndebele society. Elders of the Ndebele society mostly promoted the Ndebele culture.

6.6.1 Conclusion and discussion

This cultural study is of significance as a heritage of the Zimbabwean Ndebele society and the country at large and deserves particular note. Traditionally, in the Zimbabwean Ndebele culture, there has not been any record of information on perceptions of

alternative modes of childbirth and associated issues. What has been available has been through verbal story telling. Furthermore, there is no record of a research of the current nature. Furthermore, this study was made possible by, and could only be conducted through use of the qualitative research design, where in-depth individual interviews were utilised to allow informants to “tell stories of their lives” which were recorded in order to obtain the data that were utilised in compiling the findings for authenticity. These findings made the researcher as a western qualified midwife realise the cultural demands and the impact that these demands have on the provision of health in the area of midwifery and obstetrics.

6.6.2 Recommendation

Within the scope set by previous recommendations, the following recommendations are made with regard to cultural heritage namely the *conscientisation* of the society, regarding all aspects of the Zimbabwean Ndebele culture. It is recommended that associations for women and women’s right be approached to lobby for political acknowledgement of cultural and traditional practices during the birthing process without compromising quality of neither traditional nor medical care to mothers and infants. In essence the recommendation is for women’s groups to drive political acknowledgement and integration of indigenous knowledge systems in the field of health care in to the mainstream of health care

6.7 CONGRUENCE OF FINDINGS

There was congruence in the information that was given by the informants across all the different population groups that were interviewed. The cultural practices, religious and traditional beliefs that included “tying”, cultural interventions using traditional herbs and medicines as well as the cultural reasons for CS were found to be a crucial point of convergence as depicted in the diagram on major findings (see figure 6.1).

6.7.1 Conclusions and discussion

From this finding, or rather observation is it deduced that as far as alternative modes of childbirth, pregnancy and associated rites of passage (such as manhood, motherhood and womanhood) are recognised diffusely within the Ndebele culture. No major contradictions were found from the perspective aired by the different populations.

6.7.2 Recommendations

This cultural study has to be published for the Zimbabwean Ndebele generations to come for them to learn and read about their culture in order to break the culture of passing such crucial information by word of mouth from generation to generation because along the line very important information may be dropped as people tell the story of culture and tradition in relation to child birth. It is the researcher's intention to take up this task starting off with an article in some cultural or transcultural journal.

6.8 IMPORTANCE OF NATURAL BIRTHING

The main importance of natural birthing and the apparent opposition to alternative modes of birthing is the rite to motherhood and especially womanhood. The life of a woman appears, culturally, to revolve around procreation and is judged according to how she gives birth. The woman's dignity, fidelity and societal interactions are unveiled the day she gives birth and by way she gives birth. Of ultimate importance appears the need for the woman to "push the baby out" and to "endure the pain" associated with normal delivery.

6.8.1 Conclusion and discussion

The mode of child birth determines the societal status that the woman is accorded; both motherhood and womanhood if she gives birth naturally. Should the woman give birth through alternative mode of child birth, she loses the womanhood status and only gains

that of motherhood. The latter is however preferable to barrenness and in consideration hereof, it appears that an alternative mode of childbirth, such as CS, is “relatively” acceptable. Nonetheless, these women are still stigmatised.

6.8.2 Recommendations

It is recommended that every effort should be made to allow Ndebele women to give birth naturally where possible. The medical fraternity need to be informed about the very high stakes involved for the woman in natural birthing. This is especially necessary with the increase in foreign doctors practicing in Zimbabwe; persons who might not at all be in touch with indigenous cultural norms, values and rites. Convenience scheduled caesarean sections should not at all be done. In an economically struggling country, and a country in the so called “third world,” such scheduled caesarean sections should be done away with for both economic and cultural reasons.

6.9 ON LIFE, PREGNANCY AND BIRTHING

Findings were that although the Zimbabwean Ndebele society views pregnancy and birthing as non-sickness or non-illness they also do see it as a potential life threatening condition; apparently mostly with regard to the unborn child. Of the major threats are of magico-religious nature; of witchcraft. The ultimate in “unnatural birthing” appears to be death of a mother during labour as this has been described as “being left in the rubbish”. For this reason, it appears that throughout pregnancy traditional medicine plays an important part in the life of the woman. Even if antenatal care is sought and rendered, women still visit traditional healer and TBAs.

6.9.1 Conclusions and discussions

A large percentage of women give birth at home under the care of unskilled health care givers such as relatives, elders, TBAs and even sangomas. Preferred place of giving birth is at home attended because of the familiar surroundings and the allowance for the

execution of any cultural and traditional rituals that would probably not be allowed in a health care facility. A lot of cultural issues, beliefs, rituals and customs compel the women to home birth or “traditional” birthing.

6.9.2 Recommendations

It is reiterated that traditional birth attendants (TBAs) and traditional healers be educated in a scientific manner about pregnancy and labour. Equally important, the medical fraternity should understand the need for certain traditional practises to take place during child birth. It is thus recommended that wherever these two knowledge systems should come into contact with one another, that a common ground of understanding and accommodation be established to the benefit of the mother and child. This in the opinion of the research can only be achieved through collateral education.

6.10 NON-ACCEPTABILITY OF ALTERNATIVE MODES OF BIRTHING

In answering the research question finally, it is emphatically stated that it appear that the Zimbabwe Ndebele culture does not accept alternative modes of child birth and when these are inevitable, certain socio-cultural rites of passage, such as womanhood, are withheld and stigmatisation and social sanctioning of the woman can be expected.

6.10.1 Conclusion and discussions

The Zimbabwean Ndebele culture associates alternative modes of child birth with Diverse socio-cultural, socio-economic and magico-religious factors. Besides socio-cultural issues, the socio-economic issues of high costs of maternity fees and the sanctions raised against informants for non-payment make health care service unreachable and thus not acceptable; which on the other hand it makes services of TBAs popular because of low charges. The many cultural rituals surrounding birthing also make for non-institutionalised and natural birthing.

6.10.2 Recommendations

6.10.2.1 Orientation to culture

“The culture of a society is the way of life of its members; the collection of ideas and habits which they learn, share and transmit from generation to generation” (Giddens 2001:22; Cohen & Kennedy 2007:47). Thus culture being engrained in the Zimbabwean Ndebele society’s day-to-day activities, it becomes necessary to orient all the health workers including foreign nurses and doctors in particular to the Zimbabwean Ndebele culture in relation to childbirth for them to be able to give culturally acceptable health care services. Inasmuch as there are scientific reasons for CS. There are multiple views culturally that relate to *tying* of the mother during labour resulting in CS. In this respect, there is need to discourage non-medically initiated CS. Doctors should not do CS for personal reasons of gaining experience and for lucrative business as it has psycho-social implications for the woman and at times the husband is also affected (London et al 2006:554; Aziken 2007:46).

6.10.2.2 Advocacy

There is need to advocate for health care policies that will support culturally accepted birthing policies congruent to the Zimbabwean Ndebele culture and beliefs without compromising quality of care. Along with this there is also need to subsidised or even free maternity services in order to move towards achieving the MDG 4 and 5 objectives of maternal mortality and neonatal mortality reduction by seventy five percent (75%) and two thirds respectively by 2015. This recommendation relates to the financial cost of CS in Zimbabwe, something many Zimbabweans cannot afford leading to refusal to be admitted to a health care facility for alternative mode of birthing even in the event of emergency.

6.10.2.3 Cultural/biomedical consultations

It may be necessary for health workers to consult with *sangomas* (traditional healers), in terms of having some kind of referral mechanism and accepting clients referred directly from *sangomas* (traditional healers) in order to allow for continuity and close cooperation among *sangomas* (traditional healers), TBAs and doctors in terms of management and preventing hidden or unreported maternal and neonatal mortality. Knowledge systems in health care need to be cross pollinated. This move will prevent suspicion from both the Zimbabwean Ndebele society and health workers so that both can be acceptable as part of the health care system in Zimbabwe.

6.10.2.4 Collaboration

There is need to introduce TBA driven clinic where nurses and doctors engage with the TBAs in strategising on how to work together as health care providers of a nation with a culture that needs to be acknowledged and respected as well as preserved. One informant actually intimated this realising that a large number of women give birth under the care of TBAs who are the ones that are culturally recognised as opposed to health care providers. Studies done in South Africa reveal that traditional attendants deliver approximately sixty percent (60%) of all babies born, a situation very similar to that of Zimbabwe (Truter 2007:56).

6.11 LIMITATIONS OF THE STUDY AND PROBLEMS EXPERIENCED

The study yielded interesting results, however, is has some distinct limitations.

One of the main problems or limitations of the study is that the Zimbabwean Ndebele language originated from the South African Ndebele in the then Zululand and has evolved to become the isiNdebele which in turn has been adulterated by other languages. An example is the use of English words mixed with isiNdebele language was noted during the interviews before the translation of the transcribed transcripts. For

instance, the word *ukuoparetwa* was being used to mean “being operated upon” and yet the appropriate isiNdebele word to have been used in this instance is *ukuhlinzwa*. Many other words were used the same way which many a times distorted the meaning of what was intended. The researcher spent much time with the interviewees as they needed to clarify and try and find alternative words to ensure that the informants comprehended the question she asked and also that the researcher understood exactly what interviewees said.

The data collection process did not always run smoothly because of the nature of the study. Culture by itself is a sensitive issue and is further complicated if the topic involves gender, birthing and sexual issues. Ethical concerns infused by the acceptability and non-acceptability of ethical relativism. Consequently plagued the researcher throughout the research.

Some of the informants (women who had given birth through unnatural modes of childbirth) did not consent to tape recorded unstructured in-depth individual interviews. This was a result of the fact that hospital fees had not been fully paid due to economic constraints. The informants were suspicious that the researcher could have been part of the hospital staff at which they had given birth and feared that they would report them to the authorities which would have legal implications. This led to an alternative method of data collection using structured interviews based on the themes that had emerged from the unstructured interviews. Truly, deep lived experiences of these women could not be obtained.

Some spouses were not interested in being interviewed on issues of birthing as they expressed that the subject was women’s business. It was also not easy to secure interview appointments with some spouses as their working schedules were not convenient for either the prospective informants or the researcher. Appointments fixed would be postponed several times until prospective informants were lost.

Another limitation was with the *sangomas* (traditional healers). This group of participants was not easy to sample. Firstly, the intention was to collect data using FGIs, but this was not possible as each wanted to protect their own sacred trade's secret and did not want anybody including the researcher to know what herbs they use and how they use them lest there is competition. Secondly, the *sangomas* (traditional healers) were suspicious of the researcher as they believed that they wanted to gain entry into the profession through unprofessional means and become a *sangoma*; without having gone through the process of training and/or initiation by the spirit mediums. Being a *sangoma* requires training and being possessed by spirits (Truter 2007:57-58). To overcome the constraint, some *sangomas* (traditional healers) eventually consented to individual in-depth interviews, which in the researcher's view point yielded valuable data as the clients were free to talk and ask questions in a private environment as the researcher probed deeper.

At this juncture, the researcher would like to draw the reader's attention to the fact that *sangomas* (traditional healers) are very protective of their trade/profession as they believe that it is sacred and hard earned; hence they are sometimes not willing to engage in FGIs, divulge or volunteer information for fear of counterfeit *sangomas* (traditional healers) and competition from other *sangomas* (traditional healers) who might steal their clients or ideas: it is a matter of territorial integrity. As a result it was not easy to interview this group of informants because they were suspicious and some of them totally refused to be interviewed; which meant that the researcher had to sample a different informant altogether as replacement which became very time consuming.

All of the above might in some way have influenced the end result; the data and the findings.

6.12 GUIDELINES FOR FURTHER RESEARCH

Reflecting on the idiographic analysis of the phenomenological aspect of the study, the findings made apparent the crisis and grief that the women who had given birth through

CS and their spouses went through and thus generating a cascade of affects which included emotional, physical effect and psycho-socio-cultural aspects.

However, it is not clear whether the grief that the informants went through as result of CS was attended to and how they coped with the phenomenon both from the cultural and from the scientific perspectives. Further research in this area is therefore recommended. The research, if undertaken would assist in the psychological care of the members from the Ndebele culture following CS.

Due to the lack of research into the Zimbabwean Ndebele community and culture, each of the recommendation made earlier in this chapter also bears research potential; each recommendation could become a research topic for further research. It is the researcher's intention as a member of the academic staff of a university in Zimbabwe to take this up with future master's and doctoral candidates.

6.13 CLOSING COMMENTS FROM A STUDENT'S POINT OVERVIEW

6.13.1 Brief introduction of the researcher

The researcher is an internationally recognised midwife practitioner and Lecturer at the National University of Science and Technology (NUST) in the faculty of medicine. She has a wealth of experience in issues of reproductive health, maternal and neonatal care. The researcher is a module writer on Women's Health issues for the Zimbabwe Open University (ZOU) for the Department of Nursing Sciences and is currently involved in a number of international research activities, including:

- Referee and article reviewer for the Biomed Journal in the United Kingdom.
- Standing Research Committee member and abstract reviewer for the International Confederation of Midwives (ICM).
- Research Board Member and abstract reviewer for the Research and Innovation Department at NUST in Zimbabwe.

- Has presented three scientific papers at the 25th, 27th and 29th International Confederation of Midwives Congresses on HIV/AIDS and the midwife in Philippines, Manila in 1999; Experiences on mothers of premature infants two weeks post-delivery in Brisbane, Australia in 2005; Women's voices in Africa in Glasgow, United Kingdom in 2008.
- Discussant of the concept paper on Scaling up Midwifery Skills in New York, United States of America, May 2006.
- Held position of ICM Regional representative and Board member for Africa East – Anglophone countries 2005 – 2008;
- Global Fund Country Coordinating Mechanism Board member in Zimbabwe 2009 to date.
- Founder member of the White Ribbon Alliance for Safe motherhood in Zimbabwe 2009.

6.13.2 Lessons learned as a doctoral student

By undertaking this study, a lot has been revealed to me as a researcher and as a student. The discovery is that, what the researcher thought they knew by virtue of belonging to the Zimbabwean Ndebele culture was a tip of the ice bag. A lot of detail to cultural and traditional practices was unveiled through use of different data collection methods which included individual unstructured in-depth interviews, structured interviews and focus group discussions. The study opened a window for the researcher to see through and be able to understand the Zimbabwean Ndebele perspectives of alternative modes of childbirth.

Understanding the Zimbabwean Ndebele perspectives of alternative modes of childbirth has specific implications to practice in maternal and neonatal health with a view of reducing maternal and neonatal mortality, hence the need to consult, collaborate and engage the groups that participated in the study towards a culture bound, and culturally accepted practice and common goal.

My testimony as a doctoral student is that undertaking this study was an experience of a life time. At first, the researcher had not comprehended the demands of the type of research design and the scope of the study that she was undertaking in terms of the quality of the work and the self-application that was expected of me. She found this to be very taxing with social implications to the self and family.

As a foreign student, the logistics of securing suitable and conducive accommodation while utilising library facilities at UNISA, attending research seminar and consulting with the supervisor were very difficult.

A big frustration was the electricity loading shading back home such that it was not easy to work constantly during the day when there was no electricity for hours on end and one would be forced to virtually work at night most of the time.

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