CHAPTER 5

Conclusion and recommendations

5.1 INTRODUCTION

This chapter summarises the study, discusses the findings, and makes recommendations for nursing education and practice as well as future research. The limitations of the study are also discussed briefly.

5.2 OVERVIEW OF THE STUDY

The study was an exploratory, descriptive and contextual qualitative study in *transcultural* nursing. The researcher adopted a phenomenological approach to achieve the objectives of this study. Unstructured open qualitative research interviews were conducted with Mozambican informants purposively selected at a maternity unit in a Swaziland hospital. The interviews were conducted in the informants' mother tongue, tape-recorded, transcribed, translated into English, and analysed. Themes and categories that emerged from the data were augmented with literature, including literature from the Internet.

Trustworthiness of the data was assured and ethical considerations respected (Lincoln & Guba 1985:36).

5.3 AIMS AND OBJECTIVES

The main aim of the study was to describe Mozambican women's experience of labour pain.

This study answered the following questions:

- What are the common elements in experiencing labour pain among Mozambican women?
- How do Mozambican women respond to the experience of pain during labour?
- What are the preferred pain relief measures implemented by Mozambican women?

By answering these questions, the study achieved the following objectives:

- To describe the experiences of Mozambican women during labour
- To explain the behavioural response to labour pain described by Mozambican women.

- To describe pain relief measures utilised by Mozambican women.

5.4 SUMMARY OF THE DATA

Six themes emerged from the data, consisting of twenty-one categories and four sub-categories, based on one hundred and eleven (111) data units. The findings were discussed according to the six themes that emerged from the data, namely

Theme 1 Physiological manifestation of labour pain
Theme 2 Reactions to the experience of pain during labour
Theme 3 The cultural/Religious meaning of labour pain
Theme 4 Factors that support the research problem
Theme 5 Pain relief during labour
Theme 6 Cultural beliefs about the control of pain during pregnancy, labour and delivery

5.5 THE THEMES AND THEIR IMPLICATIONS

Theme 1: *Physiological manifestation of labour pain* contains descriptive words about the *nature* of the pain experienced: burning, piercing, throbbing, cramping, grabbing, gripping, aching, tearing, pressing, paralysing, cutting pain and a feeling of heaviness in the lower abdomen. No pertinent cultural specific description of pain was given. All the adjectives (words) used correspond with those found in midwifery textbooks. For example, Bennett and Brown (1998:186) describe labour as pricking and burning; Reeder et al (1992:516) describe labour pain as sharp, cramping, aching, throbbing, stabbing and hot.

The *location* of the pain during labour was mainly in the lower abdomen, lower back, around the waist, the bottom, and the vagina. Sometimes the whole abdomen was said to be painful and varied according to the stage of labour.

The pain *intensity* was described as mild in the first stage of labour but severe as labour progressed. The pain intervals were short at first but became long(er) towards the actual delivery of the baby. Most of the women described less pain during the second stage of labour but felt an intense urge to push. Frequency of micturition and a “show” were among the symptoms experienced.

The physiological manifestations of labour pain described are not unique to the Mozambican women. Women from any other ethnic group would describe the same physiological manifestations of labour pain as is indicated in textbooks on general midwifery. These findings imply that general textbooks, and

culturally non-specific textbooks, could be used transculturally for the education and training of midwives. Although not apparent from the data, the researcher is of the opinion that such textbooks, and the information they contain, would be more acceptable to learners of different cultures and races if colour plates displayed in these book represented ethnic variety.

Theme 2: *Reactions to the experience of labour pain* indicates some of the Mozambican women's culturally related reactions to the experience of labour pain at the physical and psychological levels. Cultural-specific reaction to labour pain was primarily indicated by stoic conduct towards labour pain.

With regard to *physical reactions*, body movements and verbalisation were mentioned. The participants' physical reactions included body movements, such as rubbing the painful area, restlessness, and moving out of bed, lying on the floor and walking up and down. These were all done in an effort to ease the pain or to distract attention from the pain. Literature on the self-management of pain during labour substantiates these findings. Neeson and May (1986:651) mention that the mother's movements may be an attempt to calm or soothe the painful experience. Pilliteri (1992:527) states that rubbing the skin of the painful area reduces the pain. Certain body **movements** are a means of self–treating of labour pain (http://www.homeurope.org … accessed 10-10-03). As most of these measures to curb pain are also described in general midwifery (non-cultural specific) textbooks, the use of such textbooks in midwifery training is again substantiated.

The participants verbally complained about the pain they experienced by either groaning, moaning, screaming or crying out aloud. At times the participants would complain that they were suffering alone yet the husbands relaxed and felt no pain. Verbalising pain has a definite cultural identity and literature sources prescribed to learners should be scrutinised for their culturally sensitive handling of this issue. In midwifery practice, the identification of sources of anxiety during labour and as these relate to labour pain deserve the attention of the caring practising midwife.

At the psychological level, the participants' reactions to the pain they experienced during labour indicated fear and anxiety, and loneliness. Uncertainty about the outcome of labour was a major cause of anxiety among the Mozambican women: fear and anxiety about their own and the baby's well-being. The anticipation of a painful experience was very frightening to these women, especially the primigravidae who had no previous experience of giving birth. Previous nasty experiences, such as prolonged labour, foetal death and episiotomies, are further causes of fear and anxiety among women in labour. These sources of anxiety should be included as items to be considered when taking the history of the mother to be.

A feeling of loneliness resulted from labour being considered strictly a woman's affair, supervised by women (midwives, female relatives and friends). The informants indicated that women in labour received little emotional or social support during labour from these attendants and from professional nurses. The informants indicated further that this resulted in a feeling of loneliness and that the presence of spouses would presumably have eased this situation.

It is important for the woman not to be left alone during labour, particularly during strong labour. In some centres, husbands are allowed to stay with their wives throughout labour and during delivery as well. However, some cultures (including the Mozambican culture) do not allow husbands to be present during labour or delivery. In this situation, women are allowed the presence of supportive female companions like their mothers, other family members or friends (Chalmers 1990:88).

The cultural expectation of not allowing male partners to witness the delivery jeopardised the participants' need for social support, especially by their husbands – the single person with whom the woman has the strongest emotional bonding as far as the whole experience of pregnancy and, ultimately, the act of giving birth is concerned. In most African extended families, the mother-in-law is portrayed as a rival, yet she is the very person supposed to offer social support during pregnancy and labour. It is sometimes difficult for women to accept the support provided by their mothers-in-law. This contributes to their level of anxiety and loneliness.

African cultural practices, including Mozambican practices, surrounding social support systems to the woman in labour and in labour pain, foster a rather "elite" insider clique. It should be considered that if the woman in labour so wishes, her spouse should be given the choice to attend the birth of their child. The presence of a third party in addition to the woman in labour and the unit staff may contribute to the more humane treatment of the woman in labour. This is an issue deeply rooted in African culture and gender politics, however, and the necessary consideration should be given to action in this regard.

In addition to the physical and psychological reaction to pain, a culturally pertinent reaction to pain observed by the researcher was that of stoic conduct. Stoicism is a culturally sanctioned reaction to labour pain among the Mozambican women.

The practice of stoicism might have grave implications for the woman experiencing labour pain as it could lead to misdiagnosis of the experience of pain, which could, in addition, lead to the misdiagnosis of complications that occur.

Theme 3: *Cultural/religious meaning of labour* revealed that cultural beliefs and practices have a *mystical* meaning for the Mozambican women in labour and this influenced their perceptions and experience of pain during labour.

The experience of labour pain as a *bitter-sweet paradox* refers to women enduring the painful experience of labour because they knew that at the end of the experience they would be happy to have the baby. In the pain, they anticipate something good (the baby), something that would make them happy.

The ability to successfully deliver a baby is an achievement of happiness and peace, of life in spite of the pain. This is a special personal achievement - a feeling of strength, of inner strength, that has to be experienced to be understood (http://www.manbit.com … accessed 13-10-03).

The experience of labour pain was also seen as the most rewarding experience, taking into account that although there was an element of suffering, there was a high expectation of some sort of reward. The birth of the baby was a comfortable and **rewarding experience** (http://www.healiohealth.com … accessed -27-10-03).

These findings direct an appeal to Swazi midwives tending Mozambican women to share in the positive expectation of women in labour. The relationship between pain and joy should be maintained with the necessary balance between stoicism and pain relief as indicated by the mother-to-be. In all of this, midwives should blend their scientific knowledge, innate human compassion and transcultural knowledge to make the experience of pain and labour, whatever the outcome, a meaningful experience for the mother.

Theme 4: *Factors that support the research problem* includes factors that relate directly or indirectly to the research problem and the concerns in this regard stated in chapter 1 (section 1.2). These factors include **ethnic stereotyping**, and labelling for "**screaming"** during labour.

The Mozambican women perceived themselves to be stereotyped as people who exaggerate their pain. They felt discriminated against in their experience of labour in a Swazi antenatal unit. The researcher observed in practice that Swazi midwives perceived Mozambican women's behaviour during labour and delivery as typically demonstrative. Observed evidence in this regard is that most of the Mozambican women were denied pain relief medication during labour, even though they asked for it.

Theme 5: *Pain relief during labour* consisted of categories on self-treatment techniques and requests for medical and midwifery interventions.

The Mozambican women used the following self-treatment techniques as a means of relieving labour pain:

- rubbing the painful site
- panting and walking about.

Midwives encouraged the former behaviour because of the belief that walking facilitates the descent of the foetal head. However, this could only be promoted in the absence of ruptured membranes because of the danger of umbilical cord prolapse. As Mozambican women also tend to move around in an attempt to ease the pain, given the dangers involved in this (depending on the stage of labour), Swazi midwives need to closely observe these practices to prevent further complications and pain.

Some of the Mozambican women did ask for pain relief in the form of pills or injections. However, others preferred to suffer silently because they feared being reprimanded by the nurse-midwives for failing to endure the pain of labour. The implication of an attitude of fear of reprimand on the part of the Mozambican women is not conducive to alleviating anxiety and making the labour and pain experience a meaningful one for the mother.

Theme 6: *Cultural beliefs and practices that relate to the control of pain during pregnancy, labour and delivery* included the use of herbal concoctions. However, the women could not provide the specific names of the herbs used to relieve pain during labour although they did mention oxytocic-like properties in the remedies that traditional healers concocted. The concoctions (remedies) are not intended so much for pain reduction as to effect a speedy delivery and shortened period of suffering.

Other concoctions work by clearing the birth canal, including concoctions that have no oxytocic effect. This confirms that traditional practices involve consultations with different types of practitioners other than professional medical doctors or nurses for various reasons, including the alleviation of labour pain (Andrews & Boyle 1995:249). In some instances, the effects of these concoctions are also grave. The oxytocic effect of concoctions might induce premature contraction, which could result in an abortion or miscarriage. It is consequently crucial that during history-taking midwives establish whether the patient visited and was treated by a traditional healer or traditional birth attendant. In addition, local birth attendants and healers should be familiar to midwives, and midwives should be familiar with the contents of these traditional health carers' recipes.

The use of "holy water" prepared by priests was also mentioned as a means to relieve labour pain. This allegedly removes any resistance in the birth canal by cleansing this birth passage. With no resistance, the baby easily slides out, causing no delay in the process of labour thus reducing the period of suffering. Another reason for using "holy water" was to ward off demons that could harm the baby while inside the uterus and complicate the delivery.

The findings of the present study concur with two of Andrews and Boyle's (1995:23) health belief paradigms or world-views, namely the *magical-religious* and the *scientific* or *biomedical* health paradigm. The use of herbal concoctions and "holy water" as well as the reference to *spirits* apply to the magical-religious health paradigm. Since most of the women believe that illness "is initiated by supernatural powers" (Andrews & Boyle 1995:23), there is a very strong belief that the same powers outside a woman's control can cause complications during labour by, among other things, blocking the birth canal thereby prolonging the period of suffering of labour pain.

The *scientific or bio-medical health belief paradigm* is also reflected by the findings of this research, as, according to this paradigm, "life is controlled by a series of physical and biomedical processes that can be studied and manipulated by humans" (Andrews & Boyle 1995:23). Although the respondents have strong ties to the magical-religious paradigm, the fact that they decided to deliver their babies in hospital is an indication that they also embrace the bio-medical health paradigm. Informants were quite aware that the nurse-midwives were educated to understand the physical and biomedical processes involved in pregnancy and labour. They also believed that midwives would be able to intervene in these processes.

5.6 RECOMMENDATIONS

The researcher makes the following recommendations, based on the findings and their implications for midwifery practice, midwifery education and client education.

The researcher is of the opinion that traditions should be made an integral part of obstetrical management. The successful implementation of health care requires a systematic identification of socio-cultural beliefs and practices and their impact on childbearing (Steinberg 1996:1766). As any transcultural interface involves at least two sides to an issue, namely the insider and the outsider perception, in the case of the experience of labour pain either perception might be underestimated or overestimated. This will depend on the outsiders' (midwives') predilection regarding cultural ways of pain expression by patients (as insiders). Midwives should apply findings on the relationship between cultural background and labour pain cautiously in order to avoid stereotyping. Midwives should rather combine this information with cultural assessment outcomes, history-taking and scientific knowledge in an attempt to understand patients' experience of pain

and their verbal and bodily expressions of pain endured. This would help midwives respond appropriately to the response to pain of different cultural groups, and, ultimately, lead to culturally congruent care (Andrews & Boyle 1995:293-296).

Midwifery practice

The experience of pain, the meaning given to that experience, and the response to labour pain are linked to various aspects of local Mozambican culture. These aspects make the experience of pain of Mozambican women as a cultural group different from that of, say, Swazi women. Nevertheless, the dimensions of pain experienced by Mozambican women, including the physiological, psychological and spiritual dimensions, are the same transculturally (Helman 2001:130). In addition, in midwifery practice, both Western-oriented medicine and traditional practices in pregnancy and labour are involved. It is thus recommended that

- The local cultural diversity surrounding pregnancy, labour and the management of labour pain be included in a continuing in-service training programme
- Cultural assessment schedules be compiled and implemented as part of the history-taking activity of midwives
- Leininger's strategies of accommodation/negotiation and repatterning/restructuring for bridging transcultural gaps in health care be implemented by midwives specifically in terms of the cultural difference among the triad of Mozambican, Swazi and Western medicine local to the area in which this study was conducted.
- Multicultural concepts and the ethics of cultural relativism are included in the suggested in-service training programme. In essence, midwives should be made aware of transcultural ethics (ethical relativism), the pitfalls inherent in this, and cautioned against prejudice, ethnocentricity and ethnic stereotyping.
- Cultural practices surrounding the management of labour pain and gestation in general be interpreted in terms of Western medical practice, and vice versa, and that the advantages of both these perspectives on health care be articulated to the ultimate benefit of the patients.
- The local traditional healers and birth attendants be identified and included in the multidisciplinary antenatal health team.
- An attempt be made to identify the medicinal and chemical content and components of the concoctions brewed by traditional healers to scientifically establish their medicinal strength or hazard.

These recommendations are especially valid in the light of McCrea et al (2000:1169) statement that personal control is influenced by the context in which labour occurs and the nature of interaction between women and their carers. The successful implementation of health care requires a systematic identification of socio-cultural beliefs and practices and their impact upon childbearing (Steinberg 1996:1766). The present study partially achieved this. The recommendations should fulfil this.

Midwifery education

To provide culture congruent care, nurse-midwives must know about the patient's culture (Jones, Bond & Cason 1998:43). It is therefore imperative that the component of transcultural nursing be incorporated into the whole curriculum and not just a portion of it.

Educational strategies for neophytes in midwifery should focus on producing nurses with a desire to render culture congruent care. Respect for culturally diverse clientele can be achieved by using various teaching strategies, such as modelling and simulation during the teaching/learning process. Clinical placement should be done so that students are exposed to rendering care to clients of different cultural backgrounds (De Villiers & Van der Wal 1995:59-60). However, this needs to be done with the necessary accompaniment.

According to Anderson (1987:9 cited in De Villiers & Van der Wal 1995:59), the clinical encounter "is a social process in which each party brings a set of expectations and beliefs about the problem at hand. The critical issue here is that both the perspectives of the nurse and the patient and his or her family are legitimate." The culturally sensitive and competent facilitator should guide neophytes and others in midwifery education and training in reconciling the cultural perspective and differences that exist between clientele and student midwives.

It is very likely that clients will receive maximum attention and sympathy if their pain behaviour matches the culturally expected behaviour by the nurse (Helman 2001:133), and yet this should not be the case in the manner nurses render care. Nursing care should be offered equally across the cultural boundary.

Client education

Based on the findings of the present study namely that the physiological basis of pain appears to be cross-culturally the same, clients of cultures other than a western medical oriented culture need to understand the physiological aspect in the experience of labour pain. During such client education, the reasons for pain during labour, the benefit of such pain, the different types and qualities of pain in association with the

different stages of labour should all be explained to clients. An understanding of labour pain might lead to a reduction in anxiety during labour.

In addition, clients should be educated regarding self-relief measures in pain control during labour; for example, deep breathing exercises as a means to relieve labour pain (http://www.iayt.org … accessed 28-10-03). Moreover, all the measures observed in this study could be offered to women experiencing labour pain.

Clients should also be informed about cultural practices surrounding pregnancy, the antenatal period and the treatment of labour pain. In this regard, clients should be instructed about potentially harmful cultural practice, such as tying strings around the body too tightly, taking certain concoctions prepared by traditional healers and traditional birth attendants, especially where such traditional carers are not familiar to the antenatal unit staff.

Concerning the cultural dietary taboos and restrictions on certain foods, midwives should make a special effort to educate the Mozambican woman in the antenatal period about food stuffs that could replace the nutritional value of those prohibited culturally. Protein and calcium intake should be emphasised and affordable sources of these should be located for Mozambican antenatal clients.

Communication

To provide effective care, midwives should understand the influence of culture on communication about pain, responses to pain and the meaning of pain (Davidhizar et al 1997:347). In this regard, the stoic nature of the Mozambican woman in labour is of the utmost importance. Swazi midwives attending to Mozambican women in labour pain should always blend their understanding of cultural stoicism with their knowledge of human physiology, psychology and, where applicable, personal experience with regard to labour pain. At the same time, midwives should also be understanding and sympathetic towards bodily movements and vocalisation indicating the experience of severe pain. The philosophy and policy of contemporary health care and antenatal care are based on the Western biomedical rather than the magical-religious model. Midwives should be reminded that cultural practices do not override the administration of pain relief medication and that the individual woman in labour pain is exactly that: an autonomous individual.

Recommendation for further research

The findings of the present study brought to the fore certain aspects relating to the pregnancy, antenatal care and pain during pregnancy which call for more in-depth research studies. To improve the Swazi

midwives' understanding of Mozambican cultural practice in an attempt to render culturally congruent care the following research topics are proposed:

- Research into the psychological effect cultural practices surrounding pregnancy, and the antenatal period has of the pregnant woman and the effect hereof in promoting delivery;
- Research into possible detrimental practices surrounding pregnancy, and the antenatal period has of the pregnant woman and the effect hereof in promoting delivery.
- Research into the contents of culturally prepared medicine and the effect hereof on both the mother and the unborn child.
- Research into the Swazi midwife's attitude towards Mozambican women experiencing labour pain.
- A comparative study into the Swazi and Mozambican cultural practices surrounding pregnancy, the antenatal period, immediate postnatal period and management of labour pain.

5.7 CONCLUSION

This study on Mozambican women's experience of labour pain found that personal and cultural meanings are equally important in the experience and treatment of labour pain. To provide effective care, midwives should practise culturally congruent care. They should understand the influence of cultural practices on communication about pain and the communication of the experience of pain. Cultural orientation and differences significantly affect both the assessment and management of women in labour pain. Cultural bias or orientation might also lead to ethnocentrism, placing the midwife in a judgmental position. Human dignity and the ethics of nursing and midwifery practice, however, call for humane nursing care, which finds its ultimate quality in a blend of Western medicine and traditional health care practices, the realm of transcultural and culturally congruent care.