

**THE PERCEPTION OF A SELECTED GROUP OF MIDWIVES
TOWARDS WOMEN EXPERIENCING LABOUR PAIN**

by

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Submitted in partial fulfilment of the requirements for the degree of

MASTER OF ARTS

in the subject

HEALTH STUDIES

at the

UNIVERSITY OF SOUTH AFRICA

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NOVEMBER 2008

DECLARATION

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I, Kgwiti Michael Mahlako, declare that:

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is my original work, and that it has not been submitted before for any degree or examination at any other institution. All the sources used or quoted have been acknowledged by means of complete references in the text and bibliography.

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ABSTRACT

This qualitative study was aimed at exploring midwives' responses and attitudes towards women in labour, as well as their perception of the pain experienced during labour. A non-probability purposive sampling method was followed, and the data collection methods selected were in-depth individual interviews and focus-group interviews, with the aid of an interview guide for both methods, the researcher being the main data collecting instrument. More than one data collection method (triangulation) was used to ensure the trustworthiness of the study. Concerning the perception of midwives towards women experiencing labour pain, the study revealed that firstly, labour pain is unique to individual women, it is natural and bearable. Secondly, labour pain may be unbearable, and the women in labour need to be given medication for pain. Furthermore, certain behaviour was identified and viewed as unacceptable by participating midwives because it could put both the lives of the mother and the unborn baby at risk; these include: drinking herbal medicines during pregnancy and childbirth; extreme activities like jumping out of bed and rolling on the floor. These behaviours were sources of frustration to midwives.

Key words: labour pain; natural and bearable; individual pain threshold and tolerance; coping with labour pain; traditional and herbal medicines; situational factors that impinge on the perception of labour pain.

ACKNOWLEDGEMENTS

“Give thanks to the Lord, call on His name, make known among nations what He has done” (Psalm 105:1).

I would like to express my gratitude to the following persons:

- Dr DM van der Wal and Mrs JE Tjallinks, my supervisors at UNISA, for their constant support and encouragement
- Ms T Burger, the librarian, for her help in finding the literature sources
- The management of Dihlabeng Regional Hospital and Harrismith District Hospital and the midwives of both hospitals, who provided me with the opportunity to conduct the study
- Prof K le Roux, for editing the dissertation

A very special word of thanks to

- my wife, Limakatso, for her love, patience and support during the completion of this research study
- my children, Kgahliso and Rebone, for their love and understanding, especially when they needed their dad's presence and I was not there

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CHAPTER 1

Introduction and overview of the study

1.1 INTRODUCTION

Giving birth is a natural process in mammals, including in human beings; being created by God. God created human beings, making them to be like Him. "So God created man in his own image, in the image of God created he him; male and female ... and God blessed them, and God said unto them, be fruitful, and multiply ... " (GNB Genesis 1:27-28). Later God said: "In sorrow thou shalt bring forth children ..." (GNB Genesis 3:16). Due to this sorrow (pain) aspect, assisting women during the birth process has become institutionalised in the midwifery profession. As a humane profession, midwifery is practised across all cultures and societies. Cultural elements like values and beliefs influence this professional practice. It also influences midwives' perception of the pain experience of patients, and has an impact on the quality of service rendered by them.

1.2 THE RESEARCH PROBLEM

The research problem is discussed under the headings: the source of the research problem, the background to the research problem and the problem statement.

1.2.1 The source of the research problem

The researcher used to be a nurse manager at a district hospital complex (Phekolong and Reitz District Hospital) in the North Eastern Free State Province. Phekolong District Hospital is situated in Bethlehem, about 3 km from the Bethlehem Regional Hospital. District hospitals provide first level health care and Regional hospitals second level care.

The researcher's interest in the topic stems from formal and informal complaints from patients who gave birth in either of the two hospitals; complaints about the *harshness of*

the midwives when patients respond to pains during labour. Furthermore, the researcher used to attend the Regional Critical Incidents Meetings where formal patients' complaints were handled on a monthly basis. Most of the registered/raised complaints or critical incidents were labour (childbirth) related where patients complained of the harshness of the nurse midwives assisting in deliveries. Analyzing those complaints, it became evident that there existed some challenges with regards to *how midwives expect the patients in labour to respond to labour pains.* The researcher thus decided to explore the midwives' perceptions towards women in labour and their expectations of *patients' responses* to labour pains.

1.2.2 Background to the research problem

Giving birth is one of the most stressful life experiences of women. Studies on pain indicate that responses to pain stimuli depend on the individual cultural background which determines the individual pain threshold. Sellers (2004:422) states that each individual has her own pain threshold. Pain threshold varies according to the individual's psychological and physical state at any given moment in time. Cultural, religious and family backgrounds are also factors in setting the pain threshold in individuals (Sellers 2004:422).

The midwife's perception and resulting attitude towards childbirth pain is, likewise, influenced by culture, religion, personal experience and professional background. Thus, the support and care she provides during the childbirth process depends on her belief about labour pain and her expectations regarding the responses of patients during labour.

Bluff and Holloway (1994:163) cite Chalmer, Enkin and Keirse's (1989:1477) view that some midwives make decisions on the behaviour of women in labour while they practise forms of care that are inappropriate and ineffective and which should be abandoned, in the light of available evidence on pain management. According to Mander (1998:7), a change in attitude towards the control of labour pain cannot occur until perceptions and attitudes towards pain in general have changed. In this regard, Sellers (2004:429-431) states that the important aspect in dealing with pain in labour is the personal attention, which is given to the woman. Every expectant mother should be guaranteed continuous personal attention throughout labour. The midwife should be

gentle but efficient, kind but firm, understanding of the woman's needs but sure of her own abilities, and always conscientious in her work. Bluff and Holloway (1994:157) state that the relationship between the woman in labour and the midwife is important as the midwife helps to ensure that the (birth) experience is fulfilling and gratifying. The complains received by women in labour referred to earlier did not reflect any of these laudable traits attributed midwives.

1.2.3 Problem statement

The fundamental parameter of the problem is that patients claimed to have been verbally abused and even physically neglected by midwives during the labour process, indicating unprofessional and inhumane conduct by the midwives involved. The essence of the research problem was, at the onset of the research, that: *it was not known exactly what midwives' perceptions of labour pain were, and what they based their perceptions on.*

1.3 THE RESEARCH QUESTION, PURPOSE AND OBJECTIVES OF THE STUDY

Stemming from the research problem, the following research question and resulting purpose and objectives were formulated for the current study:

1.3.1 The research question

Considering the research problem the research question was stated as follows:

What are midwives' perceptions of the pain experienced by women in labour?

Alternatively, the research question was interpreted as:

What do midwives regard as acceptable or non-acceptable reactions by patients to labour pain?

1.3.2 Purpose

The purpose of the study was to explore midwives' responses and attitudes towards women in labour resulting from their perception of pain experienced during labour.

1.3.2 Objectives

The specific objectives set for the current study were to

- identify the personal perspectives and views (perceptions) of midwives on labour pain
- explore possible reasons for the midwives' responses to women experiencing labour pain
- understand what midwives regard as acceptable and as non-acceptable behaviour of women during labour
- determine if midwives acknowledged the uniqueness of individual women during labour
- recommend interventions with regard to perceptions on and resulting attitude towards and care of women experiencing labour pain

1.4 METHODOLOGY

In this section a brief description of the research methodology, including the meta-theoretical foundation of the study, is addressed, focusing on the ontological, epistemological and methodological assumptions underlying this qualitative study.

1.4.1 The meta-theoretical foundation of the study

Meta-theory refers to the theory of theories (Chinn & Kramer 2008:299). As a foundation for the current qualitative study, the research departed from the meta-theoretical point of the basic dialectical phenomenological argument, namely that an object makes one think about something but does not determine what one thinks about that thing (Meyer, Maritz & Meyer 1969:25). In this study, at the ontological level, the object of interest is midwives' perception of the pain experience of women in labour and the midwives' freedom of perception and attitude towards these women. At the

epistemological level, the perception and attitude of midwives warrant a linguistic (narrative or spoken word) epistemology. This linguistic epistemology is accompanied by qualitative methodology, which, in the current study, is represented by individual in-depth interviews, focus-group interviews, open coding and constant comparative data analysis. The researcher was the main research instrument.

1.4.2 Assumptions

Whereas quantitative research is founded on theory, theoretical structures, conceptual models and frameworks that provide for *framedness* of mind (deductive thinking), qualitative research is based on meta-theoretical assumptions that provide for and reflect on openness of mind (inductive thinking).

1.4.2.1 Ontological assumption

During this study, at the ontological level, the level of social construction and reality, it was assumed that

- the individual has freedom of choice
- the life-world of the individual is constituted moment-to-moment
- the individual can change his or her attitude and perception in accordance with situational dictates
- many realities exist

1.4.2.2 Epistemological assumption

During the study, at the epistemological level, the level concerning what *knowledge* entails, it was assumed that

- a linguistic or narrative epistemology supports the current research endeavour
- individuals can express their feelings, attitudes and reasons for behaviour linguistically
- similarly named things have comparable meaning to individuals conversing in a specific language

- one can hear and understand other persons' accounts of their life experiences as separate to one's own

1.4.2.3 Methodological assumption

During the study, at the methodological level, the level of operationalising and implementing the study, it was assumed that

- qualitative methodology would yield the data sought to answer the research question
- individual in-depth interviews and focus-group interviews would yield the data sought to answer the research question

1.4.3 Research design

The current study was conducted within the qualitative research paradigm. A generic qualitative design was adhered to. In this section the research design is discussed as follows:

1.4.3.1 Research paradigm

The current descriptive and contextual research study was conducted within the qualitative research paradigm. The main aim of qualitative research is to understand phenomena (in the case of the current research, midwives' perception and reaction to women in labour pain) in its natural occurring context without imposing any control or manipulation (Polit & Beck 2008:60-61, 763; Brink 1999:108-109).

1.4.3.2 Population

The population pertinent to the current study included midwives providing midwifery health care services in the Harrismith District Hospital and Dihlabeng (Bethlehem) Regional Hospital labour wards. The research aimed at studying only this group of midwives and the initial intent was not to generalise findings to other populations.

1.4.3.3 Sampling

According to Polit and Beck (2008:357-358), qualitative studies use small non-randomised samples. A critical first step in qualitative research is a selection of a setting with a high potential for information richness. Non-probability and purposive sampling methods were used to select participants from the (target) population. A list of midwives (sample frame) was drawn from each hospital maternity ward. Midwives were from different cultural groups and included both Black and White midwives. The sample size was dependent upon data saturation (Polit & Beck 2008:357). A non-probability purposive sampling method was followed for the following reasons: the study population consisted of the widest possible variety of participants who are Black and White midwives; the researcher decided to choose respondents who were judged to be typical of the population in question or who were particularly knowledgeable about the issue under study. Purposive sampling is also used when a researcher wants a sample of experts, as in the case of needs assessments using the key informants approach (Polit & Beck 2008:355-356; Brink 1999:140-143). Experts, with regard to the current study, included midwives working in the research site hospital.

1.4.3.4 Data collection

The data collection methods selected was in-depth individual interviews (Polit & Beck 2008:399-408) and focus-group interviews (Polit & Beck 2008:394-396, 527-529). These are discussed below.

Treacy and Hyde (1999:33-34) and Polit and Beck (2008:392-393) state that in in-depth interviewing, the interview is allowed to go in directions that are beyond the bounds of a rigid format. Participants are given the opportunity to describe their experiences in, and the understanding of, their life-worlds. Interviews aim essentially at grasping the narrator's point of view, as well as to clarify discrepancies amongst the members of a subculture or between the researcher's perceptions and such members' perceptions (Munhall 2001:291). Individual in-depth interviews were conducted as dictated by the overall research question. This method was chosen as it encourages informants to define important dimensions of the phenomenon under investigation. In the case of the current research, the perceptions of midwives on labour pain experienced by patients about to give birth (Polit, Beck & Hungler 2001:26). This method allowed the researcher

to understand the meaning midwives attributed to their everyday activities and it also allowed for direct discussions and the expressions of differing opinions and points of views (Marshall & Rossman 1995:80-81; Polit & Hungler 1995:272).

The second data collection method used was the focus-group interview. This was done for the purpose of *triangulation*. De Vos (1998:359) refers to Mouton and Marais (1990:72, 91) when quoting the original meaning of triangulation as coined by Denzin (1978). The term refers to the use of multiple methods of data collection with a view of increasing the reliability (trustworthiness) of observations, and not specifically for combining qualitative and quantitative methodologies. Triangulating different data gathering methods increases the accuracy and credibility of findings. It facilitates the researcher's corroboration of findings by using different but converging lines of investigation (Munhall 2001:369).

De Vos (1998:314) states that a focus-group interview can be defined as a purposive discussion of a specific topic or related topics taking place between eight to ten individuals with a similar background and common interest. Polit and Beck (2008:394-396, 527-529) view focus group interviews as interviews with a group of about 5 to 15 people whose opinions and experiences are solicited simultaneously. The interviewer, also called a *moderator*, guides the discussion according to a topic guide or a written set of questions. Such a topic guide, which was also compiled during the current research (see appendix B) provided for the following:

- A list of *unstructured questions* containing core elements of the research topic and possible probing questions. The completely unstructured interview is used when the researcher has no preconceived views of the content or floor of information to be gathered. Its aim is to elucidate the informant's perception of the world without imposing the researcher's views (Polit et al 2001:264).
- As *observation research* is concerned with gathering data through visual observation the researcher decided what behaviour to observe, who were to be observed, what observational procedures were to be used, and what type of relationships were to be established between the observer and the informants (Nieswiadomy 2008:245). This method was chosen as it helped the interviewer to note the body language in addition to what is said by participants (Marshall & Rossman 1995:80).

- The use of both fields notes and tape recordings to record the interviews.
- The timing (scheduling) of the interviews.

1.4.4 Data analysis

The narrative data collected were analysed qualitatively through the following steps:

1.4.4.1 Preliminary activities

Raw data were transcribed and transformed from audiotape to electronic format and to hard copies. Audiotapes were replayed while reading the transcripts to ascertain that they were of reasonably good quality, and that the data were in a format that would facilitate analysis. At this point in data analysis it was also decided to do the analyses manually, using a word processing program, as will be discussed in section 3.8, rather than using computer software. Administrative issues relating to storing the data were also established during this phase (Treacy & Hyde 1999:173-174).

1.4.4.2 Developing categories and codes

During this phase, mechanisms were designed to access sections of the data. Data were converted into smaller, more manageable, and more manipulatable units through a process of open coding and categorisation. This enabled the researcher to retrieve data of interest more easily (Polit et al 2001:284-386).

During this stage the researcher

- searched for themes or recurring regularities (discovering commonalities and natural variations across the participants) and patterns
- validated his understanding of the result of thematic exploration through member checks, investigator triangulation, and debriefing sessions
- integrated and wove the thematic pieces together into an integrated whole as proposed by Polit and Beck (2008:515-517)

1.5 ETHICAL CONSIDERATIONS

The ethical issues relating to the study were approached from the perspective of the informants/participants, the institution and the scientific integrity of the researcher.

1.5.1 The participants

The main ethical issues relating to participants involve autonomy and accompanying informed consent and individual rights. These issues are discussed in detail in section 3.4.2 of the dissertation.

1.5.2 The institution

The institution at which the research was conducted was treated, as proposed by Van der Wal (2005:154) as a person. Most of the ethical issues relating to the participants also relate to the institution. These issues are discussed in detail in section 3.4.3 of the dissertation.

1.5.3 The scientific integrity of the researcher

The scientific integrity of the researcher relates to the researcher's treatment of the participant, the institution and the research process in general, and trustworthiness specifically. The central position of the researcher as the main data collection instrument intimates the researcher's concern for the trustworthiness of the research. These issues are discussed in detail in section 3.4.4 of the dissertation.

1.6 SIGNIFICANCE OF THE STUDY

The envisioned significance of the study relates to

- the contribution it could make to the body of midwifery knowledge locally (in the area in which the study was conducted) and evidence based practice in the area
- the contribution it might make towards the international body of midwifery research knowledge
- the return it may have for:

- Nurse Managers: Additional information and understanding gained of both professional and personal traits that influence the quality of health care services delivery could assist Nurse Managers to design measures to prevent/reduce complaints and to improve quality care.
- Midwives: An awareness of the impact of their personal conduct in the care they render may improve reflective practise and enhance the quality of care delivered. A reciprocating blend of elements from their professional code of practise and cultural beliefs and practises may further enhance quality midwifery care.

The outcome of the envisioned significance of the study is contained in chapter five of this dissertation as *recommendations*.

1.7 LIMITATIONS OF THE STUDY

The limitations of the study or its weaknesses relate mostly to complaints levelled at qualitative research in general (Nieswiadomy 2008:59-60). The current study was conducted in only one of the nine provinces of South Africa, in one district of this province (Free State) and in only two Government hospitals' maternity wards. The results can thus not be generalised to the entire country or larger population.

1.8 DEFINITIONS OF KEY CONCEPTS

The following key concepts and their definitions apply to the current study. It is also acknowledged that the definitions the researcher' opted for might reflect aspects of his personal stance and that these inevitably influenced the qualitative research process.

- **Attitude** implies a way of regarding; a disposition or reaction (*Oxford School Dictionary* 2004:28) or any of a number of major integrative forces in the development of personality that give consistency to an individual's behaviour. Attitude is cognitive in nature. Through interaction with environment attitude reflects the person's innermost conviction about situations, whether good or bad, right or wrong, desirable or undesirable (*Mosby's Medical Nursing and Allied Health Dictionary* 2002:158).

Attitude can be defined in terms of the following characteristics:

- it is an inner state that has to be inferred from external behaviours
- it is learned or acquired
- it is a relatively stable, enduring disposition of the individual
- it evaluates matters or objects from positive to negative (Louw & Edwards 1997:772)
- **Midwife:** According to the International Confederation of Midwives (World Health Organization, and Federation of Gynaecologists and Obstetricians), a midwife is a person who has been admitted to a midwifery educational programme fully recognised in the country in which it is located, who has successfully completed a prescribed course of studies in midwifery and has acquired the requisite qualification to be registered and/ or legally licensed to practice midwifery (*Mosby's Medical Nursing and Allied Health Dictionary* 2002:1100).

Midwife means a person registered as such in terms of Section 31 of the Nursing Act, 2005 (Act no 33 of 2005) (South Africa 2005).

- **Pain** is defined as a process of transferring physical stimulation into psychological information; a mental process by which sensory stimuli are brought to awareness (Kaplan & Sadock 1991:220). Pain is an unpleasant sensation caused by any noxious stimulation of the sensory nerve endings (*Mosby's Medical Nursing and Allied Health Dictionary* 2002:1261). Pain is also an unpleasant feeling caused by injury or disease of the body, or mental suffering (*Oxford School Dictionary* 2004:319).
- **Perception** is defined as the conscious recognition and interpretation of sensory stimuli through unconscious associations, especially memory, that serve as a basis for understanding, learning, and knowing, or for the motivation of a particular action or reaction (*Mosby's Medical Nursing and Allied Health Dictionary* 2002:1310).
- **Responses**, from the verb *respond*, imply to act or behave in an answering or corresponding manner, to show sensitiveness to a stimulus or action, etc. by

behaviour or change (*Mosby's Medical Nursing and Allied Health Dictionary* 2002:1493).

1.9 LAYOUT OF THE STUDY

The complete dissertation (research report) is structured as follows:

Chapter 1: Introduction and overview of the study

Chapter 2: Literature review

Chapter 3: Research methodology

Chapter 4: Analysis and interpretation of the data

Chapter 5: Conclusions, implications and recommendations.

CHAPTER 2

Literature review

2.1 INTRODUCTION

We all experience pain at some stage in our lives, and our bodies are created in such a way that they uniquely respond to pain stimuli. A person suffering from pain needs care and support, whether from health professionals, friends, relatives or significant others. Caregivers' interventions to the pain suffered by patients could be influenced by their perception of what is regarded as acceptable or non-acceptable responses to pain and their perception of the severity of the pain experienced. Niven and Murphy-Black (2000:244) asserts that the nature of pain during childbirth differs from that associated with disease, disorder, trauma and surgical or medical procedures. These authors further suggest that labour pain, although extremely variable among women, is typically intense, with many describing it as the most severe pain they have ever experienced.

In the discussion that follows, the result of a literature review guided by the research question: *What are midwives' perceptions of the pain experience by women during labour?* is reported on. The discussion addresses at the following aspects:

- a brief historical background to midwifery
- the nature of pain in general
- a description and the experience of pain
- physiology/mechanism of pain
- stimuli that cause pain
- psychological and social factors influencing the experience of pain
- reactions to, and expression of, pain
- types of pain
- the nature of the labour pain
 - aetiology of labour pain
 - physiology of labour pain
 - factors that influence personal perceptions and experiences of labour pain

- the origin of women's attitudes towards labour pain
 - women
 - midwives
- midwives' reaction towards women in labour and labour pain
- conclusions

2.2 A BRIEF HISTORICAL BACKGROUND OF MIDWIFERY

Throughout the ages, women giving birth sought and received care from supportive others. At a certain point in the cultural evolution, some experienced women became designated as the *wise women* to be in attendance during childbirth. Thus the profession of midwifery commenced. Indeed, as historians have noted, a midwife has been known to play an important social role throughout recorded history, regardless of culture or time (Dolan, Fitzpatrick & Herrman 1983:13-15). Biblical recognition of the function of midwives include several verses recounting the experiences of two Hebrew midwives who refused to kill male infants in defiance of the King of Egypt (GNB Exodus 1:15-22). Other verses in the Good News Bible also refer to a midwife being in attendance at birth, implying that it was ubiquitous (GNB Genesis 35:17, 38:28). The midwife is also mentioned in the Good News Bible (GNB Genesis 35:17) where it is stated “...when she was in hard labour the midwife said unto her, fear not; thou shalt have this son also.” The book of Exodus (GNB Exodus 1:20) states, “Because the midwives feared God, He was good to them and gave them families of their own”. Historians have also found the practice of midwifery referred to in papyri as well as in ancient Hindu records.

In Greek and Roman times, midwives functioned as respected autonomous care providers to women during their reproductive cycle. Some qualifications of the practice of midwifery began to evolve during this period. For example, in Greece the midwife was a woman who had borne children herself. This requirement has remained a commonality in practice of midwifery throughout several cultures and exists even today. ‘Midwife’ is a word which in English was translated to mean “with woman”, implying the supportive, not the interventive, function of the practitioner. The ancient Jews called her the *wise woman*, just as she is known in France as the *sage-femme*, in Germany, the *weise Frau* and also *Hebamme* or mother's adviser, helper, or friend. The Latin term *cum mater* and the Spanish and Portuguese term *comadre* have the same meaning

(<http://www3.utsouthwestern.edu/parlland/midwiferytxt/mdwfhistorytxt.html> – accessed 16 September 2002).

In ancient times and in primitive societies, the work of a midwife had both a technical or manual aspect and a magical or mystical aspect. Hence, the midwife was sometimes revered, sometimes feared, sometimes acknowledged as the leader of society, sometimes tortured and killed. The midwife had knowledge and skills in an area of life that was a mystery to most people. Since women had no access to formal education, it was widely assumed that the midwife's power must come from supernatural forces, such as an alliance with the devil. During the Middle Ages, a frenzy of witch burning promoted by both the church and the civic authorities was responsible for killing several million women, many of whom were midwives and healers. The profession of midwifery continued without major changes throughout the centuries, even through the Dark and Middle Ages. In practice, midwives routinely used herbs and potions, as forerunners of today's modern pharmaceuticals. The midwives of these early centuries generally continued to learn by first being an apprentice. As such, skills and knowledge were handed down from generation to generation, without the development of a formalised system of university education, until late into the 20th century. Therefore, midwives did not benefit from the scientific enquiry that developed early in medical schools. Eventually midwifery in most affluent countries developed formalised programmes, although apprenticeships are still part of some programmes today. Currently, in much of the world, professional midwives are responsible for attending women in labour and birth. In fact, in the countries with the best pregnancy outcomes, midwives are the primary providers of care to pregnant women (<http://www3.utsouthwestern.edu/parlland/midwiferytxt/mdwfhistorytxt.html> – accessed 16 September 2002).

2.3 THE NATURE OF PAIN IN GENERAL

2.3.1 Definition

Pain is defined as an unpleasant feeling caused by injury or disease of the body or as mental suffering (*Oxford School Dictionary* 2004:319). Pain is a subjective experience - only the person suffering can know what it feels like. Pain is not a single entity, it has different qualities according to its origins and it also has different meanings attached to it (Jowitt 2000:12). *Pain* can be defined as an unpleasant sensation of the nerve

endings or an unpleasant sensation caused by the noxious stimulation of the sensory nerve endings. The sensation of pain is whatever the person experiencing it says it is, and it exists whenever he or she says it does (Pillitteri 2003:1112). Pain is universally encountered but personally experienced as unpleasant and subjective (Leifer 2005:109; Kanner 2003:1).

2.3.2 Description and experience of pain

Pain is a complex phenomenon, a signal of tissue damage, threat, an integrated defence reaction and a private experience of hurt (Sofaer 1992:13; Smeltzer & Bare 2004:217). Pain perception is thus a very complex process, and there are many opportunities for information to be processed in any number of ways (Thomas 1997:40; Smeltzer & Bare 2004:220-223). Pain is a personal experience that varies greatly among individual responses to an apparently similar stimulus. Pain is often the cardinal symptom of inflammation and is valuable in the diagnosis of many disorders and conditions. It may be mild or severe, chronic or acute, lancinating or burning, dull or sharp, precisely or poorly localised or referred (*Mosby's Medical Nursing and Allied Health Dictionary* 2002:1261; Kanner 2003:10-15; Smeltzer & Bare 2004:218).

Pain management made incredible easy (2003:1) state that "Although pain seems like a simple sensation, it's actually a complex experience influenced by: (a) a person's cultural background, (b) the anticipation of pain, (c) previous experience of pain, (d) the context in which pain occurs and (e) emotional and cognitive responses." These factors are corroborated by Smeltzer and Bare (2003:223-225). Pain is a multi-dimensional experience with physiological, psychological and social components (Niven & Murphy-Black 2000:245; Kanner 2003:10-15). Jowitt (2000:12) also asserts that pain is not a single entity; it has different qualities according to its origin and it also has different meanings attached to it.

Pillitteri (2003:1112) also states that pain is difficult to define because different people experience it differently. It is subjective (experienced by the person), not objective (able to be determined by observations).

2.3.3 Physiology/mechanism of pain (pathophysiology)

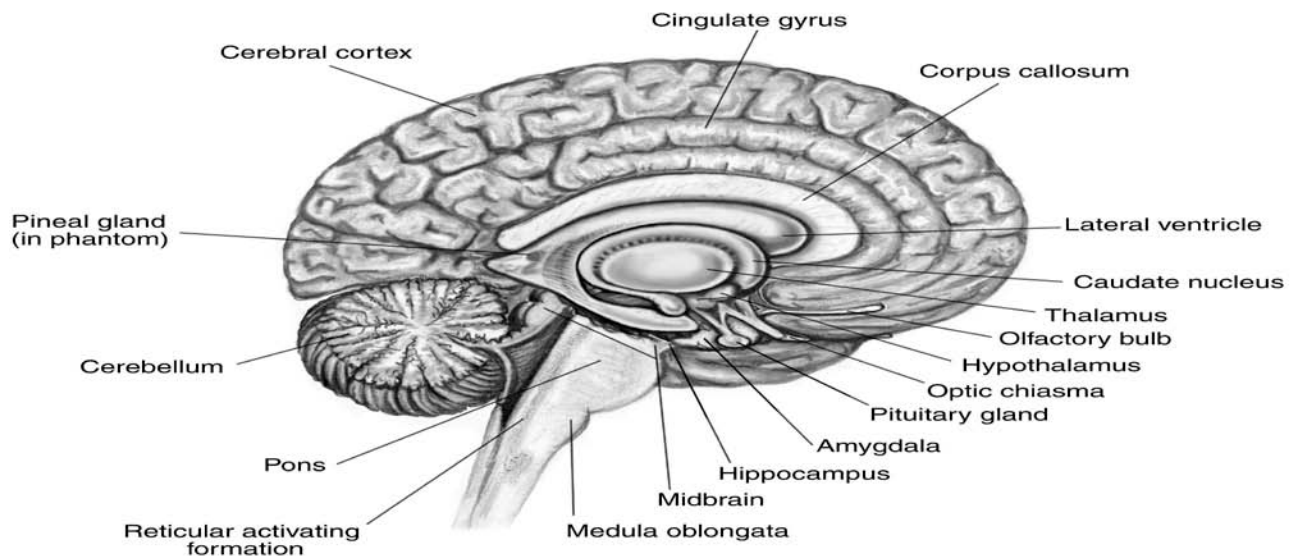


Figure 2.1 The cross section of the human brain

(Source: GIF Image Discoverthis 1986)

Pain mechanism is the network that communicates unpleasant sensations and perceptions of noxious stimuli throughout the body in association with physical disease and trauma involving tissue damage. The *gate control theory* of pain (Kanner 2003:3, 256) is an attempt to explain the role of the nervous system in the pain response. It states that pain signals that reach the nervous system excite a group of small neurons that form a pool. When the total activity of these neurons reaches a minimal level, a theoretic gate opens up and allows the pain signals to proceed to higher brain centres. The areas in which the gates operate are considered to be in the dorsal horn of the spinal cord and brainstem. The *pattern theory* holds that the intensity of stimuli evokes a specific pattern, which is interpreted by the brain as pain. This interpretation is the result of the intensity and frequency of stimulation of a non-specific end organ. Some authorities, including Smeltzer and Bare (2004:220) believe that *bradykinin* and *histamine*, two chemical substances produced by the body, intensify pain.

Recently discovered natural painkillers produced by the body, are grouped as the enkephalins and the endorphins (Smeltzer & Bare 2003:220). Some studies indicate that the enkephalins are 10 times as potent as morphine in reducing pain. It is known

that after histamine and some other naturally occurring chemical substance are released in the body, a pain sensation travels along fast conducting and slow conducting nerve fibres. These pain transmitting neuro-pathways communicate the pain sensation to the dorsal root ganglia of the spinal cord and the synapse to certain neurons in the posterior horns of the grey matter. The pain sensation is then transmitted to the rectangular formation and the thalamus by neurons that form the anterolateral spinothalamic tract. It is then conveyed to various areas of the brain, such as the cortex, and the hypothalamus, by synapses at the thalamus. The immediate reaction to pain is transmitted over the reflex arc by the sensory fibres in the dorsal horn of the spinal cord and by synapsing neurons in the anterior horn. This pattern of anatomic sensory and motor neurons allows the individual to move quickly at the touch of some harmful stimulus, such as extreme heat or cold. Nerve impulses alerting individuals to move away from such stimuli are simultaneously sent along different nerve fibres from the brain (*Mosby's Medical Nursing and Allied Health Dictionary* 2002:1263; Leifer 2005:113; White & Duncan 2002:287-288; Smeltzer & Bare 2004:220-223).

According to Pillitteri (2003:1114), pain conduction consists of four major steps:

- transduction (sensing the pain sensation)
- transmission (routing the pain sensation to the spinal cord)
- perception (the brain interprets the sensation of pain)
- modulation (which affects physiological responses to various waveforms, and which may be continuous, interrupted, pulsed or surging) (Pillitteri 2003:1114; *Mosby's Medical Nursing and Allied Health Dictionary* 2002:1113)

The nerve fibres that conduct impulses away from pain receptors are of two main types namely, acute pain fibres and chronic pain fibres. The *acute pain fibres* (also known as A-delta fibres) (Kanner 2003:10; Smeltzer & Bare 2004:220) are thin and myelinated nerve fibres. They conduct nerve impulses rapidly, at velocities of up to 30 meter per second. These impulses are associated with the sensation of sharp pain, which typically seems to originate in a local area of the skin. This type of pain seldom continues after the pain stimulus response stops.

The *chronic pain fibres* (C fibres) (Kanner 2003:10; Smeltzer & Bare 2004:220) are thin unmyelinated nerve fibres. They conduct impulses more slowly than the acute pain fibres, at velocities up to 2 meters per second. These impulses cause dull aching pain sensations that may be widespread and difficult to pinpoint. Such pain may continue for some time after the original stimulus has ceased. Although acute pain is usually sensed as coming from the surface, chronic pain is likely to be felt from deeper tissue as well as in the skin. Visceral pain impulses are usually carried on the C fibres. This is important as far as labour pain is concerned.

Commonly, an event that stimulates pain receptors will trigger impulses on both types of pain fibres. This causes a dual sensation: at first a sharp pricking pain, then a dull aching pain. The aching pain is usually more intense and may worsen over time (Smeltzer & Bare 2004:220).

Pain impulses that originate from the tissue of the head reach the brain along sensory fibres of the fifth, seventh, and tenth cranial nerves. All other pain impulses travel on sensory fibres of spinal nerves, and they pass into the spinal cord by way of the dorsal roots of these spinal nerves. Upon reaching the spinal cord, pain impulses enter the grey matter of the posterior horn, where they are processed. The fast conducting fibres synapse with the long nerve fibres that cross over to the opposite side of the spinal cord and ascend into the lateral spinothalamic tract. The impulses carried on the slow conducting nerve fibres pass through one or more inter-neurons before reaching the long fibres that cross over and ascend to the brain. Within the brain, most of the fibres terminate in the reticular formation and from there are conducted on fibres of still other neurons to the thalamus, hypothalamus and cerebral cortex (Shier, Butler & Lewis 2002:460; *Mosby's Medical Nursing and Allied Health Dictionary* 2002:1263-1264; Kanner 2003:10; Smeltzer & Bare 2004:220).

2.3.4 Stimuli that cause pain

Pain receptors are stimulated when body tissue is damaged. Damage that causes stimuli to trigger pain in tissue is trauma, ischemia (lack of blood and oxygen), intense heat, intense cold (especially freezing of tissue), and the chemical irritation of tissue (Guyton 1984:153). Pain usually results from such noxious stimulus applied to the

periphery. A noxious stimulus is one that may result in tissue damage (Davis, Blakely & Kidd 2001:268).

When adults are hurt, specialised sensory nerves known as nociceptors send signals to the spinal cord and brain, which prompt the body into automatic awareness of pain (Littleton & Engebretson 2005:483). *Nociceptors* play an important part in pain and are sensory receptors formed from branched free nerve endings of unmyelinated C-fibres and small-diameter myelinated A-fibres, which respond to noxious stimuli (Davis, Blakely & Kidd 2001:268; Kanner 2003:10; Smeltzer & Bare 2004:220).

2.3.5 Psychological and social factors influencing the experience of pain

Pain threshold (Kanner 2003:32-33; Smeltzer & Bare 2004:226) is the point at which the stimulus, usually one associated with pressure or temperature, activates pain receptors and produces a sensation of pain. Individuals with low *pain thresholds* experience pain much sooner and faster than those with higher thresholds. Pillitteri (2003:1114) states that although people may have the same *threshold sensation* (the amount of stimulus that results in pain), their *pain threshold* (the point at which the individual reports that a stimulus is painful) and *pain tolerance* (the point at which an individual withdraws from a stimulus) varies greatly. According to Vellay's Theory (in Sellers 2004:22), the brain has a threshold below which pain is not perceived. Individuals have varying thresholds, varying according to the individual's psychological and physical state at any given moment in time. A low pain threshold means the pain is experienced when a person is subjected to a relatively light and/or small amount of stimuli, while a high pain threshold indicates that the pain is only experienced when a relatively stronger and/or greater amount of stimuli is present.

Factors which may lower the pain threshold (Sellers 2004:422; Smeltzer 2004:223-226) are worry and anxiety, insecurity, fear, ignorance, fatigue, intense heat or cold, poor general physical condition, malnutrition and starvation, dehydration, continuous pain, or severe pain experienced over an extended period, either intermittently or continuously. According to Sellers (2004:422-423), factors that can raise the pain threshold, can be divided into emotional, psychological and physical factors.

Some general factors influencing pain perception, pain threshold and tolerance are discussed below.

➤ **Gender**

In a study to investigate the relationship between measured levels of masculinity-femininity, and the responsiveness by men and women, the analysis of this interaction indicated that; for men, there was a correlation between masculinity-femininity and pain, where higher masculinity was associated with a higher pain threshold and the findings were not the same for the women (<http://www.ncbi.nlm.nih.gov/pubmed/4069906> – accessed 7 June 2008). In earlier studies Thomas (1997:21) stated that even though the influence of an individual's gender on the experience of pain is contradictory, three studies to one indicated that females experience a higher level of pain than males. Thomas (1997:21) concluded that “It appears that the gender of a patient can influence pain experience and analgesic requirements, however, there is no consistent pattern”. In a study to determine gender differences in cutaneous pain perception, women showed a tendency to rate the stimuli as more unpleasant and more intense than men (http://www.psychosomatic_medicine.org/cgi/content/full/62/4/517 – accessed 7 June 2008). Smeltzer and Bare (2004:225) also discuss the issue of gender and pain concluding that the results of studies in this domain are inconclusive.

➤ **Age differences**

Thomas (1997:21-22) further stated that the literature addressing the influence of age on pain experience is also not clear-cut. She concludes that psychological coping strategies are more useful in explaining the differences in pain experience and behaviour than variables like age and gender. Andrews and Boyle (2003:407) also state that specific biological factors and psychosocial factors influence people's perceptions and experience of pain. This implies that age alone as a factor does not clearly influence pain perception. Smeltzer and Bare (2004:225) indicate that much more research into these variables is needed.

In recent studies by Lin, Hsieh, Chao, Chang and Hsieh (2005:269-281) on *the influence of age on the thermal and vibratory thresholds on quantitative sensory testing*, the study findings suggested that age is the most significant factor in determining

sensory parameters (<http://www.ncbi.nlm.nih.gov/pubmed/16221286?ordinalpos=1&itool=EntrezSystem2> – accessed 7 June 2008).

➤ **Ethnic differences**

Culture seems to influence the expression, rather than the sensory experience of pain itself. Cultural norms that determine when and where to express pain are learnt at an early age. People from Latin origin are more typically expressive and inclined to dramatise pain expression with excessive vocalisation and posturing (Thomas 1997:22). A person's culture dictates attitudes towards pain and the proper response to pain (Pillitteri 2003:58). These findings are generally in accordance with information from Smeltzer and Bare (2004:224) and Kanner (2003:33, 36). Furthermore, some patients have a cultural tendency to express pain openly, but some do not, and those who are very vocal may not be merely dramatic, but may indeed experience severe pain (Gruenberg 2006:64). Helman (2007:185-187) also mentions the relationship between culture and privacy/openness towards pain as well as cultural views on pain as misfortune. In relation to the research topic, these statements imply that perceptions towards pain experiences and responses should not be stereotyped. Midwives should regard pain experiences by women in labour as unique with unique reactions to it.

➤ **Personality differences**

Thomas (1997:24-26) asserts that the influence of personality on the experience of pain has been the subject of much research, and it appears that personality can influence both the sensory and the expressive aspects of pain. This is reflected as

- *extraversion*, being associated with increased reports of pain in patients suffering chronic pain
- *post operative neuroticism*, which correlates positively and significantly with the pain experience of both men and women
- *trait anxiety*, which predisposes people to react in a highly anxious manner in a stressful situation
- the prolonged stress of chronic pain which influences people to learn a sense of helplessness

In addition, Pillitteri (2003:58) states that a person's response to pain is both *individually* and *culturally* determined. Smeltzer and Bare (2004:228) conceptualise pain as a product of the individual's responses to noxious sensory input as affected by the interactive influences of social/cultural, conceptual/judgmental and emotional/motivational factors (Smeltzer & Bare 2004:224-227).

➤ **Previous clinical experiences**

Roy (in Thomas 1997:26) states that clinical experiences support the role of negative events in exacerbating chronic pain. The memory of pain can be more damaging than its initial experience (Niven & Murphy-Black 2000:244). This is corroborated by Smeltzer and Bare (2004:223) indicating that prolonged experience of pain does not equate tolerance of pain. In relation to the research topic this statement implies that if women had traumatic birth experiences in the past, that feeling could be equated with chronic pain, which can in future affect their pain experiences negatively, e.g. increase the intensity of labour/childbirth pain. Clinical or self-experience in this instance may also influence the midwives' perception of the severity of pain experienced by patients.

➤ **The role of meaning in the experience of pain**

People attach meaning to pain; and evidence suggests that such meaning may influence the way individuals tolerate pain. The meaning associated with pain and suffering may dramatically influence the intensity and quality of the individual's experience of pain (Smeltzer & Bare 2004:227-228). Rituals and rites of passage ceremonies also convey symbolic messages, which can override pain, e.g. hook swinging. This returns us to the cultural influence of pain and pain experience and expression (Thomas 1997:28-29).

2.3.6 Reaction to, and the expression of, pain

As indicated previously, responses to pain vary widely among individuals, depending on various physical (such as specific diseases and injuries, health, pain thresholds), psychological (such as anxiety), and socio-cultural factors (*Mosby's Medical Nursing and Allied Health Dictionary* 2002:1262; Smeltzer & Bare 2004:223-226).

Responses to pain vary widely among individuals depending on many physical and psychological factors, such as specific diseases, injuries and health, pain threshold, anxiety, fear and the cultural background of the individual involved, as well as the way the individuals express their pain experiences (*Mosby's Medical Nursing and Allied Health Dictionary* 2002:1262; Smeltzer & Bare 2004:223-226).

According to *Pain management made incredible easy* (2003:50), pain behaviour is the way in which a patient communicates pain, distress or suffering. These authors further suggest the following behaviours and pain expressions to be included in a checklist when assessing a patient's pain experience: grimacing, moaning, sighing, clenching teeth, holding or supporting the painful body area, sitting rigidly, frequently shifting posture or position, moving in a guarded or protective manner, moving very slowly, limping, taking medication, using a cane, cervical collar or other prosthetic device, walking with an abnormal gait, requesting help with walking, stopping frequently while walking, lying down during the day, avoiding physical activity, being irritable, asking such questions as, "Why did this happen to me?", and asking to be relieved from tasks or activities. In addition to *Pain management made incredible easy* (2003:1262) comments, Helman (2007:185) indicate that pain has two components namely the *original* sensation and the *reaction* to that sensation. The latter, whether voluntary or involuntary, is referred to as *pain behaviour* and includes facial expressions, grimaces, changes in behaviour or movement as well as certain sounds made by sufferers, or words uttered to describe the nature and intensity of pain.

2.3.7 Types of pain

Pain is categorised into three broad categories, namely, acute pain, chronic non-malignant pain and cancer pain (*Pain management made incredible easy* 2003:11). In addition, pain may be mild or severe, chronic, acute, lancinating, burning, dull or sharp, precisely or poorly localised or referred (*Mosby's Medical Nursing and Allied Health Dictionary* 2002:1261).

2.3.7.1 The nature of acute pain

Acute pain is generally characterized by being associated with a specific event: (a) trauma, such as sport injury, burns or accident; (b) disease, such as migraine,

headache, gout and sickle cell crisis, cancer or myocardial infarction; or (c) therapy, such as surgery, dental work or diagnostic procedures. Acute pain has a sudden onset and a foreseeable end. It comes suddenly and lasts from a few days to a few weeks (*Pain management made incredible easy* 2003:11; Pillitteri 2003:1114; Smeltzer & Bare 2004:218). Sudden or slow onset of pain of any intensity from mild to severe with an anticipated or predictable end and duration of less than six months is defined as acute pain (*Mosby's Medical Nursing and Allied Health Dictionary* 2002:1261). It may be constant (as in a burn), intermittent (as in muscle strain that hurts only with activity) or both, as in an abdominal incision that hurts a little at rest and a lot with movement or coughing (*Pain management made incredible easy* 2003:11; Kanner 2003:8; Smeltzer & Bare 2004:218).

Chronic acute pain: discomfort that occurs almost daily over a long period, has a potential for lasting months or years and has a high probability of ending; also known as progressive pain (White & Duncan 2002:1066).

2.3.7.2 The nature of chronic pain

Chronic pain refers to pain that has lasted more than six months. Chronic pain is usually not a symptom, not a warning signal, and not a need for rest. It is a syndrome composed of a number of physical, emotional and behavioural changes which can convert otherwise healthy individuals into invalids. Chronic pain is like a 'false alarm' - a warning signal that serves no purpose. In its effect on the individual who experiences it and on the family, chronic pain is a debilitating disease (Siang-Yang 1996:29; White & Duncan 2002:285; Pillitteri 2003:1114; Kanner 2003:8). Smeltzer and Bare (2004:218) also refer to chronic acute pain as non-malignant pain.

Pain is considered chronic when it lasts beyond the normal time expected for an injury to heal or for an illness to resolve. It causes serious disability (as in arthritis or avascular necrosis), or it may be related to poorly understood disorders such as fibromyalgia and complex regional pain syndrome (*Pain management made incredible easy* 2003:12).

2.3.7.3 Cancer pain

Cancer pain generally becomes progressively more severe as the disease infiltrates more and more tissue, causes obstruction and metastasis (Kanner 2003:134; Smeltzer & Bare 2004:218). Ignatavicius and Bayne (1991:589) state that in terminal cancer, pain is a problem in 75% of all clients, and 25% of all clients die without adequate pain control. Smeltzer and Bare (2004:218) state that in about 50% cases, cancer pain is described as moderate to severe.

2.3.7.4 Pain relating to somatic location

Pain is also categorised according to somatic location as follows:

Superficial/cutaneous pain is caused by stimulation of the cutaneous nerve endings in the skin or mucous membranes and results in a well-localised 'burning' or 'prickling' sensation; getting a knot in the hair that is pulled out during combing may cause cutaneous pain (White & Duncan 2002:283). It can be described as bright, pricking or burning (Sofaer 1992:15). It arises from skin or other superficial structures of the body. The pain is well localized by the individual to the point of injury (Davis et al 2001:266) According to Kanner (2003:6), somatic or cutaneous pain is carried along sensory nerve fibres.

Visceral pain is the pain that arises from the internal organs, and differs in many respects from superficial and deep pain. The stimuli that lead to visceral pain are often very different from those producing superficial pain. Visceral pain is usually diffused and poorly localized (Davis et al 2001:266) discomfort in the internal organs and is less localised and more slowly transmitted than cutaneous pain. It is difficult to assess because the location may not be directly related to the cause (White & Duncan 2002:283) Kanner (2003:6) indicates that visceral pain is carried along autonomic nerve fibres.

In *referred pain impulses* travel to the cortex where they are interpreted as painful, but pain is felt at a site other than that which has been stimulated (Sofaer 1992:15). Camic and Brown (1989:21) state that "It is a well-known fact that irritation of deep somatic or visceral structures may provoke a sensation of pain in distant regions innervated by the

same neural segment.“ Referred pain results only from stimulation of pain receptors located in deep structures, such as the viscera, the joints, and the skeletal muscles and never from pain receptors in the skin (*Mosby’s Medical Nursing and Allied Health Dictionary* 2002:1264; White & Duncan 2002:283; Kanner 2003:13; Smeltzer & Bare 2004:217).

2.4 THE NATURE OF LABOUR PAIN

2.4.1 Description

As indicated previously, pain is a sensation of discomfort, is subjective and a personal symptom. It is what the person says it is and is present when the person says it is and it is unique to the individual. Thus, in labour pain too, only the woman experiencing it can describe or know the extent of her pain (Pillitteri 2003:520; Smeltzer & Bare 2004:217).

Childbirth or labour pain differs from pain experienced in other conditions in the following ways:

- Labour pains are part of the normal process of child bearing, whereas pain at other times usually indicates illness or injury.
- The sources of pain during labour are known: the purpose of excruciating muscle contractions during the birthing process is to propel the baby through the birth canal. The sensation is thus also referred to as a contraction, and not necessarily as pain.
- Women have time to prepare themselves. Knowledge and skills can be developed to manage the expected pain (Leifer 2005:109).

2.4.2 Aetiology of labour pain

The pain experienced by the woman in labour is caused by the uterine contractions and the dilatation of the cervix, and in the late first stage and the second stage by the stretching of the vagina and the pelvic floor to accommodate the presenting part (Bennett & Brown 1989:179; Pillitteri 2003:522; Levasseur, Raines & Scheetz 2003:181; Littleton & Engebretson 2005:483; Leifer 2005:113).

During contractions blood vessels constrict, reducing blood supply to the uterine and cervical cells, resulting in anoxia and ischemia to muscle fibres. This causes pain in the same way that blockage of the cardiac arteries causes the pain in a heart attack. As labour progresses and contractions become longer and more forceful, the ischemia to cells increases and the pain intensifies (Pillitteri 2003:522; Levasseur et al 2003:181; Fraser, Cooper & Nolte 2006:458).

Niven and Murphy-Black (2000:245) indicate that labour pain is normally experienced in the first and second stages of labour during each contraction, although some women also experience continuous back pain. Levasseur et al (2003:181) state that during the first stage of labour, the pain is generally referred to the lower abdominal wall, lumbar region and sacrum. During the second stage of labour, the pain is somatic and is caused by hypoxia of the uterus, distension of the vagina and perineum and pressure on adjacent tissues. Pain in the second stage is felt in the lower back and suprapubic area or referred to the flanks and the thighs. Pain during the third stage of labour is similar to the visceral pain of early labour and is related to the rapidly decreased blood flow to the uterine tissue.

2.4.3 Physiology of labour pain

In accordance with the general physiology of pain as discussed previously, Pillitteri (2003:522) and Bennett and Brown (1989:178), state that the pain sensation in labour also begins in nociceptors, the end points of afferent nerves, when they are activated by mechanical, chemical, or thermal stimuli. The nociceptors are located predominantly in the skin, bone periosteum, joint surfaces and arterial walls. When end terminals are stimulated, chemical mediators such as prostaglandins, histamine, bradykinin, and serotonin are synthesised and sensitize the nociceptors. The pain impulses are transmitted along small unmyelinated (C-Fibres) and large myelinated (A-delta Fibres) to the spinal cord through the lower thoracic dermatomes at levels T-10 to L-1. A dermatome is an area of the body innervated through a specific spinal nerve. Pain impulses from the vagina and the perineum are transmitted through the pudendal nerve which is composed of fibres that enter the spinal column through the sacral nerves S-2 to S-4. The more numerous C-fibres conduct slowly and apparently carry dull, low level pain; the fewer A-delta fibres apparently carry sharp, well-localized pain. In the dorsal horn of the spinal cord, somatostatin, cholecystinin, and substance P serve as

neurotransmitters or assist the pain impulse across the synapse between the peripheral nerve and spinal cord. The pain impulse then ascends the spinal cord to the brain cortex where it is interpreted as pain (Littleton & Engebretson 2005:483; Fraser et al 2006:456).

The experience of pain during labour is the result of the complex processing of multiple physiologic and psychosocial factors on the woman's individual interpretation of nociceptive labour pains. The nature of labour pains, particularly its physiologic and psychological influence, is reviewed in the context of a multi-dimensional framework of pain experience and an understanding of the origin of labour pain, stimuli of the potential effects of the pains response and of the concept of suffering and comfort <http://www.../serve?action=searchDBandsearchDBfor=artandartType=absandid=a121427andnav=ab> – accessed 16 September 2002). According to Littleton and Engebretson (2005:483), the degree of pain changes as the dilatation of the cervix progresses. Maternal tolerance of the changes varies, but is often impacted by the duration of labour.

According to Pillitteri (2003:522-523), the foetal position is a physical variable that can influence pain. A woman with a foetus in an occiput posterior position often reports intense or nagging back pain during labour, even between contractions. Other specific pain sensations may be indicative of an abnormal presentation, such as an occiputo-posterior position or different problems such as uterine rupture (Littleton & Engebretson 2005:483).

2.4.4 Factors that influence personal perceptions and experiences of labour pain

Sellers (2004:421) and Fraser et al (2006:455-456) state that the degree of pain during labour varies in different women, in the same woman during succeeding labours and at different stages in the same labour. This is due to both the individual and personal make-up and to external influences and experiences.

According to some studies (such as Green et al's cited in Fraser et al 2006:641), labour pain is influenced by many factors specific to the individual woman and her environment. Many of these factors are 'modifiable' and offer the potential to enhance comfort and reduce pain. These include (1) features of the birth and environment (2)

levels of fear and anxiety (3) the woman's coping strategies and expectations. The choices women make about labour pain relief methods have a profound effect on their labour experience and outcomes. A woman's confidence in her ability to cope appears to influence her experience of labour more than any other factor (http://www.emu'szine.com/Health.../labor_pain_affects_4_million_u_s_women_anually.html – accessed 16 September 2007). Fraser et al (2006:454-456) also indicate the following main areas of factors influencing women's perception and experience of labour pain; mobility and positioning, culture, and control over pain.

2.4.4.1 Psychological factors

Psychological factors that influence pain include fear, anxiety and worry, expectation of pain, body image, and self-efficacy (Pillitteri 2003:523). These can be aggravated by exhaustion from loss of sleep due to prolonged labour (Littleton & Engebretson 2005:483). Kline (<http://www.nuring.edu/sites/PedsPain/anxtt.htm> – accessed 4 September 2007) indicates that the psychology of pain experience relates to *anxiety*, which in turn is influenced by cultural factors, the immediate environment and past experiences. Gélis (in Mander 1998:15) notes that fear, for example of death, was thought to weaken a woman's endurance and reduce her pain tolerance. Gibbins and Thomson (2001:302) suggest that the pain women expect to feel can provoke anxiety, because it is unknown. Women with high levels of anxiety and fear tend to have high levels of pain. Anxiety causes tension and decreased muscle relaxation, which decreases tissue oxygenation, and therefore causes a more intense pain experience (Levasseur et al 2003:181). Fraser et al (2006:640-641) also indicate that certain normal emotional changes occur during the three trimesters of pregnancy. The third trimester changes which may have pertinent impact on the experience of labour pain are the psychological effects of changed body image, the psychological effects from physiological discomforts such as backache, and anxiety about labour and labour pain.

In a study conducted to determine the memory of pain throughout life experience, it was found that pain associated with childbirth was the most memorably reported (Brigh in Niven 2000:245). It is further suggests that there is a striking difference between labour pain experience in the context of helplessness, suffering and loss, and pain experiences in the context of coping resources, comfort and the sense of accomplishment. The philosophy behind prepared childbirth or psychoprophilaxis is that

ignorance; misinformation, fear and anxiety appear to intensify pain (Littleton & Engebretson 2005:482-483).

Emotional sources of pain (fear of the unknown, lack of education, etc), although contributory to increased levels of pain experience, can be overcome by childbirth education, reading, by visiting birth facilities, discussion with care providers, and numerous other sources of information (<http://www.childbirth.org/articles/laborpain.html> – accessed 9 June 2007).

Ultimately, the experience of pain, as a unique experience, will be dictated by the individual woman's coping strategies and mechanisms. These are often formed by previous pain experiences. Women who had a number of operations as a child and adolescent may think that the experience of labour is almost painless, whereas the woman who has never experienced pain beyond a paper cut may perceive labour pain as unbearable (Levasseur et al 2003:181). The patients' previous exposure to pain will often influence their reaction. Coping mechanisms that were used in the past may affect their judgement about how the pain will affect their lives and what measures are within their control to manage the pain (White & Duncan 2002:288).

2.4.4.2 Culture, nationality and religion

With regard to *culture*, researchers found that there exists a difference in pain sensitivity as experienced by Blacks in comparison to Whites. In a study Blacks reported a greater sensitivity towards pain as compared to their White counterparts. In the treatment arena, such discrepancies in pain perception or cultural attitudes about discomfort take on added importance, because they may influence the decision whether a person seeks prompt medical attention or not. The difference in pain behaviour among these cultural groups may be due more to factors such as role models, education, economic status and access to medical and social support, than to racial or ethnic composition (<http://www.partnersagainstpain.com> – accessed 16 September 2007).

Mander (1998:13) noted cultural factors that impinge on childbearing in general, and associated pain in particular. In a literature review conducted concerning clinical staff's difficulty to cope with the differing reactions to pain by patients from different

nationalities, it was found that Italians, Jews and the Irish differ with regard to their reactions to pain (Mander 1998:14). Furthermore, religion was found to influence culture by advocating pain acceptance, adopting either a prospective or a retrospective approach, as portrayed by Muslim *kismet (destiny)*, Hindu *Karma (reincarnated burden)* and Christian *atonement* (Mander 1998:14). According to Levasseur et al (2003:181) in some cultures women are expected to be stoic, whereas in other cultures vulnerability and outward expressions are expected.

Perry and Lowdermilk (2006:339) cite examples of how women of different cultural and national backgrounds may react to pain:

- Chinese women may not exhibit any reaction to pain, although it is acceptable to exhibit pain during childbirth.
- Arab and Middle East women may be vocal in response to labour pain.
- Japanese women may be stoic in response to labour pain, but they may request medication when the pain becomes severe.
- South East Asian women may endure severe pain before requesting relief.
- Hispanic women may be stoic until late in labour, when they may become vocal and request pain relief.
- Native American women may use medication or remedies made from indigenous plants.
- African-American women may express pain openly, although the use of medication for pain varies.

Gélis (1991 in Mander 1998:6) reports that different societies regard the expression of labour pains differently. His French sources viewed crying out as permissible, even admirable. Cheung (in Mander 1998:6) suggests that other societies regard crying out as dishonourable. Childbirth education has made the woman's relationship with her body to change and thus her perception of pain.

With the above in mind, Littleton and Engebretson (2005:482) assert that it is useful for the nurse to identify in advance the most frequently seen patient's ethnic groups and to develop profiles of culturally specific childbirth practices, including pain behaviour. The nurse must be aware of, and must be sensitive to individual variations in a patient's choice of dealing with pain in labour and delivery.

The development of attitudes to pain and its interpretation occurred along with the development of societies. However, ancient ideas about pain in general, and pain as intense as labour pain in particular, may be deeply held and may manifest themselves under the stress of childbirth. According to Caton (in Mander 1998:3), there exists a gradual change from regarding pain as a divine phenomenon to accepting pain as a natural phenomenon. Simultaneously, this idea is transformed from being regarded as a generally beneficial to a potentially destructive process. Caton (in Mander 1998:3) further discusses pre-Christian Greek and Jewish perceptions of pain as having a dual role, namely:

- Pain operated as a divine punishment for transgression; thus Greeks, such as Homer, attributed pain to arrows released by the gods. Such external attribution was widespread and applied also to disease processes.
- Simultaneously, pain was regarded positively as an opportunity for healing through cleansing to achieve redemption from sin. These ideas persisted until enlightenment (Mander 1998:3).

Under the Judeo-Christian influence, pain continues to be interpreted as a divine retribution for wrongdoing. Fundamental to these ideas is the church's dependence on the dogma of the origin of sin, which materialised in the woman's inherently evil nature (Mander 1998:14-15). Therefore, pain's dual role as both punishment and redemption emerged. The philosopher Lock (1632-1704) clung to the established idea of pain as a divine gift to preserve life. Later, Bentham (1748-1832) modified this idea to interpret laws of nature as punitive interventions initiated by a deity, and thus pain was inherently evil, while John Steward Mills (1806-1873) (in Mander 1998:14) denied the divine contribution and attributed pain to natural processes. Mander (1998:3-15) continues by indicating that more recently moral and religious interpretations of pain have become obsolete in the developed world. As in other aspects of life personal responsibility for individual welfare has become prevalent. The expression of pain is also governed by cultural values. In some cultures the tolerance of pain, and therefore "suffering in silence" is expected. In others, full expression of pain may include animated physical and emotional responses (White & Duncan 2002:288).

2.4.4.3 Education

Education as a factor in labour pain is addressed by McIntosh (Mander 1998:15). This researcher argues that women in lower socio-economic groups have their own-shared perspectives of attitudes towards childbearing, which are more culture bound. Mander (1998:15) concludes that culture, nationality, religion and education combine to demonstrate that socio-economic class carries a range of features contributing towards pain perception. This is qualified by Levasseur et al's (2003:181) conviction that women who are better educated and informed about the childbirth process are more secure and being more secure, perform at a higher level.

2.4.4.4 Factors intrinsic to labour

Parity also plays a part in women's pain perception and experience during labour. The cervix of a multiparous woman often softens before the onset of labour and therefore is not as sensitive as the cervix of a primiparous woman. The intensity of uterine contractions is greater and the length of labour is often longer in primiparous women (Levasseur et al 2003:181). In normal labour, primipara women usually experience more pain than multipara women (Sellers 2004:423). Patients' previous exposure to pain often influences their later reaction to pain. Coping mechanisms that were used in the past may affect patients' judgement about how the pain will affect their lives and what measures are within their control to manage pain (White & Duncan 2002:288).

Foetal size and the position of the foetus understandably play a part in labour pain. Larger foetuses or foetuses in posterior or breech positions are likely to cause more pain than foetuses in normal positions (Levasseur et al 2003:181). Backache is prominent in the posterior position of the vertex and is severe when there is uncoordinated uterine action, especially when the vertex is abnormally resistant (Sellers 2004:423).

An increase in the number of medical interventions such as frequent vaginal examinations, placement of intra-uterine catheters and eventual instrumental delivery have shown to correlate with increased pain perception (Levasseur et al 2003:181).

2.4.4.5 The control of pain

Sellers (2004:422) states that there is no perfect method to relieve labour pain. All methods involve trade-offs between risks and benefits. Therefore women need full information from the best evidence available on the benefits and risks of labour pain control methods. Such information needs to be passed on to patients well before labour begins so they can weigh the options, obtain answers to questions, clarify preferences and make careful arrangements that will accommodate their needs and preferences.

Perry and Lowdermilk (2006:246) corroborate the fact that a woman's pain during childbirth is unique to her and that it is influenced by a variety of factors, including physiologic factors (e.g. endorphins level and maternal position), cultural background, anxiety levels, previous childbirth experience, preparation for childbirth, the comfort and support given by nurses and significant others, the quality of labour and the birth environment. As indicated previously, clinical experiences support the role of negative events in exacerbating chronic pain (Roy, as cited in Thomas 1997:26). Page and McCandlish (2006:111) also state that anxiety about pain has been shown to be a strong predictor of negative experience during labour, lack of satisfaction with birth, and poor postnatal emotional well-being.

Functional sources of pain (cervical dilatation, contractions, descent of the baby, position, procedures, etc) although unavoidable, can be reduced by relaxation, change of position and by remaining mobile. Physiological sources of pain (derivation from normal posterior position of the foetus) can be reduced by manipulating the baby's position (<http://www.childbirth.org/articles/laborpain.html> – accessed 9 June 2002).

2.5 THE ORIGIN OF WOMENS' AND MIDWIVES' ATTITUDES TOWARDS LABOUR PAIN

The origin of certain attitudes towards labour pain derives from early times. Distant history indicates culture and religion as the main sources of attitudes and views pertinent to childbearing and labour pain; an attitude and view that for the better part emphasised 'nature' and a non-involvement philosophy (approach) (Sellers 2004:417). The advancement of contemporary scientific knowledge within the medical field swung the view of informed persons from a philosophy of no intervention to a philosophy of

drug intervention as an essential element during labour and childbirth. Knowledge empowers women so they can decide how best to relieve pain during labour within the limits of medical safety (Pilliteri 2003:523). This aspect is also emphasised by Fraser et al (2006:32) in their discussion of “The new midwifery” – a women oriented approach.

According to Sellers (2004:418), there have lately been suggestions that perhaps women should experience some pain during labour. They should not be told that labour is painful, but be taught to cope with the pain. Furthermore, in order to enable women to deal successfully with labour and to promote natural childbirth, they should receive psychological and moral help and support throughout pregnancy and labour/childbirth; and then, if really necessary, be given some means of pain relief, depending upon the woman’s outlook, her faith, her pain threshold and the type of labour/childbirth she is experiencing. This could create a new positive source (or origin) to create positive attitudes towards labour pain. In this regard, midwives play a key role in educating women and their extended social support systems about numerous comfort and pain relieve strategies available, making sure they understand the choices available to them, with the benefits and risks (Pilliteri 2003:523). White and Duncan (2002:282) state that it is, therefore, important for midwives to understand not only the psychological and physiological components that add up to the pain experience, but also the wide range of interventions available to provide relief.

In a sense, attitude begets attitude in the labour ward. Midwives as caregivers during the labour process should be non-judgmental (Sellers 1997:422). In addition, midwives’ presentation of themselves as being professional and competent secures trust on the part of the patient. According to Fraser et al (2006:33-34), the relationship between the woman in labour and the midwife is important as the midwife helps to ensure that the experience is fulfilling. Culture, religion, family and professional background also, as indicated previously, influence the midwives’ attitude towards childbirth pain. Thus, the support and care she provides during the childbirth process depend on her belief about labour pain and her expectations regarding behavioural responses of patients to labour pain. As Bluff and Holloway (1994:163 citing Chalmer et al 1989) indicate, “Some midwives make decisions on the behaviours of women although they are still practicing forms of care that may be inappropriate or ineffective and should be abandoned in the light of available evidence.” This is corroborated by Leap’s (2000:49-53) study results that reveal that midwives were clear that their approach to pain in labour was different

from that which they were taught during training. In this regard Leap (2000:49-53) describes two approaches adopted by midwives to pain in labour, namely:

- a '*pain relief*' paradigm in which pain relief was taught as an essential role for midwives and an important choice for women regardless of the type of labour
- the '*working with pain*' paradigm that involves developing an understanding of normal pain as part of the process of labour. Under this paradigm the reasons for not giving pain relief include the view that pain is purely a physiological phenomenon that pain cautions the woman and indicates that she should find a place of safety to give birth, and that pain venerates the birthing occasion.

Jowitt (2000:12) also suggests that midwives' attitudes may be influenced by what they have been taught, by their experience of having assisted many women in labour and for those who have given birth, by their own experience of childbirth. Leap (in Hunter 2001:441) indicates that the way midwives cope with the experience of caring for women having labour pain *varies according to their personal philosophies*. Since the childbirth environment is highly emotive, Smith (in Hunter 2001:441) indicates that some midwives *become task orientated and distance themselves from the women but others can still be there for their clients*. McCrea, Wright and Murphy-Black (1998:175-176) indicate the following factors as foundational to the midwife's approach to caring for a woman having labour pain: philosophy of care in the unit, active labour management (inducing labour, checking monitors, etc), staffing levels, which affect the amount of time midwives spend with the woman allocated to them. All of these directly or indirectly influence the midwives' state of mind (attitude) in the labour ward, and this state of mind is picked up by the woman in labour.

Closely related to the above, is Nyberg, Boykin's and Schoenhofer's notion (cited in Minnaar 2002:35) that most literature concentrates on the patient's expectations with little description of nurses' perceptions and expectations. Minnaar (2002:35) further suggests that a caring attitude is not transmitted from generation to generation by genes, but by the culture of the caring profession. The provision of a human value system in nursing management would give nurses an environment conducive to quality nursing care. In such an environment midwives and nurses would nurture hope, contributing positively to the recovery of the patients. Without the cultivation of sensitivity to oneself and to others nursing and midwifery care would fail because

nurses need to be sensitive towards their own needs and to the needs of others to develop the ability to learn about another person's view of the world (Minnaar 2002:37). Watson (1985:19) suggests that persons, who are not sensitive towards their own feelings, might find it difficult to be sensitive and responsive to the feelings of others. If nurses fail to be humane in sensitive situations such as in childbirth and labour, they essentially fail in nursing and caring. In this regard Sellers (2004:429) suggests that the most important aspect in dealing with pain in labour is the personal attention, which is given to the woman, and every expectant mother should be guaranteed and be given continuous personal attention throughout labour.

Probably the most important factor of all affecting women's experience of labour is the interaction that they have with people around them (Wickham 2006:11). Women in labour experience varying needs for pain relief and their choices may change during the course of their labour (Page & McCandlish 2006:349). The midwife's role is to ascertain what the patient wants and to be sensitive to the possibility that she may change her mind during the course of labour following clinical assessment (Page & McCandlish 2006:350). This is in line with Fraser et al's (2006:32-33) view on women centred midwifery.

2.6 MIDWIVES' REACTIONS TOWARDS WOMEN IN LABOUR AND LABOUR PAIN

Midwives should also recognise their own responses to pain and how they respond to other's expression thereof (White & Duncan 2002:282). In a study conducted by Baker, Ferguson, Roach and Dawson (2001:171-179) to determine the perceptions of labour pain by mothers and their attending midwives, it was found that midwives assess individual women's pain relative to other women with whom they have shared the birthing process. They conclude that if midwives were previously involved with particularly distressing traumatic labour episodes, they may view average labour as comfortable, while for the women it still remains one of the most painful experiences of their lives.

Seibold, Miller and Hall (1999:21) suggest that there exists a need for studies, which will identify the strategies used by midwives in assisting women to manage their labour pain, as well as the support they offer in all aspects of the birth process. Baker et al

(2001:171) suggest that the accurate and the appropriate management of pain is a significant problem for the attendant medical and nursing personnel. They further mention that it was found in many of the literature reports that pain is often under- or over-estimated by the nursing staff who, as a consequence, consistently fails to administer adequate analgesia.

According to Kirkman (1998:329), midwives could be seen to be present, absent and presently absent. Only the midwife who engages fully with the client was seen to soothe and help reduce fear. Seibold et al (1999:21) suggest that a woman–midwife relationship should be a partnership and be based on equality, shared responsibility, empowerment, continuity of care-giving, individual negotiation and informed choice and consent.

A study conducted by McCrea et al (1998:174-180) identified three types of midwives with regards to pain relief approaches, indicating midwives' reactions towards labour pain, namely:

- *Cold professionals*, who do not work with women but do things *for* them and *on* them. They keep their distance from the labouring women. When these women use coping strategies such as shouting, these midwives respond by telling them not to shout and waste their energy.
- *Disorganised carers*, who give pain relief information only on request and who are influenced by their experiences and personal opinions. They spend most of their time in social chatting rather than listening actively to patients.
- *Warm professionals*, who provide adequate and appropriate information on pain relief in an informed way to the women, who give women an opportunity to ask questions and seek clarification without feeling that they are asking silly questions. These midwives also provide emotional support. Generally they work with women to help them to cope with their labour pain.

Warm professionals, as defined by McCrea et al (1998:174-180), are characterised by women's encounters with midwives, as described by Berg, Lundgren, Hermansson and Wahlberg (1996:12) participants who emphasised

- the importance of being met on an equal level with respect

- not being made to feel ashamed of their behaviour
- midwives who are friendly and gentle
- support and encouragement when it is necessary
- to be guided by the midwife, but on the women's own terms
- warmth and nurturing producing feelings of comfort, strength and relaxation

Lundgren, Hermansson and Wahlberg's (1996) assertions are resonated by Fraser et al (2006:32-33) stating that in principle midwifery should reflect:

- "women-centred care, including choice, control and continuity for women
- the potential for the development of a personal continuous relationship between the woman and her midwife
- midwifery autonomy and a clear expression of the distinct nature of midwifery practice
- appropriate support for midwives
- a positive organisational culture"

Although these factors may not directly contribute to midwives' reaction to women experiencing labour pain it may indirectly and supportively lead to improved midwifery care and consequently more appropriate action and reaction to patients in pain.

The 'Pain Relief Paradigm/Subculture' originates from what midwives were taught during training regarding pain relief during labour. Leap states (2000:49-53) that in this paradigm midwives feel pressurised to offer pain relief because of the personal discomfort experienced by practitioners being with women in pain. It is thus all about the midwife needing not to have to deal with someone else's pain or expression of pain. Some midwives expressed a view that it is hard work for a midwife to be interacting with somebody who is agitated, is making a lot of noise and is being demanding. In this subculture, midwives commented on how the pressure to offer pain relief is exacerbated in labour wards by reactions to the noise that women in labour make, particularly when they are frightened.

The 'Working with Pain Paradigm/Subculture' (Leap 2000:49-53) suggests a different approach to pain management, which is the one that 'works with pain'. The core issue here is developing an understanding of pain as part of the normal process of labour.

Transcending the two paradigms is an anonymous agreement that abnormal pain is associated with abnormal labour/childbirth and that pain relief is appropriate in such cases (Leap 2000:51). Whichever the paradigm adhered to, it is crucially important for the midwives to make themselves emotionally available to allay anxieties and fears (Kirkman 1998:329). Only midwives who engage fully with the patient will soothe her and help reduce fear. Gruenberg (2006:138) also states that a caregiver's knowledge and application of comfort measures can be enormously advantageous to the woman in labour.

2.7 CONCLUSION

In the above discussion the literature related to the topic of midwives' perception of women's experience of labour was reviewed. Based on the research topic the following issues were discussed: the historical background of midwifery, factors influencing pain perception, pain tolerance and threshold, the social meaning of labour pain, attitudes towards labour pain, attitudes of caregivers, the emotional labour of midwives, the care and support given to women in labour, and the origin of some of the perceptions (attitudes and views) on labour pain.

The next chapter explicates the research methodology and research design of the research.

CHAPTER 3

Research methodology

3.1 INTRODUCTION

In this chapter the researcher will discuss the research paradigm, namely the qualitative research paradigm (also seen as the meta-theoretical grounding of the research), and the research design selected for the study. The latter includes sampling procedures, data collection methods and instruments, data analysis and interpretation, and ethical considerations and measures to ensure trustworthiness. In essence, the researcher embarked on a generic qualitative, descriptive, explorative and contextual study in order to answer the research question, and to attain the set purpose and objective of the research. These are reiterated as follows (also see section 1.3.1 through 1.3.3):

➤ **The research question**

The problem as posed in the research question that the current study set out to answer is:

- *What are midwives' perceptions on the pain experience of women in labour?*

Alternatively, the research question is stated as:

- *What do midwives regard as acceptable and as non-acceptable reactions to labour pain?*

➤ **Purpose**

The purpose of the study was to explore midwives' responses and attitudes towards women in labour resulting from their perception of pain experienced during labour.

➤ Objectives

The specific objectives set for the study are to

- identify the personal perspectives and views (perceptions) of midwives on labour pain
- explore possible reasons for midwives' responses to women in labour pain
- understand what midwives regard as acceptable and non-acceptable behaviour of women during labour
- determine if midwives acknowledge the uniqueness of individual women in labour
- recommend interventions with regard to perceptions of midwives on women in labour pain

3.2 THE RESEARCH PARADIGM: QUALITATIVE RESEARCH

Flick (2002:2) suggests that the qualitative approach is of specific relevance to a study of social relations, owing to the pluralisation of life-worlds. With regard to the current study, the midwife/patient relationship, as implied by the perceptions of midwives towards women in labour pain, constitutes a social relationship, and the life-worlds of these individuals constitute 'pluralisation'. Cormack (2000:19) and Burns and Grove (2005:24) state that the term 'qualitative research design' is used as an umbrella term for those strategies that seek to explain human behaviour in terms of the reasons people have for behaving the way they do. Qualitative research approaches are believed to embody, humanistic and naturalistic philosophy (Burns & Grove 2005:24), which holds that the world is known through human perceptions and subjectivity; they are considered more closely associated with the interpretative and critical paradigms. Key methods include participant observation, small purposive samples, in-depth interviewing and the use of literary descriptions and analysis. Table 3.1 compare the basic differences between qualitative and quantitative research. These comparisons proved to be a major guideline for the researcher as a novice researcher, especially since the researcher was trained and is working in a more quantitatively oriented environment.

TABLE 3.1 DIFFERENCES BETWEEN THE QUANTITATIVE AND QUALITATIVE RESEARCH PARADIGMS		
	QUALITATIVE	QUANTITATIVE
Philosophical origins	Interpretive Critical social theory	Logical positivism
Main concerns	Discovers, describes and verifies; in short, identifies patterns that can lead to development of theories and hypotheses Seeks to uncover the understandings and motives that lead to certain actions Search for reasons	To test hypotheses and theories Aim to uncover relations of cause and effect Search for causes
Research objectives	Holistic approach. Interested in views, feelings and perception of individual. Focus on whole process (Subjective data) Uses human speech and writing as data	Quantifying/comparing individuals or groups (Objective sense data) The whole is equal to the sum of the parts Use numbers as data
Research design	Framework not always predictive, i.e. phenomenology, historical, grounded theory, ethnography	Logical predictive framework Experimental or descriptive
Research instruments	Unstructured and open, i.e. interviews, participant observer, personal/historical documents	Structured, i.e. questionnaire, structured interviews, non-participant observer, critical incidence
Presentation of findings	Narrative, i.e. extracts from interviews/diaries	Statistical data (descriptive or inferential)
Sampling	Non-random	Random
How knowledge is obtained	Inductive Emphasises the importance of subjectivity- the assumption that the sole foundation of factual knowledge is private experience	Deductive Aspire to objectivity- the assumption that facts can and should be presented in a manner untainted by feelings, opinions or biases of the researcher/or researched (Smith & Hunt 1997:207; Cormack 2000:19, 141-142; Burns & Grove 2005:24))

3.3 THE RESEARCH DESIGN

According to Polit et al (2001:470), a research design is the overall plan for addressing a research question including specifications for enhancing the integrity of the study. The research design incorporates some of the most important methodological decisions that the researcher makes in answering the research question(s) and in attaining the research objectives. Crookes and Davies (1998:116) and Hek, Judd and Moule (2002:25) also assert that a research design is a plan of *how* research will proceed. Hek et al (2002:25), as well as Polit et al (2001:40) further suggest that a research design might be founded on either a quantitative (deductive/experimental) and/or a

qualitative (inductive/non-experimental) approach to research. The choice will affect all aspects of the research design including aspects such as the size of the sample, data collection methods, instruments and techniques, and will be most evident in the type of data obtained and the analysis of such data.

The research design must of necessity be feasible and must aim at providing answers to social questions. Consequently, the design must also be flexible enough to adapt to an ever-changing social reality and unexpected conditions in the social situation that could give rise to unexpected questions, which cannot always be anticipated in advance. In short, the principal objective of the research design is to plan a *scientific* investigation into the object of interest.

According to Speziale and Carpenter (2007:35), the choice of the research design will be influenced by the research question, the research approach (paradigm) selected the sensitivity of the subject matter, and the availability of resources. In addition, Smith and Hunt (1997:13) suggest the following factors as influencing the choice of the research design:

- some approaches are more suitable to certain topics than others
- researchers may base their decisions on past experiences and personal preferences
- the availability of a research supervisor and guidance in the specific field might also be a consideration
- the practical issues surrounding time and money could be seminal

All these points were considered during the current research.

Hek et al (2002:39) add that the focus of a study might not be solely on the object of interest (topic) but on the theoretical or the philosophical stance the researcher takes. Polit et al (2001:17-21 and Nieswiadomy (2008:48-49) share a common view that the purpose of research is to explore, describe, and explain phenomena in qualitative research and add prediction and control phenomena and variables via quantitative research. Emphasis on any one or a combination of these purposes will guide the researcher to the design more appropriate for a specific study. For the purpose of this study the author decided on a qualitative, descriptive, explorative and contextual

research design based on the general principle of phenomenology. The researcher is of the opinion that a true phenomenological study calls for much more than what is called for in a dissertation of limited scope. For this reason the researcher was prepared only to explicate the main dialectical argument underlying phenomenology and to commit himself during the research to this dialectic argument (Nieswiadomy 2008:172-173).

This argument, as indicated in chapter one, proposes that thinking is always directed to some object (whatever is knowable); objects make one think about something but do not determine what one thinks about such objects. This dialectical argument spells out the implications that determinism and indeterminism have for each other and leaves the argument settled in a position of relative determinism/indeterminism (probability/possibility) open to multiple realities, a description of experience (that which is knowable) and in a general 'qualitative' state (researcher's interpretation and understanding). This calls for a qualitative *descriptive explorative and contextual research design* that sets the stage for a process of observing, describing and documenting aspects of the situation as it occurs *naturally*. It also provides a starting point towards hypothesis and theory generation (Polit et al 2001:178).

According to Crookes and Davies (1998:119), such a research design allows the researcher to come to *understand* a phenomenon from the perspective of the actors involved in a situation. These authors further suggest that in this instance (qualitative research), phenomena are investigated in-depth, which provides a considerable amount of rich narrative data from relatively small numbers of participants or informants.

3.3.1 Sampling

As it is often not feasible to work with a total population researchers rely on a portion (sample) of the population to investigate a specific phenomenon (Nieswiadomy 2008:411).

3.3.1.1 Site sampling

The research was conducted at two hospitals only, namely in the labour wards at Harrismith District Hospital and Dihlabeng Regional Hospital in Thabo Mofutsanyana District, Free State Province, Republic of South Africa. The decision to make use of

these two hospitals was based on the fact that the one is a District hospital and the other a Regional hospital. The extraordinary medical incidents handled by the District Unusual Incident Committee (a Committee that addresses the patients' complaints about services), and which gave rise to the current research problem and ensuing research question, came from these hospitals. District and Regional hospitals render a 24-hour maternity service.

3.3.1.2 Population and participant sampling

The term *population* refers to the entire set of individuals or objects (elements) having some common characteristics (e.g. all midwives in Hospital or area X), which the researcher is interested in. This is also referred to as a *universe* (Polit et al 2001:467). According to Babbie and Mouton (2004:174), a *study population* is that aggregation of elements from which the sample is actually selected; all elements (individuals, objects, or events) that meet sample criteria for inclusion in a study. This notion is affirmed by Nieswiadomy (2008:188-189).

With regard to this study, the *population* involved midwives in general. The *target population* was those midwives providing midwifery health care services in the Harrismith District Hospital and Dihlabeng Regional Hospital labour wards.

A *sample* is a subset of a population or universe selected to participate in a research study (Polit et al 2001:470). Babbie (2004:174) refers to the term *sampling unit* as the element or set of elements considered for selection in some stage of sampling. The term *sampling* as a verb indicates the process of selecting a sample of elements from the population. Cormack (2000:23-24) and Nieswiadomy (2008:411) define a *sample* as a proportion of the defined population who are selected to participate in the study and is intended to reflect all the characteristics of that population.

Sampling in most qualitative projects involves *selection criteria*, which seeks individuals with special knowledge or unique experience to increase the researcher's understanding of the topic or phenomenon studied (Polit & Beck 2008:356). According to Polit et al (2001:234), sampling is a process of selecting a portion of the population to represent the entire population. These authors (Polit et al 2001:248) further assert that in qualitative research, the sample size should be determined on the basis of

information needs. A guiding principle in sampling during qualitative research is *data saturation*, which implies sampling to the point where no new information is obtained and redundancy is achieved.

The *sampling process* during the current study was carried out within the parameters of a *non-probability, purposive or judgmental sampling* (Cormack 2000:24; Burns & Grove 2005:352-353), where

- *non-probability* entails the selection of the subjects or sampling units from a population using non-random procedures; examples include convenience, judgemental and quota sampling (Polit et al 2001:466).
- *purposive/judgmental sampling* is defined as the process in which the researcher selects the sample on the basis of his or her knowledge of the population, the elements involved in the study and the nature of the aim of the research; thus, the purpose of the study and the judgement of the researcher (Babbie and Mouton 2004:166-167; Nieswiadomy 2008:198-199). According to Polit et al (2001:239-240), *purposive/judgmental* sampling is based on the assumption that the researcher's knowledge about the population can be used to handpick the cases to be included in the sample. The researcher might decide purposefully to select the widest possible variety of participants or might chose participants who are judged to be typical of the population or phenomenon in question.

With regards to the current study the *strengths* and *limitations* of this sampling approach were considered, as explicated by Polit and Beck (2008:355-356) and Cluett and Bluff (2000:155, 187), namely:

- the major *strength* is that a sample of experts is selected as far as the research topic (experience) is concerned
- the major *limitation* is that generalising from a purposive sample to the broader population is not advisable. This is quite acceptable, as with the current research the researcher was not interested in generalising the results of the study but only to understand the reason for certain conduct or behaviour and the *thinking* behind certain views.

The reasons for choosing this sampling method were that

- the researcher was well acquainted with the population of midwives
- this population was knowledgeable (experts) about the issue being investigated, namely the personal perception of reactions to women in labour pain

The main inclusion criterion (Babbie & Mouton 2004:287; Burns & Grove 2005:343) for the selection of participants for the current study was that a participant had to be a *midwife*, the *title* and *legal description* of a person who, having been regularly admitted to a midwifery educational programme fully recognised in the country in which it is located, has successfully completed the prescribed course of studies in Midwifery and has acquired the requisite qualifications to be registered and/or legally licensed to practice Midwifery (*Moby's Medical and Nursing Dictionary* 2002:1100). In South Africa the term 'midwife' refers to a person registered under section 31 of the Nursing Act (Act No 33 of 2005) (South Africa 2005).

The *inclusion criteria* for this study were further refined to include midwives

- who had given birth vaginally without medical assistance. The reason for deciding on this criterion was based on the assumption that a woman who had had a normal delivery also experienced the different intensities of labour pain during the different stages of labour, and the experience of the labour process had not been masked by medical interventions such as vacuum or forceps assistance.

As exclusion criteria the researcher considered the following:

- an accoucheur (a male who practices midwifery). As a male midwife, the accoucheur cannot experience labour pain (Nursing Act, 1978, Act No 50 of 1978, as amended) (South Africa 1978).
- a midwife whose labour was abnormal and gave birth by means of assistance like a caesarean section, vacuum extraction or instrumental delivery, or epidural medication. This category of women was excluded because they did not have total autonomy over the labour process, and certain moments during their labour process were changed from normal to artificial.

- a midwife who has not given birth. This category of participants was excluded based on the same reasons as those for excluding the accoucheur.

The eventual sample size for the current research was determined by data saturation. According to Polit et al (2001:470), Burns and Grove (2005:750) and Polit and Beck (2008:70-71) *saturation* is a process of collecting data to the point at which a sense of closure is attained because new data yield only redundant information. The researcher hears a repetition of themes or ideas as additional participants are interviewed in a qualitative study (Nieswiadomy 2008:411). This researcher conducted seven individual interviews and two focussed-group interviews. The total number of interviewees involved in the research was seven participants for one-on-one interviews, four participants in the first focussed-group interview and three participants in the second focussed-group interview. In each focussed-group interview the researcher interviewed the same participants from whom the data was collected during the individual interviews; the reason for this action being that the researcher wanted to strengthen credibility to ensure the trustworthiness of the study through *method/methodological triangulation*: the use of multiple methods to address a research problem, e.g. observation plus interview) (Polit et al 2001:316; Burns & Grove 2005:225). Saturation of data was established on analysing the collected data.

3.3.2 Data collection: approaches, methods and praxis

A variety of data collection methods and instruments can be used in qualitative research allowing for triangulation and the enhanced trustworthiness of the study (Nieswiadomy 2008:66). Method-triangulation was implemented during the current research using both individual in-depth interviews and focus-group interviews to generate data.

3.3.2.1 Self-report methods

For the purpose of this study the researcher will discuss two methods of data collection used, labelled by Polit et al (2001:186, 263-269) and Cluett and Bluff (2000:155, 187) as *self-report* methods, namely *in-depth qualitative research interviews* and *focus-group interviews*. Other methods, categorized as self-report methods, include structured interviews (including questionnaires), personal narratives, life histories and critical

incident techniques. In human sciences, a good deal of information can be gathered by self-report methods, questioning persons directly about the phenomenon under investigation (Polit et al 2001:264). These authors describe this approach as consisting of a range of techniques that vary considerably with regard to the degree of structure imposed on data during the data collection process. The end points here are

- *loosely structured* (even unstructured) methods, that do not involve a formal written set of questions
- *tightly structured* methods, involving the use of formal documents such as questionnaires

To attain the purpose under investigation the researcher followed the unstructured manner because the primary purpose of the study is to gather information in the natural unstructured setting, the unaltered accounts of the lived experiences of the participants. Whatever the method within the self-report approach, the researcher is regarded as the main instrument in qualitative research (Polit et al 2001:266).

Among the reasons why the researcher has opted for self-report, count that self-report techniques

- are persuasive with regard to directness and veracity, e.g. if you want to know how people feel about a phenomenon, you ask them about it
- frequently yield information that would be difficult, if not impossible, to gather by any other means
- can gather information retrospectively about activities and events that occurred in the past or gather projections about behaviour in which participants plan to engage in the future
- can be designed to measure psychological characteristics through direct communication with participants
- are versatile with respect to content coverage, e.g. people can be asked to report on facts about their personal background, about other people known to them, about events or environmental conditions, beliefs about what the facts are, attitudes, feelings and opinions, reasons for opinions, attitudes or behaviours, level of knowledge about conditions, situations or practices, and intentions for future behaviour (Polit & Beck 2008:369-370; Cluett & Bluff 2000:156)

Among the most serious weaknesses (limitations or disadvantages) of self-report techniques is the question about validity and accuracy. The researcher was mindful about this throughout the current study. Questions that plague self-report research in terms of a more objective quantitative approach are:

- How can we be sure that participants feel or act the way they say they do?
- How can we trust the information that the participants provide, particularly if the questions could potentially require them to reveal an unpopular position on a controversial issue or to admit to socially unacceptable behaviour?

The answer to these questions is that the researcher has to

- overcome the communication barrier and enhance the flow of meaning by using commonly known vocabulary with participants
- establish and maintain rapport and trust
- assume that most of his/her participants have been frank (Polit & Beck 2008:369-370) and that they have no inherent reason not to tell the truth

These points will be returned to during the course of the discussion that follows.

3.3.2.2 Data collection methods: interviewing

Interviewing was the method of choice for this study. The interview may facilitate a process of exploration and offer a sense of freedom, enabling participants to steer the interview from their personal perspective (Cluett & Bluff 2000:156) In the human sciences, a good deal of information can be gathered by questioning people directly (Polit et al 2001:264). According to Roe and Webb (1998:153), interviews rest on three assumptions, namely

- participants and interviewers use the same vocabulary, phraseology, or dialect, so that every question means the same thing to each person
- words used to explore the topic will have a uniform meaning to all participants
- the order in which the questions are posed will provide the same stimulus to all participants

Leedy and Ormrod (2001:159) state that interviews can yield a great deal of useful information. The researcher can ask questions related to any of the following: facts (e.g. biographical information), people's belief about facts, feelings, motives, present and past behaviours, standards of behaviour (that is, what people think should be done in certain situations), and conscious reasons for actions or feelings (for example, why people think that engaging in a particular behaviour is desirable or undesirable).

Both individual in-depth and focus group interviews were conducted during the current study. This was done for the purpose of triangulation. *Triangulation* refers to the use of multiple methods or perspectives to collect and interpret data about some phenomenon, in order to converge on an accurate representation of reality (Polit & Beck (2008:768; Cluett & Bluff 2000:216; Nieswiadomy 2008:66).

➤ **The individual interview**

The completely unstructured individual interview is used when the researcher does not wish to impose any preconceived views on information to be gathered. The aim is to elucidate the informant's perception of his/her world without imposing the researcher's views (Polit & Beck 2008:392-394; Nieswiadomy 2008:63-62). This is the method the researcher utilised during this research. Although the researcher kept a number of themes relating to the research question at hand, as indicated in the research guide, the actual technique was to pose a single 'grand tour question' to interviewees. The researcher explained the research objective to the individual interviewees after which he posed the central (grand tour) research question

- *What is your view on labour pain as experienced by women in labour?*

The responses of interviewees to this question were followed up by noting hints and by probing information given to arrive at an in-depth understanding of participants' experience and perceptions of labour pain as experienced by women, and related issues. Data displays 3.1 and 3.2 exhibits evidence of this questioning technique of probing for more information and for establishing rapport with interviewees.

The following issues about the in-depth interview, as indicated by Cormack (2000:146-147) were also adhered to during the current research:

- The rationale for using in-depth interviewing, namely to give the participants the opportunity to describe their experiences in their own words, was of primary importance to the researcher. It was assumed that if people are allowed to talk freely about their lives in a non-threatening environment, they will be more forthcoming.
- It was also argued that in-depth interviews would overcome problems associated with structured interviews, namely
 - participants feeling pressurised into agreeing to what they perceive as the researcher's preconception about the correct answer
 - the danger that the researcher may be entirely off the mark, asking inappropriate questions about the phenomenon being investigated

The researcher's point of view to these two potential predicaments is that it is exactly the openness of qualitative interviews and the empowerment of interviewees during this process that counteract these concerns (possible predicaments).

➤ **The researcher as main instrument**

Instrument in research context refers to a device or technique that a researcher uses to collect data (e.g. questionnaires, tests, observations, guides, and so forth). In qualitative research, and especially in interviewing, the researcher is the main research instrument (Polit & Beck 2008:225; Speziale & Carpenter 2007:23-24). These authors further state that the successful collection of interview data is strongly dependent on interpersonal skills and the ability of the interviewer to probe in a neutral manner. *Probing* is a technique used by the interviewer to elicit more useful or detailed information from a respondent than was volunteered in the initial reply.

➤ **The interview guide or topic guide**

The *interview or topic guide* (Polit et al 2001:265; De Vos 2002:302-303) as instrument in individual in-depth interviews serves to guide the researcher through an interview, as it indicates the main themes relating to the research topic that must be addressed.

Nonetheless, each of the themes was probed in depth during the current research. The researcher, in this research, also did not work systematically through the guide, but rather noted which of the themes the interviewees addressed. Whenever an interview seemed to end without a theme being addressed, the researcher pertinently turned to such themes, asking a general introductory question on the theme.

The themes contained in the interview guide for individual in-depth interviews during the current study were

- midwives' views about labour pain
- what midwives regarded as acceptable and unacceptable behaviour displayed by women in labour
- the stages of labour that deserve pain management
- midwives' personal experience of labour pain
- midwives' preferred medication and intervention regarding pain management

In addition to the interview guide, the researcher also planned for interview sessions according to an interview schedule. The following two issues are important in this regard:

- all the interviews were conducted during 2006
- interviews were conducted between 12:00 and 14:00 because during this time there was only the minimal disruption of the participant's work

Only one set of interviews was conducted per day to allow the researcher to transcribe the interviews, to contemplate what happened during the interview and to make field-notes.

➤ **Focus-group interview**

The second phase of the interview was a focused-group discussion in both hospitals to validate the data collected earlier in the individual in-depth interviews. As indicated in paragraph 3.3.2.2, this action was done for purposes of triangulation. Polit et al (2001:265) state that in a focus-group interview, 5 to 15 people are assembled for group discussions. Hek et al (2002:136) define an 'interview' as a data collection

technique that involves gathering information through verbal communication. This researcher chose a group of four (4) midwives, and these participants were the same individuals who were involved in the face-to-face interviews from each hospital, and engaged them in a discussion on the topic of the study which is:

- “What are your views about labour pains and the patient’s response?”

As indicated by De Vos (2002:302-303) the interviewer (in this instance, the researcher) guides the discussion according to a written set of questions or topics to be covered. The *topic guide* or interview schedule (interview guide) prepared for the focus group interviews was the same as that used for individual interviews. This corresponds to Polit et al’s (2001:265) notion that in the *focus-group interview* the researcher keeps a list of topics that needs to be covered during the interview. The *topic guide*, a list of broad questions, is used to ensure that all important areas are covered. The interviewer’s role is to encourage participants to talk freely about the topics on the list (Polit et al 2001:265).

During this research the researcher adhered to and implemented the *characteristics* of a focus-group interview (Krueger 1994:57 as cited in De Vos 1998:315; Leedy & Ormrod 2001:158-160) which are the following:

- Involving a *small* group of people, small enough for all participants to have the opportunity to share their insights and large enough to provide diversity of perceptions. In Harrismith Hospital’s maternity ward 6 midwives and in Dihlabeng Regional Hospital, 4 midwives were part of the focus group. The researcher involved four midwives from each hospital to participate in a total of two focus-group interviews (De Vos 2002:311).
- To ascertain the *homogeneity of group members* and in order to counteract observation effects and to maximise the validity of findings generated by the focus group interview, the researcher selected the same persons, as stated in paragraph 3.3.1 (sampling). This is in line with De Vos’ (2002:308) reference to the myth that focus groups must be made up of “strangers”. Care was, however, taken by the researcher to remain neutral during interviews and also not to readily associate with any specific interest group or community group. Both groups consisted of midwives according to the selection criteria (paragraph

3.3.1) stated in the sampling phase. The researcher remained neutral at all times.

The focus-group interview, in addition to validating and increasing the data gathered during individual in-depth interviews, were also used because of the following advantages it had:

- it was effective in that the researcher obtained the viewpoints of many individuals in a short time (Polit et al 2001:270; De Vos 1998:314; Nieswiadomy 2008:63)
- it allowed the researcher to explore and describe the meanings people ascribe to their everyday activities (Marshall & Rossman 1995:80-81; Polit et al 2001:265; De Vos 2002:319)
- it also encouraged discussions and the expression of differing opinions and points of view (Marshall & Rossman 1995:80-81; Polit et al 2001:265; De Vos 2002:319)

Some inherent weaknesses and disadvantages of the focus-group interview the research had to attend to included:

- some participants may have been uncomfortable with expressing their views in the presence of others (Polit et al 2001:265). The researcher surmounted this limitation by allowing participants to write down their views that they felt uncomfortable about expressing in the presence of others.
- the presence of the researcher could easily have caused biased reactions from participants. According to Hek et al (2002:83), the researcher has the potential to bias the results in many ways, such as through non-verbal and verbal cues, and by the nature of the relationship with the respondent. A researcher in a perceived position of power may not receive true responses, and a researcher seen to be of lower status than the respondent may be dealt with in a dismissive way by the interviewee. During the current research, the researcher avoided these possible obstacles by being critically aware of the type of non-verbal and verbal reactions he communicated during the interview processes.

The *duration* of data collection during the focused-group interviews also depended on data saturation (Nieswiadomy 2008:411), i.e. collecting data to the point at which a sense of closure is attained and no new information is yielded.

3.3.3 Data collection

In this section on the research design and a number of practical issues relating to the implementation (practise and praxis) of the current research are discussed.

3.3.3.1 *The researcher as the main instrument in qualitative research*

Although, in qualitative research, participants are the researcher's primary concern from both an ethical and a scientific point of view, the entire research endeavour still articulates on the researcher as the main instrument in qualitative research. Speziale and Carpenter (2007:22-23) state that the researcher is the *main research instrument* because in most qualitative studies the same individual who conducts the fieldwork also collates and prepares the data and undertakes the analytical procedures that lead to the publication of the results. The smooth integration of these activities relies on the researcher's subjective or reflexive engagement with the topic of study. *Reflexivity* (Speziale & Carpenter 2007:36) refers to the process whereby our knowledge of our social world (in the case of the current research, the researcher's involvement with the research topic) explains and is explained at one and the same time. We continually engage in procedures to account for the world, i.e. to explain it (De Vos 2002:359:143). In the same way the researcher attempts to understand these accounts, accounting for participants' (midwives') experiences in the form of a research report. In a sense, the whole research design, the planning and execution thereof was done to secure this important role of the researcher, whereby setting the stage for all other activities to be completed, including ensuring the quality of data and findings and maintaining appropriate ethical standards. In essence, reflexivity entails self-reflection by the research (Speziale & Carpenter 2007:36).

3.3.3.2 *Overcoming the disadvantages of self-report when using the interview*

With reference to the possible disadvantage of self-report methods relating to maintaining trustworthiness and rigour during interviewing and in linking up with the

researcher as main instrument in qualitative research, Cormack (2000:295-296) suggests the following:

➤ ***Openness***

In qualitative interviewing, the emphasis is on encouraging interviewees to let interviewees tell their stories and to avoid predetermining the course of the interview. Interviewers have to be able to listen actively, analyse and probe issues that they may not have anticipated and still allow the interviewees to recount their experiences. This means that the interviewers must possess a repertoire of tactics and techniques to ensure that full and representative data are collected during the interview. For this researcher, as a novice, this meant that he had to orientate himself towards taking on the role of listener and to allow interviewees to communicate their experiences.

➤ ***Milieu***

In interviewing there are some logistical considerations that have to be attended to. For interviewees to be able to answer questions appropriately, they have to reside in a venue that allows for uninterrupted communication and privacy. This means that the venue should be free of distractions of noise, visual stimuli and auditory events inside and outside the venue. These were all attended to in selecting a venue for the interviews. In addition, consideration was also given to the gender relationships between the interviewer and the interviewees. The latter was of special concern as the researcher is a man, and as indicated by the exclusion criteria, no male midwives were included in the study. (De Vos 2002:300; Burns & Grove 2005:540).

3.3.3.3 The preparation phase

De Vos (1998:256-258) and Nieswiadomy (2008:62) advise adherence to the following aspects during the preparation phase:

- Getting into the field of study can be difficult (Speziale & Carpenter 2007:28-29, 38). Although the researcher was acquainted with the field of research he still experienced some frustrations in gaining permission to conduct the research, settling into the actual premise where the research was conducted and selecting

participants. The researcher experienced a feeling as if he had been dropped off in a 'foreign country', where the true interpretation of meaning is hindered by a lack of understanding of the language, the customs and the value systems of the inhabitants.

- The researcher's chances of obtaining permission to undertake the research were increased by his previous involvement in the field, which added to his ability to explain the purpose and methods of research in such a way that the gatekeepers and participants could understand the potential benefits (De Vos 1998:257). Speziale and Carpenter (2007:49) also emphasise the importance of prolonged and previous involvement with the population as important in qualitative research.
- In addition to a well-prepared research protocol (research design and diarising activities) the researcher's emotional preparation for entering the field was of vital importance. Even though the researcher had previously been closely involved in the area, later hierarchical distance left the researcher with a feeling of not 'being in touch' any longer, as well as with a feeling of 'having to know it all, but not'. As De Vos (1998:258) as well as Speziale and Carpenter (2007:26, 37) indicate that experience with the group are especially important as the attitude of the researcher is crucial for the success of the study. The research thus adhered to De Vos' (1998:258) golden rule, namely entering the setting with an open mind (allowing himself appreciation of the situation) without being judgmental (accepting what he was told without trying to correct the behaviour observed or to criticise opinions aired by participants).
- Successful fieldwork is usually determined by the accessibility of the setting and the researcher's ability to build and maintain a relationship with the gatekeepers. Once the researcher has located and established contact with the gatekeepers (in this case the Free State Department of Health authorities), he or she must gain these people's cooperation. Identifying particulars presenting the researcher's credentials are vitally important in order to reassure everybody that they are dealing with a *bona fide* researcher. Honesty and candour are therefore important qualities for an interviewer. The aim and objectives of the proposed investigation, how it will be undertaken and the envisaged purpose of the results should be set out clearly. Practical aspects of the research such as data collection methods and the recording of the data should be discussed in detail (De Vos 2002:397, 399). In this regard the reader is referred to Appendixes C

and D, which contains evidence of the researcher's correspondence with the authorities (gatekeepers) regarding approval to conduct the research.

- Researchers need to be very careful as to what agreements are reached with gatekeepers and how this may influence future relationships with them. The researcher needs to let the gatekeepers understand that once he is in the setting they will have to provide enough space to let him form his own relationships with the group members. Thus, permission to enter the setting should place no obligations on the researcher and he must be free to detach himself from the gatekeepers, if necessary (De Vos 2002:397, 399). In this study the researcher had discussions with the Directors of the two hospitals involved in the research regarding the venues they had to provide for the researcher to be able to conduct the interviews. These discussions also focused on the ethical principles the researcher had to uphold with regard to participants and the information provided during interviews.

3.3.3.4 *Conducting the interviews*

While conducting the interviews, the following advice, as contained in Leedy and Ormrod (2001:159-160) was implemented:

- The researcher ensured, through sampling and inclusion and exclusion criteria that the interviewees are 'representative of the population' and that they are considered to be experts in order to give typical perceptions on the research topic. With regard to the current qualitative research, 'representative of the population' implies "having the necessary experience regarding the phenomenon under investigation to provide an inclusive description and understanding thereof". During the study this was ascertained through the sampling process as discussed in section 3.3.1. In this study the researcher selected midwives rendering midwifery services in Dihlabeng Regional Hospital and Harrismith District Hospital.
- A suitable location that is quiet, where interviewees are unlikely to be distracted or interrupted, was located. In both hospitals the interviews were conducted in quiet offices with little distraction or interruption (Burns & Grove 2005:540).
- The researcher used a few minutes to establish rapport (Polit & Beck 2008:400, 404) with the interviewees. Initial small talk served as an icebreaker (Polit & Beck

2008:400) which, like the rest of the interview, the researcher conducted in a courteous and respectful manner. In every interview the researcher started by introducing himself and explaining the purpose of the interview. Data display 3.1 contains evidence obtained from the verbatim transcripts of the interviews on this issue.

DATA DISPLAY 3.1
EVIDENCE OF PROBING QUESTIONS TO ESTABLISH RAPPORT AND
FOLLOW-UP HINTS

- The purpose of this interview is to obtain the midwife's perception concerning labour pain, and the responses of the patient around labour pains. Firstly, what are your views about labour pains? (Data unit: 69)
 - Now Ladies, I have interviewed you individually about the topic around labour pains. Now you are in a group; you can share your ideas around the same topic. What is your view regarding labour pains, the patients' responses to them? (Data unit: 103)
 - As I explained to you earlier on the purpose of this interview, I will now get straight to the point: What are your views about labour pains and the responses to it? (Data unit: 156). As I explained the purpose of this interview briefly, we shall now go straight to the discussion to save time. What are your views about labour pains, and your views about the responses to it? (Data unit: 212)
 - As I have explained to you the purpose of this interview is to explore and describe the labour pains and the responses to them, what are your views about labour pains, what do you understand about labour pains? (Data unit: 245)
 - I have interviewed you individually regarding the topic. Now, I would like you to share the information amongst yourselves. Anyone who would like to start? (Data unit: 266)
-
- The researcher obtained the *written* permission from the participants and explained the nature of the study and his plans for using the results to the participants, and asked them to sign an informed consent form which meets with Burns and Grove's (2005:193-194) set criteria (see appendix A). The researcher also offered to provide a copy of the research report to the institution once the study was completed. Data display 3.1 also contains evidence indicating that the objectives of the research had been explained to participants. Before the researcher visited the two hospitals written permission was granted by the Head of the Free State Provincial Health Services (see appendix D). Additionally, each participant signed a consent form (appendix A) before being interviewed.
 - The researcher focused on the actual experiences and perceptions of midwives rather than on abstract or hypothetical issues. This enhanced the possibility of obtaining more revealing information. The *grand tour* research question (Speziale & Carpenter 2007:213) and the themes contained in the interview guides assured this.

- The researcher did his best to maintain openness and unstructuredness. This demands that researchers generally do not put words in people’s mouths but allow participants to choose their own way of expressing their thoughts. In all the interviews the researcher allowed the participants to express their thoughts freely without disturbances. The *grand tour* question also attests to this issue. However, there were incidents where the researcher did impose on the ‘openness’ of the interview. These incidents were identified during the data analysis and information following directly on leading questions were ignored until such time as the subject (topic) of these questions surfaced again (naturally) during the interview. Data display 3.2 exhibits evidence in this regard as well as with regard to probing and clarifying questions.

DATA DISPLAY 3.2: METHODOLOGICAL ISSUES
CATEGORY 1: EXAMPLES OF LEADING, PROBING AND CLARIFYING
QUESTIONS EMERGING FROM INTERVIEWS

Leading questions

- ... you do mean that there are some differences when you refer to books, the theory and the real situation? (Data unit: 33)
- At what stage do you think a woman in labour needs to be given medication for pain? (Data unit: 50)
- What is the purpose of the programme? (Data unit: 144)
- At what stage of labour do you recommend pain medication? (Data unit: 251)

Probing and clarifying questions

- Is there anything wrong if someone is keeping quiet? (Data unit: 65)
 - Do you normally get feedback from your patients after delivery, especially after the care you have given with soft porridge and a hot bath? (Data unit: 78)
 - So, what I get from you is that through the experiences of delivering these women you are able to detect some practices, even if they do not tell you? (Data unit: 139)
 - Can I interrupt you here; you mentioned natural methods that you could use to alleviate pain? Can you elaborate on that? (Data unit: 158)
 - You talk about those extreme responses of the patient, which ones of them do you regard as unacceptable? (Data unit: 167)
 - When you are confronted with such situations, how do you handle them? (Data unit: 169)
-

Interviews were recorded verbatim. All interviews were tape recorded and transcribed. The researcher took into consideration what De Vos (1998:285) stated where he mentioned that it is unwise, if not dangerous, to rely solely on memory to preserve data for analysis. Leedy and Ormrod (2001:158) also state that the researcher should record any potential useful data thoroughly, accurately, and systematically, using field notes, audiotapes, sketches, photographs, or any other suitable means (Polit & Beck 2008:437).

The research topic, namely 'perceptions', enjoyed the researcher's special concern. As Leedy and Ormrod (2001:160) indicate, it must be remembered that one does not necessarily obtain facts during open qualitative research, however confident and convincing some of your participants may be. One should in a sense treat information as *perceptions* rather than as *facts*. With regard to this research, although the researcher was interested in the *perceptions* of midwives, these perceptions are fact, the way the participating midwives perceived the experience of women experiencing labour pain.

3.3.4 Data analysis

According to Polit et al (2001:381) and Polit and Beck (2008:507), regardless of the type of data and regardless of the tradition that has driven its collection, the purpose of data analysis is to impose some order on a large body of information so that some general conclusion can be reached and communicated in a research report. Qualitative data analysis is the processing and interpretation of non-numerical data; that is words and text (Hek et al 2002:138; Tesch 1990:4). Polit and Beck (2008:507) further contends that although qualitative research means different things to different people, qualitative researchers reject standardisation of methods, including methods of analysis. Whenever they describe these methods they are usually eager to point out that this is just one way of going about it. Hek et al (2002:26) state that the analysis of qualitative data begins during data collection, as the researcher starts identifying trends or themes whilst gathering information. Probing questions attests to this early data analysis.

3.3.4.1 Data management and organisation

Polit and Beck (2008:507-509) assert that data in qualitative analysis are usually in textual or narrative format (transcribed interviews), written description of observations (field notes), and reflections (ideas and conjectures) recorded in the researcher's diary. All qualitative studies involve content analysis procedures in one form or another. In general, content analysis involves creating categories of data and developing rules for coding data into these categories (Nieswiadomy 2008:64). During this research the researcher transcribed all audio-recordings of both individual in-depth interviews and focused-group discussions. Cluett and Bluff (2000:157) recommend that it is best for

the researcher to personally transcribe the recording because this process permits familiarity to grow and allows the researcher to become immersed in the data.

Schurink (1996:3-12) (in De Vos 1998:335) proposes three types of files for storing data, namely:

- *Master files* contain field-notes, transcribed interviews and/or human documents in their raw form. In order for them to be easily accessible they should be catalogued according to date. It is important that the master file is kept in a safe place where it cannot easily be tampered with, since it contains the only ingoing and complete record of all the material gathered in the study.
- *Mundane/background files* consist of material collected during the course of the research on the most important figures and/or the most obvious of units to allow one to gain a fuller understanding thereof. They also help one to understand links between diverse events or patterns not contemplated before.
- *Analytic files* are used as the basis to read newly obtained data in order to identify particular theoretical themes and concepts which have evolved in the course of the research or which have been recently found in the material and then sorted, referenced and placed in the appropriate analytic or thematic files. These analytic files ultimately form the basis of the manner in which the study is to be presented or written.

Polit and Beck (2008:523) indicate that prior to the advent of computer assisted qualitative data analysis, researchers compiled only “conceptual” files. During the current research the researcher did not make use of computer assistance, however, would call the files he created both master and analytic files.

3.3.4.2 General guidelines for data analysis

Polit et al (2001:383) and Polit and Beck (2008:383) state that qualitative researchers often read narrative data over and over in search of meaning and a deeper understanding. During the current research the researcher, by following the above stated guidelines, maintained the following:

- themes, acts and statements noted in the researcher's material were compared with one another to establish whether there existed a concept (label or synonym) that could unite them
- as the researcher identified different themes, he searched for underlying similarities among them

The researcher took special note of the personal vocabulary of interviewees, including words in their native language for which no adequate English words exist. This is most evident with regard to theme 3 (see chapter 4, section 4.2.3) on Traditional medicine.

3.3.4.3 Strategies for data analysis

Schurink (1996:19-29) (in De Vos 1998:338) suggests three strategies of analysing data in qualitative research, namely:

- *Constructing typologies*, a conceptual framework, which classify phenomena in terms of the elements they have in common. There are two types of typologies, namely emic and etic approaches. The *emic* approach focuses on first order concepts or classification based on categories of meaning of the people being studied, while the *etic* approach is connected to the researcher's own concepts or/and typologies.
- *Analytic induction* serves to develop universal statements containing the essential features of phenomena or those things that are found to cause or lie behind the existence of a social occurrence (Manning 1982:27, in De Vos 1998:338). In this approach the researcher is constantly searching for cases that could disapprove or falsify his hypothesis, thus compelling him to develop his conceptual framework in such a manner as to correspond with the subjective everyday experience of *participants*.
- *Constant comparison* is used to develop and refine theoretically relevant categories. The categories elicited from the data are constantly compared with data obtained earlier in the data collection process so that commonalities and variations can be determined. As the data collection proceeds, the enquiry becomes increasingly focused on emerging theoretical concerns. *Saturation* refers to the sense of closure that the researcher experiences when data collection ceases to yield any new information.

These strategies in data analysis are also discussed by Polit and Beck (2008:509-511) and Speziale and Carpenter (2007:46-48). Knowledge of these strategies all contributed towards the researcher's understanding of qualitative data analysis. Although none of these figure as individual outcomes of the current research they all worked together as mental (thinking) processes during data analysis.

3.3.4.4 Analytic procedures

Analytic procedures to analyse qualitative materials discussed below follow what the following authors provided in their guidelines: (Polit et al 2001:388; Leedy & Ormrod 2001:153).

The strategies stated in paragraph 3.3.5.3 are, however, embedded in general qualitative analytic procedures, which were also adhered to during the current research. These are explicated as follows:

- Bracketing/epoche (Speziale & Carpenter 2007:27-28; Polit & Beck 2008:228, 748) implies that throughout the data collection process the researcher suspends any preconceived notions or personal experiences that may unduly influence what the researchers hear the participants say (Leedy & Ormrod 2001:153; Polit et al 2001:458). Listing one's own presuppositions in writing so that it becomes easier to hold them at bay might be useful. In this instance the researcher followed this principle by listing his own presuppositions on paper to guard against the unduly influence of what the researcher may have heard the participants say.
- Transcribe raw data in electronic format by listening to the tapes and checking that all the data are there, are of reasonable good quality, and are in the format that facilitates organization. Decide whether to analyse the data manually and/or by means of computer. Setting up administrative fields for storing the data on computer is suggested by Polit et al (2001:386). The exact way in which this was done is explicated below (Polit & Beck 2008:508-509).
- Read carefully through all the transcripts to get a sense of the whole.
- Pick any transcript file and read through it, jotting down ideas as they come to mind, asking yourself what the interview is all about, while writing thoughts in the margin and identifying the major categories.

- Read again through all the transcript files and underline units of meaning to identify major categories.
- Identify statements that relate to the topic. Separate relevant from irrelevant information in the interview and break the relevant information into small segments (e.g. phrases or sentences) that each reflect a single, specific thought (Leedy & Ormrod 2001:154).
- Search for themes or recurring regularities (discover commonalities and natural variations) and patterns (Polit et al 2001:388; Polit & Beck 2008:510) Place the units of meaning into major categories while at the same time identifying sub-categories within the major categories (Tesch 1990:155, in De Vos 1998:345).
- Group statements into meaning units. Segments are grouped into categories that reflect the various aspects (meaning) of a phenomenon as it is experienced (Leedy & Ormrod 2001:154). Identify relationships between major- and sub-categories and reflect these as theories (Tesch 1990:155, in De Vos 1998:345).
- Develop categories and codes. Design mechanisms to access parts of the data. Data must be converted into smaller, more manageable units that can easily be retrieved. Develop category schemes and then code data according to these categories (Polit et al 2001:389-390; Polit & Beck 2008:509-511).
- Validate the understanding that the thematic exploration has provided by either member checks, investigator triangulation, debriefing sessions etc (Polit et al 2001:389). *Seek divergent perspectives*: the researcher looks and considers the various ways in which different people experience the phenomenon (Leedy & Ormrod 2001:154).
- Integrate or weave the thematic pieces together into an integrated whole (Polit et al 2001:390) Construct a composite composition: the researcher uses the various meanings identified to develop an overall description of the phenomenon as people typically experience it (Leedy & Ormrod 2001:154). In terms of grounded theory research this integration of categories is referred to as axial coding (Babbie & Mouton 2004:500; Polit & Beck 2008:748).
- The final result is a general description of the phenomenon, as seen through the eyes of people who have experienced it first-hand.

3.3.4.5 Documentation of data and analyses

Doing this research the researcher also followed these 12 steps. Data were manually analysed using the MS Word (2003) Word Processor Program on computer. In addition to the steps followed as indicated above, the research followed Van der Wal's (1999) sequence of documentation during the data analysis process:

- Verbatim transcripts were made of each interview keeping it as a separate document.
- Additional copies were made of each transcript to work on. In these documents columns provided for the actual transcript to be placed in the first left hand column. Three additional columns allowed for main- and sub-categorisation of data units, as well as a column in which the researcher could enter any notes, such as the reasons why a specific data unit was categorised in a specific way. Data units were numbered in the text as they emerged. Data unit numbers thus do not necessarily follow sequentially/numerically on one another. The importance of this numbering system is that it would greatly ease any data audit, or if the researcher should at any point in time need to reread a data unit in its original context.
- A third document was prepared and all the categories and sub-categories that emerged from the data were listed in this document. After this the appropriate data units constituting these categories and sub-categories (including the number assigned to data units) were transferred from the previous documents to this one by means of the 'cut and paste' function. Once all the data units had been copied and pasted, all data units were read together keeping in mind the rubrics of the categories and sub-categories they pertain to. This assisted in refining categorisation.
- Finally, categories were edited and presented in the chapter on data presentation as 'data displays' containing all evidence pertaining to a category or sub-category. Thus the researcher refrained from providing the reader with anecdotal data units and adhered to the qualitative research professing to 'thick descriptions'. These data units and categories are displayed in chapter four in the form of data displays.

3.4 ETHICAL CONSIDERATIONS

Ashcroft (cited in Pera & Van Tonder 2005:147) asserts that in general terms, health care research is perceived as being of overall good intention, providing benefits for the society at large. However, the history of health care research illustrates how the pursuit of such 'good' can be abused and manipulated by a minority of researchers. Polit et al (2001:72-87) and Leedy and Ormrod (2001:107) support the use of ethics in research by stating that when humans are used as subjects in scientific investigations - as is often the case in nursing research – greater care must be exercised to ensure that the rights of these individuals are protected. Pera and Van Tonder (2005:1) state that consideration of ethical issues is a hallmark of the nursing and midwifery professions. *Ethics* thus refers to a system of moral values that is concerned with the degree to which the research procedures adhere to the professional, legal and social obligations to the research subjects (Polit et al 2001:461, Pera & Van Tonder 2005:4). Leedy and Ormrod (2001:107) state that most ethical issues in research fall into one or more of the following four categories: protection from harm, informed consent, honesty and the right to privacy. In fact, research involves the four basic ethical principles of autonomy, justice, non-maleficence and beneficence.

Van der Wal (in Pera & Van Tonder 2005:151) states that when applying ethical principles to research, it is helpful to bear the following three considerations in mind:

- the participant
- the institution
- the scientific integrity of the researcher

3.4.1 The participants

Van der Wal (in Pera & Van Tonder 2005:151) states that all measures towards practicing ethically sound science and research must be directed towards maintaining the *self-respect* and *dignity* of participants. To observe these considerations the researcher should

- obtain *permission* before using personal data, regardless of its source, but within the moral framework of maintaining autonomy, confidentiality, providing

informed consent, telling the truth; guaranteeing the non-coercion and non-exploitation of the individual concerned

- allow individuals the *freedom* to conduct their lives as autonomous agents without external control, coercion or exploitation, especially when they are asked to participate in research
- ensure that *informed consent* is obtained from participants by the principal researcher or the person who is going to intervene in the lives of participants via study, control measures, and the like. Candidates must be informed about the following issues: the purpose of the research; the methods and procedure to be followed; the duration of the study; the nature of the participation of the participants; the way in which the results will be used and disseminated; the identity of the researcher(s) and fieldworkers; the manner in which confidentiality and privacy will be secured; and the financial implications – whether or not the candidates will be remunerated.
- ensure that no information provided by the candidates is divulged in any way except for research purposes (maintaining *confidentiality* and *autonomy*)
- ensure that *individual privacy* is assured. The extent of disclosure and the general circumstances under which personal information will be shared must be clarified with the participants.

The above were observed as follows by this researcher:

- Two meetings were held in each hospital's maternity ward with participants before each interview session. The first meeting was held with each participant in each hospital's labour ward and the second meeting with each group in each hospital's labour ward to fully explain the purpose of the research; the methods and procedure to be followed; the duration of the study; the nature of the participation of the participants; the way in which the results will be used and disseminated; the identity of the researcher; the manner in which confidentiality and privacy were to be secured; and the financial implications- whether or not the candidates would be remunerated. Verbal and written consent were obtained. Data were collected from all midwives who gave their consent in both hospitals. *Consent forms of participants are attached as appendix A.*
- The individual's right to confidentiality was observed by assuring the participants that the information given to the researcher would not be divulged in any way,

but would be used for research purposes only. They were further assured that the information they provided to the researcher would not be used against them in any way.

- Participants were also assured that an after-study follow-up feedback session would be arranged with them.
- The individuals' right to voluntarily participate in the study was ensured by allowing them to quit the interview sessions at any time they felt like doing so.
- The researcher obtained the informed consent from the participants (see appendix A).

3.4.2 The institution

Van der Wal (in Pera & Van Tonder 2005:154) quotes Brink (1999:52) as stating that whenever research is undertaken in the field of health care, permission for such research must be obtained from the authority in charge of the field or service point at which the research is going to be conducted. In addition, the researcher must treat the institution as a *person*, that is, the ethics that apply to individual participants also apply to the institution. The information that needs to be made available to the authorities of an institution includes the data collection instrument; the sample (means of selection and size); the principal researcher's name and expertise; the perceived ethical issues that may be encountered; and the statement of approval of the research proposal or protocol by the institution under whose auspices the research will be conducted. With regard to this research, the Research and Ethics Committee of the University of South Africa approved the research proposal before it was submitted to the institutions at which the research was to be conducted. This approval was presented to the institutions at which the research was conducted.

Written permission to access the research setting was requested by the researcher (appendix C), and granted by the Free State Provincial Health Authorities and also the authorities of the two hospitals. The Ethical Clearance Certificate from the Research and Ethics Committee in the Provincial Health Department is attached as appendix D.

3.4.3 The scientific integrity of the researcher

Van der Wal (in Pera & Van Tonder 2005:158) states that the scientific integrity and competence of the researcher are important to the entire research process. Ashcroft (2002:280 cited in Pera & Van Tonder 2005:157) states that the scientific integrity of the researcher must be indisputable and incontrovertible. Examples of misconduct in research that could result in dispute and controversy include: fabrication and falsification of data through inappropriate techniques of analysis; plagiarism; dishonest manipulation of design or methods; and irrelevant, exploitative, unoriginal, incompetently and fraudulently performed research.

In case of research conducted for educational purposes, the required competency of the researcher is supplemented by the inputs of the research supervisors and promoters. Clear guidelines regarding accountability and responsibility need to be set in this regard. Formal contact between the student researcher and the supervisors or promoters is indispensable (Van der Wal, in Pera & Van Tonder 2005:158). In this respect it should be noted that at the time of the current research, the researcher was a student at the University of South Africa, registered for the Masters Degree in Health Studies. The research study was undertaken for educational purposes with the aim of developing and improving the researcher's (student's) research skills.

3.4.4 Measures to ensure trustworthiness

Measures for assuring trustworthiness in qualitative research were considered part of the scientific integrity of the research during this research and are, for this reason, discussed at this point.

The central concern relating to research data is the quality (*trustworthiness/validity* and *reliability*) of that data. *Trustworthiness* is a term used to assess the 'truth value' of qualitative research; it suggests that the research has been conducted in such a way as to give the reader confidence in the findings (Polit & Beck 2008:768). According to Polit et al (2001:472), Polit and Beck (2008:539) and Leedy and Ormrod (2001:106) (citing Lincoln & Guba 1985), there are four criteria relating to trustworthiness and truth-value, namely credibility, transferability, dependability and confirmability.

3.4.4.1 Credibility

'Credibility' is defined as referring to confidence in the truth-value of the qualitative data; a criterion for evaluating data quality (Polit et al 2001:460; Polit & Beck 2008:539). Trustworthiness in qualitative research implies that a study is said to be credible when participants and those familiar with the study topic recognise the findings to be true (Cluett & Bluff 2000:211).

The proposed measures to attain credibility in this study were as follows:

- To ensure that participants were accurately identified and described (Marshall & Rossman 1995:143).
- The use of multiple data sources in the study and the use of multiple methods to address a research problem (Polit et al 2001:312; Polit & Beck 2008:540-542).
- Leedy and Ormrod (2001:106) state the following additional strategies to be employed to ensure the trustworthiness of qualitative data.
- *Extensive time in the field* – the researcher may spend several months studying a particular phenomenon, forming tentative hypotheses, and continually looking for evidence that either supports or disconfirms those hypotheses.
- *Negative case analysis* – the researcher actively looks for cases that contradict existing hypotheses, then continually revises his or her explanations or theory until all cases have been accounted for.
- *Thick description* – the situation is described in sufficiently rich, thick detail in order that the readers can draw their own conclusions from the data presented.
- *Feedback from others* – the researcher seeks the opinions of colleagues in the field to determine whether they agree or disagree that the researcher has made appropriate interpretations and drawn valid conclusions from the data.
- *Respondent validity* – the researcher takes his or her conclusion back to the participants in the study and asks quite simply, "Do you agree with my conclusions? Do they make sense, based on your own experience?"

The requirements for this principle were met as follows:

- Participants were Black and White midwives working in the labour wards (accurately identified and described) or involved in the birthing process in the two hospital maternity wards.
- Multiple key informants (midwives in the area in which the research problem resulted) were interviewed on the same topic until saturation point was reached.
- In-depth individual interviews plus focus-group interviews were used.

3.4.4.2 *Transferability*

Transferability refers to the ability to move qualitative research findings to similar contexts within similar groups (Marshall & Rossman 1995:144; Cluett & Bluff 2000:216; Polit et al 2001:312; Polit & Beck 2008:539).

The researcher ensured that thick, sufficient data were collected and contained in data displays to enable anyone interested in conducting a transfer of research findings to reach a conclusion as to whether a transfer can be contemplated as possible. This is reflected by the evidence contained in the data displays, listing all applicable data units that emerged from the data rather than having woven single anecdotal units into the text.

3.4.4.3 *Dependability*

Dependability refers to the stability (reliability) of data over time and over conditions (Polit & Beck 2008:539) including the ability of another researcher to follow the same qualitative audit trail with similar findings (Cluett & Bluff 2000:211; Speziale & Carpenter 2007:49).

According to Babbie and Mouton (2004:278), there can be no dependability without credibility. The demonstration of the latter is sufficient to establish the former. This is corroborated by Speziale and Carpenter (2007:458).

3.4.4.4 Confirmability

This concept refers to the objectivity or neutrality of the data as such that there would be agreements between two or more independent people about the data's relevance or meaning. An audit trail, a systematic collection of material (like audio tapes) and documents (like transcripts), was developed to allow an independent auditor to be able to come to a conclusion about the data, including the data units numbering in the report (Polit et al 2001:315). An issue of trustworthiness in which the findings of a qualitative study are recognised as a reflection of the research and not the researcher's biases (Cluett & Bluff 2000:210).

An inquiry audit can be done whereby a scrutiny of the data and relevant supporting documents by external reviewer is done (Polit et al 2001:315). Smith and Hunt (1997:221) state that an audit ability is required in order for the reader to evaluate the study as dependable or not. The numbering of data units will ease the audit exercise.

Both tape recordings and transcribed data should be made available (kept safe for 3 years) so as to enable any inquiry audit to be done, whereby a scrutiny of data and relevant supporting documents by external reviewer could be done.

The condition of trustworthiness of the study could be met by making all interview transcripts available to be read by more than one researcher, to construct independent interpretive summaries of the interviews and to compare the findings to see whether they reach consensus.

3.4.4.5 Triangulation

Triangulation refers to the use of multiple referents to draw conclusions about what constituted the truth (Polit et al 2001:316; Polit & Beck 2008:196-197; Speziale & Carpenter 2007:379). Types of triangulations:

- *Data source triangulation*: the use of multiple data sources in the study (e.g. interviewing multiple informants about the same topic).
- *Investigator triangulation*: the use of multiple individuals to collect data, analyse, and/ or interpret a single set of data.

- *Theory triangulation*: the use of multiple perspectives to interpret a single set of data.
- *Method triangulation*: the use of multiple methods to address a research problem (e.g. observation plus interview).

These types of triangulation are corroborated by Speziale and Carpenter (2007:381-389).

To enhance the credibility of this study, the researcher used multiple methods to address the research problem. Two methods were employed to collect data for the study, namely individual in-depth interviews and focus-group interviews.

3.5 CONCLUSION

In the above discussion the researcher took the reader step by step explaining how he conducted research on the topic “The perception of midwives towards women experiencing labour pain”.

The research methodology was discussed focusing on the following points: research design, sampling method/design, the data collection instrument and the self-report approach, ethical considerations, data analysis and measures to establish and maintain trustworthiness.

In the next chapter the data collected via the research design discussed in this chapter, will be presented.

CHAPTER 4

Analysis and interpretation of data

4.1 INTRODUCTION

In this chapter the analysed data units are presented in themes, categories and sub-categories. Data units are presented in the original language of the participants. These have not been edited. The themes and categories that emerged from the data are as follows:

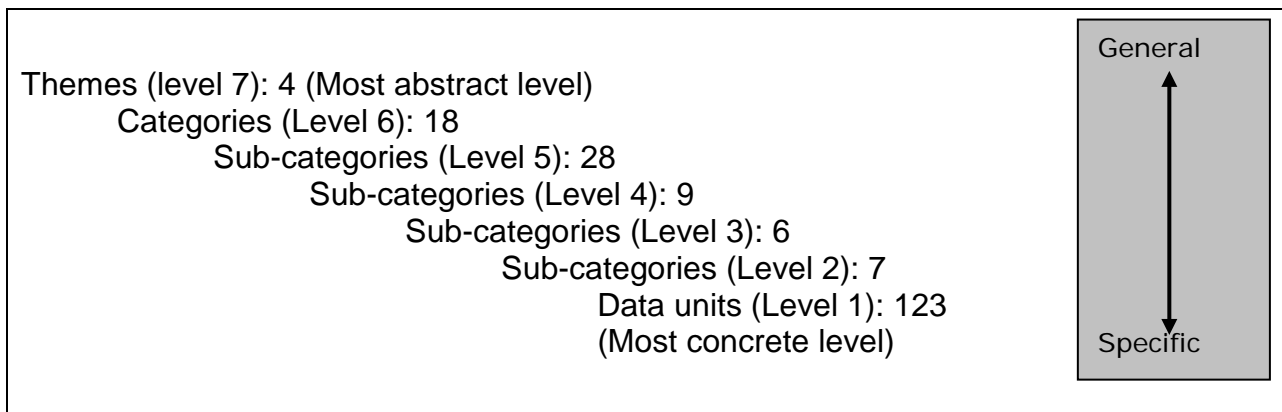


Table 4.1 gives a further detailed overview of the themes and categories that emerged from the data and serves to provide an overview to the reader regarding the structure of the final analysis and construction of the research topic.

TABLE 4.1: SUMMARY OF THEMES AND CATEGORIES	
PAR 4.2	THEMES AND CATEGORIES
4.2.1	THEME 1: LABOUR PAIN
4.2.1.1	CATEGORY 1.1: Naturalness of labour pain
4.2.1.2	CATEGORY 1.2: Midwives' perceptions of the naturalness of labour pain
4.2.1.3	CATEGORY 1.3: Midwives' account of personal experience of labour pain
	Category 1.3.1: Confusion Category 1.3.2: Uniqueness Category 1.3.3: Withholding normal reaction to labour pain/hide/masked real feeling Category 1.3.4: Learning experience Category 1.3.5: Benefits of the learning experience Category 1.3.6: Pain plus urge to push Category 1.3.7: Very painful Category 1.3.8: Unbearable

4.2.1.4	CATEGORY 1.4: Factors relating to the bearableness and manageability of labour pain
4.2.1.4.1	Category 1.4.1: Age Category 1.4.1.1: General indicators Category 1.4.1.2: Specific evidence
4.2.1.4.2	Category 1.4.2: Parity and pain
4.2.1.4.3	Category 1.4.3: Psychological state Category 1.4.3.1 General indicators Category 1.4.3.2: Psychological preparation of women Category 1.4.3.2.1: General indicators Category 1.4.3.2.2: Psychological preparation of women Category 1.4.3.2.3: The need for repeated psychological preparation Category 1.4.3.2.4: Recommendations regarding psychological preparation Category 1.4.3.2.5: Gaps pertaining to mother education Category 1.4.3.2.6: Sources of psychological stress Category 1.4.3.2.6.1: Parity Category 1.4.3.2.6.2: Not realising their own health status Category 1.4.3.2.6.3: Poor antenatal preparation Category 1.4.3.2.6.4: Rumours about labour pain intensity Category 1.4.3.2.6.5: Unwanted pregnancy Category 1.4.3.2.6.6: Unaccepted pregnancy Category 1.4.3.2.6.7: Previous experience
4.2.1.2.4	Category 1.4.4: Hunger
4.2.2	THEME 2. COPING WITH LABOUR PAIN
4.2.2.1	CATEGORY 2.1: Women's natural reactions to labour pain Category 2.1.1.General indicators Category 2.1.2. Specific indicators/reactions
4.2.2.2	CATEGORY 2.2 Midwives' perception of acceptable behaviour of women in relation to labour Category 2.2.1. Crying Category 2.2.2. Screaming
4.2.2.3	CATEGORY 2.3: Midwives' perception of non-acceptable behaviour of women in relation to labour
4.2.2.4	CATEGORY 2.4: Individual pain threshold and tolerance Category 2.4.1: General indicators Category 2.4.2: Uniqueness relating to analgesics Category 2.4.3: Problem associated with high pain threshold
4.2.2.5:	CATEGORY 2.5: Midwives' reaction on their perception of the uniqueness of individual patients Category 2.5.1: Midwives' reactions Category 2.5.2: Motivation for their reactions
4.2.2.6	CATEGORY 2.6: Pain control
4.2.2.6.1	Category 2.6.1: Formal pain control and sedation Category 2.6.1.1:General indicators Category 2.6.1.2: Origin of decision on administering analgesics Category 2.6.1.3: Reasons for administering analgesics

4.2.2.6.2	Category 2.6.2: Alternative ways of managing pain Category 2.6.2.1: General indicators Category 2.6.2.2: Alternative ways of managing pain
4.2.3	THEME 3: TRADITIONAL AND HERBAL MEDICINES AND THE MIDWIFE
4.2.3.1	CATEGORY 3.1: Effects of traditional and herbal medicines on patients Category 3.1.1: General indicators Category 3.1.2: Effect of traditional and herbal interventions
4.2.3.2	CATEGORY 3.2: Midwives' perceptions of traditional and herbal medicine Category 3.2.1: Acceptance of traditional and herbal interventions Category 3.2.2: Non-acceptance of traditional and herbal interventions Category 3.2.3: Origin of midwife's frustrations
4.2.3.3	CATEGORY 3.3: Midwives' suggestions regarding traditional and herbal medication Category 3.3.1: Research Category 3.3.2: Tolerance towards women
4.2.4	THEME 4: SITUATIONAL FACTORS THAT IMPINGE NEGATIVELY ON THE PERCEPTION OF LABOUR PAIN
4.2.4.1:	CATEGORY 4.1: Factors that impinge negatively on the perception of labour pain Category 4.1.1: Time Category 4.1.2: Workload/staff shortages

4.2 THEMES, CATEGORIES AND SUB-CATEGORIES

In this section the structure of the data as it emerged from the verbatim transcriptions is presented in the form of themes, categories and sub-categories. The evidence supporting the data is exhibited in data displays, containing all data units pertaining to the category, and not mere anecdotes of single 'best example' data units. Data are summarised in 19 data displays. In cases of 'minute' categories, if for some reason deemed appropriate by the researcher, these categories are indicated within a data display. The term *general indicator* as a category is derived from the work of Van der Wal (1999) and contains data units (evidence) or an indication of the subject of a category, although it does not say anything about the subject.

4.2.1 Theme 1: Labour pain

4.2.1.1 Category 1.1: Naturalness of labour pain

Category 1 within theme one: *labour pain*, contains evidence of participants' perception of the naturalness of labour pain. Data display 1.1 contains the evidence in this regard.

DATA DISPLAY 1
THEME 1: DISCRPTION OF LABOUR PAIN
CATEGORY 1.1: NATURALNESS OF LABOUR PAIN

- I think labour pain is part of the natural process, whereby the uterus responds on its own (Data unit: 4)
- It (labour pain) is an entity which most of women are aware of (Data unit: 5).
- Nobody can explained the labour pains to the patient, unless you have gone through that pain as a human being, (Data unit: 6).
- Labour pain is something that is natural, that a person must have, although it is painful for a person to feel those pains (Data unit: 36).
- I believe we cannot take the labour as a natural labour without a pain (Data unit: 70)
- ... so every woman coming whilst in labour, we are expecting them to have pain (Data unit: 70.1).
- We understand labour pain as normal pain that is experienced during childbirth (Data unit: 267).
- My own views are we all know that if the woman is in labour, during the latent phase there is pain but a bit mild and they feel discomfort sometimes but as labour progresses towards the second stage the intensity of pain increases a lot and the frequency as well (Data unit: 186).
- Those people haven't made any mistakes (sins) to have that pain, we learn about contractions, their strength and intensity, what we have learned is to have full understanding of how that particular person feels whilst she is in pain (Data unit: 204.2).

Viewing labour or childbirth pain as natural has definite implications for midwifery practice. These implications relate to the

- interpretation of the severity of labour pain
- involvement of nursing interventions to control pain
- administration of pain relief medication
- response to the reaction of women in labour to labour pain

The perception of labour pain as natural forms a pivotal point of departure of participants' perception of the nature of labour pain and their response to patients in

labour and labour pain. It is also against the background of this *naturalness* that the following categories pertaining to the nature of pain need to be interpreted. The pain experienced by the woman in labour is caused by the uterine contractions and the dilatation of the cervix, and in the late first stage and the second stage, by the stretching of the vagina and the pelvic floor to accommodate the presenting part (Bennett & Brown 1989:179, Pillitteri 2003:522, Levasseur et al 2003:181, Littleton & Engebretson 2005:483; Leifer 2005:113).

The value of labour pain, culturally, is that it is viewed as essential to a woman's transition to motherhood, empowering her through a sense of her own achievement. Pain is also seen as a benefit in triggering the neuro-hormonal cascade that keeps the birth normal (Page & McCandlish 2006:348)

4.2.1.2 Category 1.2: Midwives' perceptions of the naturalness of labour pain

Data display 1.2 contains evidence of midwives' perceptions of labour pain and pain during labour.

DATA DISPLAY 2
THEME 1: DISCRPTION OF LABOUR PAIN
CATEGORY 1.2: MIDWIVES' PERCEPTIONS FOUNDED ON NATURALNESS OF LABOUR PAIN

- Most women are able to bear that pain (Data unit: 7).
 - Labour pains can be manageable (Data unit: 10).
 - Labour pains ... can be handled if you (as patient) have been prepared (Data unit: 11).
 - Labour pain, although natural and expected, can become unbearable (Data unit: 53).
 - I regard it as when a woman is in labour I am expecting her to be having labour pains (Data unit: 106).
 - I know really, that labour pain is painful (Data unit: 60).
-

The main impression derived from the evidence contained in data display 1.2 is that labour pain is *bearable* and *manageable*, however, it can become unbearable but still be manageable. What participants expressed in this regard can be attributed to both the body of knowledge of midwifery practice the midwives possess and to their personal experiences of labour pain. As one participant indicated in this regard: *Nobody can*

explain the labour pains to the patient, unless you have gone through that pain as a human being (Data unit: 6).

With regards to the body of knowledge of midwifery practice, the impression of labour pain being *bearable* and *manageable* are supported by Leifer (2005:109) in a description of *labour pain* and in a comparison drawn between labour pain and pain caused by injury or illness. In the latter regard, Leifer (2005:109) reports that *childbirth pain* differs from pain experienced in other conditions in the following ways:

- labour pain is *part of the normal process*, whereas pain at other times usually indicates illness or injury
- the *sources of pain are known*. The purpose of muscle contraction helps in the birthing process
- the *woman has time for preparation*. Knowledge and skills can be developed to manage the pain. The sensation is referred to as a contraction, not pain (Leifer 2005:109)

It is reiterated that these perceptions and acceptance of pain attitudes could further influence participants' intervention approaches in practice, that is, their midwifery professional practice, their attitudes towards patients and their relationships with patients. Jowitt (2000:12) suggests that midwives' attitudes will be influenced by what they have been taught, the experience of having been with many women in labour and for those who are mothers, their own experience of childbirth. Smith (in Hunter 2001:441), in this regard observed dichotomous behavioural patterns portrayed by midwives. Some midwives become task orientated and distance themselves from the women in labour while others maintain, "being there for" their clients.

4.2.1.3 Category 1.3: Midwives' account of personal experience of labour pain

As pointed out previously in the literature supporting category 1.2, Jowitt (2000:12), states that personal experience of labour pain may influence the way a midwife may judge patients' pain experiences. This point is further taken up in data display 1.3 on the personal experience of midwives of labour pain. The evidence in data display 1.3 mainly implies: confusion; uniqueness; withholding normal reaction to pain; hiding or masking real

feelings; pain versus urge to push; and the benefits of having experienced labour pain oneself.

DATA DISPLAY 3

THEME 1: DISCRIPTION OF LABOUR PAIN

CATEGORY 1.3: MIDWIVES' ACCOUNT OF PERSONAL EXPERIENCE OF LABOUR PAIN

Confusion (1.3.1)

- my first-born was a normal vertex delivery ... I have been a registered professional midwife already, and it was totally confusing for me, I could not identify myself that I was in labour, been a midwife (she laughs at her self). That was the first thing that I noticed, I could not handle the pain (Data unit: 23.2).

Uniqueness (1.3.2)

- Nobody can explain what a woman in labour is going through unless they have themselves gone through that experience. It is not the same for all (Data unit: 24).

Withholding normal reaction to labour pain (1.3.3)

- ... but I am going to try and contain myself, so I actually suffered this tremendous pain that actually mislead the nursing staff, or the doctor to say this woman (myself) is not in labour (Data unit: 25).

Learning experience (1.3.4)

- If you have not gone through that process you will not know what is the actual feeling (Data unit: 28.1).
- Fortunately one got a chance of going through the same process self; so not only you have learned about it but also you have experience of it (Data unit: 204.3).

Benefits of the learning experience (1.3.5)

- What I am saying by that: on the personal experience that one had, you become a better midwife if I can say. You know what to do to a woman in labour. You would know why she needs sedation. If you give your attention you will know that with this pain she is not screaming for a lie, she really is suffering, so in that line you are going to give what is due to this woman, who would be able to just now be quiet and you will be able to care for this woman in totality, because with labour pains most of the time you would find that the body does not work symmetrically (Data unit: 30.1).

Urge to push (1.3.6)

- It is painful, you want to push, and the way a pain is coming (Data unit: 40).

Very painful (1.3.7)

- Labour pain is a very painful thing, but anyway it differs with people, people differ with pain threshold (Data unit: 213.).

Unbearable (1.3.8)

- Labour pain is something that is often unbearable (Data unit: 246).
-

In a study conducted by Brigh and Stil (Niven & Murphy-Black 2000:245) to determine the recollection of pain throughout life experiences, it was found that pain associated with childbirth was the most memorably reported (Niven 2000:245). It is thus reiterated that the labour pain experiences of midwives may have a strong influence on their midwifery practice.

In this category, it becomes clear that the reality of the experiences that the participating midwives had during labour was unique and added to their knowledge of professional midwifery. This could also be explained as an encounter with reality wherein the reactions and responses become primarily intuitive (immediate apprehension by mind without reasoning) and then be followed by the 'norm', what one has learnt as an acceptable way of behaving in a given situation. According to the evidence, these encounters are characterised by confusion, uniqueness, and unbearable pain with an urge to push; all of which are considered a learning experience.

The natural perspective on labour pain, as it emerged from the data and which is contained in data display 1.2, is, however, not a given to participants. According to the participating midwives, several factors impinge on the intensity of labour pain. Many authors also support this. For instance, Perry and Lowdermilk (2006:246) state that a woman's pain during childbirth is unique to her and it is influenced by a variety of factors, including physiological factors (e.g. endorphins level and maternal position); cultural background; anxiety levels; previous childbirth experience; preparation for childbirth (e.g. gate control theory used for technique to relieve pain); comfort and support given by nurses and significant others; and the quality of labour and the birth environment. In addition, psychological factors that influence pain include fear, anxiety, worry, expectation of pain, body image, and self-efficacy (Pillitteri 2003:523). Exhaustion from loss of sleep or prolonged labour contributes to pain perception (Littleton & Engebretson 2005:483). All of these, if experienced personally, might have influenced the participating midwives' perception of the intensity of labour pain suffered by their patients.

4.2.1.4 Category 1.4: Factors relating to the bearableness and manageability of labour pain

Several factors that impinge on the bearableness and manageability of labour pain were identified during the current research. Some of these factors are also discussed in the literature while others, such as *hunger*, is more contextual to the area in which the current research was conducted. The factors that emerged from the current study include age, parity, psychological state, and hunger.

4.2.1.4.1 Category 1.4.1: Age

Data display 1.3.1 contains evidence pertaining to age as this factor relates to labour and labour pain.

DATA DISPLAY 4
THEME 1: LABOUR PAIN
CATEGORY 1.4: FACTORS RELATING TO THE BEARABLENESS AND MANAGEABILITY OF LABOUR PAIN
SUB-CATEGORY 1.4.1: AGE

General indicators (1.4.1.1)

- I do not know but I also feel now that the age group for first pregnancy and resulting labour has gone down to the level of twelve years of age. Can we change that? We cannot change that. What is for us to be done, by the profession, by the researchers? (Data unit: 116.4).

Specific evidence (1.4.1.2)

- This woman in labour might be 16 years of age, and what do you expect from a 16 year old? She will be so confused by the time the baby is born, that she will not remember the process of giving birth tomorrow (Data unit: 32.5).
- So perhaps what we need to do is to get some information on these teenage pregnancies, because I think the teenage woman and the elderly prime-up and totally different things, the elderly- she wants this baby, the teenage pregnant woman- it could be a mistake and that she was not actually prepared for this baby and both the age and the “wanting” the child may impact on her experience of pain (Data unit: 116).
- I have learned *nna hore (translated to: myself)* that ... if they have birth at this tender age something, logically something happened there. The labour was painful; it was something that was not expected (Data unit: 122).
- You know with elderly women everything just falls into place, but with this younger generation so many gaps, some of them would lie about bleeding and about the pain (Data unit: 126).
- Really they do have problems, being as young as they are, because what I have seen as well, whenever they want to go to toilet they feel no need to inform the midwife, they would not ask for help, whenever they got up they would feel dizzy, they would go to an extent of collapsing on the floor, not saying a thing you understand (Data unit: 128).

The data revealed that there is a general view among the participants about the decreased age levels for first time labouring women. Participants stated that the age group of first pregnancy has gone down to as young as 12 years of age; this situation was described by participants as contributing to problems during deliveries, including a more intense pain experience.

In South Africa teenage pregnancy is an important indicator of the situation of teenage girls, especially in regard to not attending educational institutions. In 2002 there were 66 000 teenage girls who reported pregnancy as the main reason for not attending an educational institution. This rose to 86 000 in 2004, but dropped to 71 000 in 2006. In

summary, teenage pregnancy rates between 2002 and 2006 were as follows: 11,8% in 2002, 17,4% in 2004 and 13.9% in 2006 (http://www.statssa.gov.za/news_achieve/23_August_2007_1.asp – accessed 28 May 2008).

The views of participants on the influence of the age of labouring women on pain experiences and responses are supported by Andrews and Boyle (2003:407) who stated that age relates to specific biological and psychological factors influencing people's perceptions and experience of pain. Brodwin and Kleinman (in Mander 1998:15) add that both gender and age influence cultural orientation factors to pain and the individual's expected reaction to pain (including labour pain).

The age of an individual also relates to knowledge and experiences, and these, in the context of child bearing, influence the behaviour of women during labour. Labour pain in older women was perceived by participants to be more manageable and more bearable to suffering individuals. This aspect is further evidenced by the data on parity and labour pain as explicated in the next category.

4.2.1.4.2 Category 1.4.2: Parity and pain

The influence of past experiences of childbirth was identified by participants as playing a significant role in determining responses to labour pain. This factor relates to parity and personal learning experiences as an important factor influencing women's reactions to labour pain. Since labour pain is unique to individual women, to primigravidas it is also new in their repertoire of experiences, hence they become confused, unlike with multiparity women where, even though the pain is unique, the woman can identify with it. The labour pain in multiparity women seems more manageable and bearable than in primigravidas. Also, as is evidenced by the data contained in the next data display (data display 1.6), the psychological state of the woman in labour is of concern to the informants.

DATA DISPLAY 5
THEME 1: DESCRIPTION OF LABOUR PAIN
CATEGORY 1.4: FACTORS RELATING TO THE BEARABLENESS AND MANAGEABILITY OF
LABOUR PAIN
SUB-CATEGORY 1.4.2: PARITY AND PAIN

- OK, especially when it is the first baby, sometimes in the younger patients you find that they are a little bit bewildered they didn't expect that the pain would be quite so severe like it can be (Data unit 162).
 - So perhaps what we need to do is to get some information on these teenage pregnancies (usually the first when they are so young), because I think the pregnant teenage woman and the elderly prime-up are totally different (Data unit: 116.6).
 - That is why I say with the first baby, the younger patient is like, they are a little bewildered and they are quiet, they are sort of scared to verbalise, the fact that the pain is very severe. Then you find the other patients that are showing physical discomfort, they will get up from bed and its difficult to calm such patient (Data unit: 164).
 - Some have a high level, they are very quite, you have trouble to ascertain whether she is definitely having severe labour pains, whereas other patients even from the very first milestone have quite a reaction, sometimes it's a verbal reaction, sometimes it's a physical one. Most of the time I find that a patient, especially when it is the first baby, the labour pain is a surprise experience (Data unit: 157.1).
-

According to Levasseur et al (2003:181), the cervix of multiparity women often softens before the onset of labour and therefore is not as sensitive as the cervix of primiparity woman. The intensity of uterine contractions is greater and the length of labour is often longer in primiparity women (Levasseur et al 2003:181). Sellers (2004:423) states that in normal labour the woman undergoing her first labour will usually experience more pain than the woman who has given birth previously.

4.2.1.4.3 Category 1.4.3: Psychological state

The psychological state of patients also emerged as a sub-category within the category of factors that qualify the bearableness and manageability of labour pain. Within this sub-category, the psychological preparation of pregnant women regarding labour pain emerged as an antenatal issue.

4.2.1.4.3.1 Category 1.4.3.1: General indicators

Data display 1.6 (sub-category 1.4.3.1) carries evidence of general indicators relating to psychological state as an impinging factor in the bearableness and manageability of labour pain.

DATA DISPLAY 6
THEME 1: DESCRIPTION OF LABOUR PAIN
CATEGORY 1.4: FACTORS RELATING TO THE BEARABLENESS AND MANAGEABILITY OF
LABOUR PAIN
SUBCATEGORY 1.4.3: PSYCHOLOGICAL STATE
1.4.3.1: GENERAL INDICATORS

- It is perhaps to also research this age group (teens) - what is the effects of pregnancy down there, we should try to accommodate them according to their psychological level, because what we were dealing with in the past, was the older woman that were accepted as reasonable age of delivery, and then in the past we had our mothers who got married at the age of seventeen, but they got married and want children, but today there is a different set-up, they become pregnant they suffer those effects and they become abandoned (Data unit:116.5).
 - if you attend to a teenage pregnant woman, you need to sit down with her and explain things from A-Z, what is to happen to her. If you not do this her emotion will run away with her (Data unit: 104.4).
-

Concerns about discomfort and the actual experience of pain during labour and birth can sometimes dominate a pregnant woman's thoughts about childbirth. Littleton and Engebretson (2005:482-483) report that the philosophy behind prepared childbirth or psycho-prophylaxis is that ignorance; misinformation, fear and anxiety appear to intensify pain. Pilliteri (2003:520) states that providing information during prenatal visits about the numerous methods for comfort promotion and pain control available to the woman can help allay some of these fears. Singh (cited in Cronjé & Grobler 2003:84) adds that in labour, a vicious circle may develop easily; *whereby* pain leads to anxiety *and* anxiety increases pain which again increases anxiety.

The psychological state of the younger and the older women during childbirth was perceived not to be the same by participating midwives. The older women were reported to be more understanding of their circumstances whereas to the younger women their circumstances were strange to them. One participant suggested research on the effect of pregnancy at the early age, especially the psychological aspects of teenage mothers, relating to labour pain. The reason advanced by this participant is to enable them (midwives) to structure their interventions to accommodate these teenage mothers. According to participants, their current midwifery intervention is based on the past interventions, which focused on older women who were married and who, for the larger part, wanted to fall pregnant.

4.2.1.4.3.2 Category 1.4.3.2: Psychological preparation of women

Antenatal classes for the psychological preparation of women play an important role in the labour ward and beyond. The data display below reflects what the participating midwives said about this variable (impinging factor).

DATA DISPLAY 7
THEME 1: DESCRIPTION OF LABOUR PAIN
CATEGORY 1.4 FACTORS RELATING TO THE BEARABLENESS AND MANAGEABILITY OF
LABOUR PAIN
SUBCATEGORY 1.4.3: PSYCHOLOGICAL STATE
SUBCATEGORY 1.4.3.2: PSYCHOLOGICAL PREPARATION DURING ANTENATAL CARE

General indicators (1.4.3.2.1)

- I think most of the patients do not think it can be so severe (Data unit: 157.2)
- I think these patients, whether it is the first time they are to have children or not, they must be explained clearly that they are going have pain during labour, so that their fears could be cleared. They should do whatever they are told, the cooperation is very important although the pain is unbearable sometimes for other people, so I think explanation is very important (Data unit: 258).

Psychological preparation of women (1.4.3.2.2)

- Most women are able to bear that pain if they have been psychologically prepared, concerning the issue (Data unit: 8).
- Sometimes this patient had a very traumatic delivery experience, where they were screaming and shouting, everything becomes incomprehensible to them, they become psychotic post delivery, and then when ever you get hold of relatives and try to get a history from the family, then you find that pregnancy was never accepted from the beginning (Data unit: 116.1).
- So this child/woman has gone through tremendous stress levels with this pregnancy that is not wanted at home, so she has been suffering alone, and then here comes the terrible pain that she could not handling because no body could explain *hore naa* how does labour pain actually feel, and then it becomes such traumatic experience to them especially the teenagers that they become psychotic post delivery (Data unit: 116.2).
- So psychologically if they are not prepared for their pregnancies that could cause them a very traumatic birth - they scream throughout, they don't hear, like sister X who said she talk to them and sometimes even tease them, what about the one that do not want to be teased, you understand the thing (Data unit: 116.7).

The need for repeated psychological preparation (1.4.3.2.3)

- You find that might this patient is a primigravida and she is not clear about labour pains, she just heard outside about labour pains by the community, then you have explain everything about labour pains to her, but the second one, maybe she and a child before and she didn't have knowledge and the pain experienced with the first delivery differ from the one experienced now, so also you have to explain everything to her about pain regardless of the number of deliveries she had (Data unit: 215.2).

Recommendation regarding psychological preparation (1.4.3.2.4)

- So I really feel, perhaps what can also be done is that from the antenatal care level, there's a gap as far as the information is concern, because I feel that if this woman has been prepared psychologically, they would be experiencing what they have been taught about, so don't you think that their responses would be better during the labour process and post the delivery, if they had satisfactory levels of information, so I don't know, but here, locally, I got the feeling that the antenatal classes is not effective or is not conducive if they are conducted information is not given (Data unit: 129).

Gaps pertaining to mother education (1.4.3.2.5)

- I feel you can even see sometimes, that those women that we see here they know nothing about their problems, they would not know what are that entails. You ask the RH-negative mother why should I give you this anti D and they do not know. They become suspicious (Data unit: 131.1)
- This is how I think that perhaps the information they get from the clinic level is so minimal, it is unfortunate that the time we spend with the labouring woman is so short that she even missed out that aspect, so is so difficult to teach that RH – negative mother here (Data unit: 131.2).
- I also think it's an assumption to say that if a woman attended the antenatal clinic got the information about labour pains she knows what to do during labour process. Because there they are been told with the partner (Data unit: 271).

Sources of psychological stress (1.4.3.2.6)

- **Parity**
 - I think these patients, whether it is the **first time** they are to have children or not
 - **Not realising their own health status**
 - they know nothing about their problems
 - **Ill-preparedness through non-antenatal attendance**
 - from the antenatal care level, there's a gap as far as the information is concern
 - **Rumours about labour pain intensity**
 - just heard outside about labour
 - **Unwanted pregnancy**
 - tremendous stress levels with this pregnancy that is not wanted at home
 - **Unaccepted pregnancy**
 - pregnancy was never accepted
 - **Previous experience**
 - patient had a very traumatic delivery experience
-

Page and McCandlish (2006:60) support the attendance of formal antenatal classes, stating that in traditional and herbal societies, preparation for parenthood was managed less formally, with most women receiving information, advice and help from female kin and neighbours, but as social ties become more diffuse, women increasingly relied on midwives and other professionals for such preparation. Singh (cited in Cronjé & Grobler 2003:85) also support the importance of encouraging women to attend antenatal classes by stating the that in addition to educating them to know and understand their bodies and pregnancy they are taught to develop new conditioned reflexes by which pain perception or transmission may be inhibited. This author further states that scientific evidence shows that childbirth education is associated with greater maternal control and less anxiety *during labour*.

In this sub-category it emerged that the psychological preparation of women at the antenatal clinic is a key determinant of the women's behaviour during labour. The preparation of women for labour is done during antenatal classes, the purpose of which is for the patient to manage the experience of labour in terms of pain and emotional distress, as well as to ascertain her cooperation during childbirth (labour). Slade, Escott, Spiby, Herderson and Fraser (2000:555) state that antenatal classes are a well-

established feature of routine antenatal care. The purposes of the classes include preparation for parenthood through discussions of feeding and other care issues and the facilitation of social support through bringing together those who are about to become new mothers. However, one of their main aims is the preparation of women for labour through the provision of information and the development of strategies (such as breathing and relaxation) to manage the experience of labour in terms of pain and emotional distress.

The participating midwives further stated that, if women were well prepared (well informed about pregnancy, labour and the *post partum* phases) during antenatal visits at the clinics they would respond better during and after giving birth. There would then be minimal traumatic birth experiences, the latter decreasing the incidence of *post partum* depression with psychotic features, a syndrome mostly characterised by depression, delusions, and negative thoughts by the mother, harming either the infant or herself (Lowdermilk & Perry 2007:915).

The benefit of attending antenatal classes by pregnant women cannot be over-emphasised considering its benefits regarding the pregnant woman's psychological preparation. The most important aspect of these classes is the application of psychological preparation strategies. The current data imply that most participants believe that antenatal psychological preparation, and therefore attendance of classes, plays an important role in determining the future behaviour of pregnant women, especially their responses to labour pain. The psychological stress experienced during and after labour could have far-reaching consequences, as stated above. The factors associated with this potential complication are lack of knowledge about labour pain, unwanted and unaccepted pregnancies, and traumatic previous birth experiences.

4.2.1.4.4 Category 1.4.4: Hunger

Data display 1.7 contains evidence of a more specific nature regarding the manageability and bearableness of labour pain than usually found in textbooks.

DATA DISPLAY 8
THEME 1: DESCRIPTION OF LABOUR PAIN
CATEGORY 4: FACTORS RELATING TO THE BEARABLENESS AND MANAGEABILITY OF LABOUR PAIN
SUBCATEGORY 1.4.4: HUNGER

- Yes, it was severe. When I am hungry I am nauseous and vomit, not because of the pain, but because of the hunger but it also makes the pain more severe (Data unit: 77).
 - ... and normally with the strength that they (women in labour) get from food, they can tolerate pain better (Data unit: 77.2).
 - But the other one like the one I have just delivered now, she could tolerate the pain, she cried but she managed to eat without feeling nauseous because I was treating her with soft porridge this morning (she laughed), because she managed to take something down even when she was 8cm without feeling nauseous and it makes the pain better (Data unit: 81.2).
 - So I normally use my own methods to control the pain and I tell them use *umtogo* (soft porridge), but there those who cannot cope and they come and say it was effective, and also I like to give them food, not to take away pain but to lessen it somehow (Data unit: 106.2)
-

The common approach in the midwifery practice regarding serving patients food is the fact that during the active phase of labour food is never served, and patients are provided with intravenous infusion to boost their energy until after the birth of the baby. Pilliteri (2003:487) explains the rationale for this practice as the fact that the gastro-intestinal system becomes fairly inactive during labour. This is probably due to the shunting of blood to more life-sustaining organs and also to pressure on the stomach and the intestines from the contracting uterus. Digestion and the emptying of the stomach is prolonged, explaining why eating during labour is restricted. Some women also experience loose bowel movements, as contractions grow stronger.

In addition, ketone levels rises resulting in hunger, and this situation is supported by Littleton and Engebretson (2005:283) who state that in fasting, like during the active labour state where food intake is not promoted and also because of food shortages due to socio-economic (poverty) status, the pregnant woman experience hypoglycaemia and a state of keto-acidosis which develop more quickly than in non-pregnant women.

In this study a different approach was revealed whereby one participant indicated that all the women that she assisted during childbirth were encouraged to eat before she could attend to them because, according to her personal experience, hunger intensifies labour pain. In many areas and among many socio-economic groups in South Africa, people go

without the necessary daily food required. This is probably true in the area where this research was conducted. Nonetheless, this practice was found to be unique and needs to be explored further because the current literature does not support this practice, but contra-indicates it.

4.2.2 Theme 2: Coping with labour pain

The naturalness of labour pain, midwives' personal experience of labour pain, their professional experiences with women in labour and their perceptions of factors influencing labour pain as sub-categories of theme 1 on *labour pain* also have bearing on theme 2, namely the behaviour and actions of patients and professional midwives concerning labour and labour pain.

4.2.2.1 Category 2.1: Women's natural reactions to labour pain

In relation to the naturalness of labour pain, this sub-category implies women's natural reaction towards labour pain; the individual woman's natural coping mechanisms to deal with the pain. These include closing of the thighs, the taking off of clothing, getting off the bed, jumping up and down, screaming, not reporting abnormal situations, e.g. bleeding and the like. Littleton and Engebretson (2005:484) state that the nurse must always be aware of the fact that pain is a very individual experience. It is subjective in nature, and can only be defined by the client experiencing the pain, who may communicate it in many different ways. Data display 2.1 contains evidence in this regard.

DATA DISPLAY 9
THEME 2: COPING WITH LABOUR PAIN
CATEGORY 2.1: WOMEN'S NATURAL REACTION TO LABOUR PAIN

General indicator (2.1.1)

- Whatever she (women in labour pain) is doing is needed because the threshold of the patients' are not the same, patients are individuals- others used to scream, others keep quite, it is acceptable, but even if the patient is quite, since you are checking the contractions or not you can see that this one is having contractions you must (Data unit: 108.1).

Specific reactions (2.1.2)

- ... most of the time you find that they do close up their thighs, take off their cloths ..., (Data unit: 8).
- Sometimes it's a verbal reaction; sometimes it's a physical one (Data unit: 157.1).

-
- ... especially sometimes when she is near second stage of labour you find it is difficult to some patient to keep quiet so that you can manage the actual birth, they turn to get up from the beds, not really kicking out, just a little restless (Data unit: 166).
 - The one where the patient is jumping up and down in the bed (she laughs) (Data unit: 168).
 - People react with different behaviours when experiencing pain, others may be uncooperative, others may cry, others may choose to walk around. (Data unit: 269).
-

Although all women expect to experience at least some pain and discomfort during childbirth, it is their culture and religious belief system that determine how they perceive, interpret, respond to and manage pain (Lowdermilk & Perry 2007:467). According to Orshan (2008:677), nurses should recognise that every patient has cultural beliefs and values that influence her perception, regardless of whether she openly recognises these factors. Experiencing pain is influenced by physical, mental, biochemical, psychological, physical, social, cultural and emotional factors (*Mosby's Medical Nursing and Allied Health Dictionary* 2002:1261). According to Engel (1950) (in Helman 2007:185), pain has two components: the original sensation and the reaction to sensation. The reaction, whether voluntary or not has been called pain behaviour and includes certain changes in facial expression, grimaces, changes in demeanour or activity, as well as certain sounds made by the person, or words used to describe his or her condition or appeal for help. Patients' responses to pain can generally be classified into two broad categories: stoic and emotive. Stoic responses are generally characterised by fewer verbal and non-verbal expressions. Conversely, emotive responses are frequent, often verbal and expressive (Orshan 2008:677). Some patients have a cultural tendency to express pain openly, but some do not, and those who are very vocal may not be merely dramatic, but may indeed feel real pain (Gruenberg 2006:64).

According to *Pain management made incredible easy* (2003:50), pain behaviour denotes the way in which a patient communicates pain, distress or suffering. These authors further suggest the following behaviour and pain expressions to be included in a checklist when assessing a patient's pain experience: grimacing, moaning, sighing, clenching teeth, holding or supporting the painful body area, sitting rigidly, frequently shifting posture or position, etc. These also apply in reaction to labour pain.

The women's behavioural responses as evidenced by the data display give a broad picture of the labour ward milieu during delivery. These behaviours are evident of both

voluntarily and involuntarily communication of labour pain experienced by women towards the attending midwives. The different behaviours listed in the data display and those mentioned in the supporting literature also reflect the *naturalness* of labour pain experiences. The midwives should identify and relate to ethnicity and religion within the immediate geographic location to women's behaviour and should develop a profile of cultural specific responses to pain. Understanding these specific behavioural responses to labour pain can assist midwives greatly to recognise and support individual women. According to Pillitteri (2003:58), a person's culture dictates attitudes towards pain and the response to it.

4.2.2.2 Category 2.2: Midwives' perception of acceptable behaviour of women in relation to labour

Participants' (midwives') perception of acceptable and expected behaviour of women in relation to labour pain also emerged as a category during the current research. Their perceptions greatly influence their actions and the way in which they 'cope' with the situation. Two sub-categories emerged which demonstrated acceptable (data display 10) and non-acceptable (data display 11) behaviour to attending midwives.

DATA DISPLAY 10
THEME 2: COPING WITH LABOUR PAIN
CATEGORY 2.2: MIDWIVES' PERCEPTION OF ACCEPTABLE BEHAVIOUR
OF WOMEN IN LABOUR PAIN

Crying (2.2.1)

- even when she cry loud, we just expect them (Data unit: 70.2).
- I am adaptable, myself actually, even when I want to correct behaviour, I do not expect a patient to behave like the other one, I don't expect one patient to behave like the other one, I just accept it like that (Data unit: 71).

Screaming (2.2.2)

- If she can scream it is acceptable its pain, if she scream and still do the right thing its OK, it is time to push the baby out, she screams in between but she is probably trying to do the best, you can see that she want to do the best but now maybe the threshold she cannot tolerate the pain and she is saying to you I want to do the right thing and she is probably trying, it's acceptable, (Data unit: 196.4).

Pain is a unique experience that varies from person to person. What one woman describes as mild, cramping, achy discomfort, another might describe as the most excruciating feeling she has ever known (Orshan 2008:672). The most common behavioural response reflected as evidence in the data display was *screaming*. The *screaming* of women when experiencing labour pain was conditionally considered

acceptable to participants. The condition for accepting the *screaming* response was that it should be accompanied by doing the correct things (listening to instructions). The acceptance of screaming also depends on the stage of labour in which a woman is. One of the statements from participants supports this:

"If she can scream it is acceptable, its pain, if she screams and still does the right thing its OK, it is time to push the baby out, she screams in between but she is probably trying to do her best You can see that she wants to do her best but maybe she cannot tolerate the pain and she is saying to you: I want to do the right thing, and she is probably trying. Then it is acceptable" (Data unit: 196.4).

The condition for accepting the woman's pain responses by participating midwives is an evidence of the *nursing subculture expectations* about pain, as described by Andrew and Boyle (2003:410). They state that nurses expect people to be objective about the very subjective experience of pain. In clinical practice, nurses may expect a person experiencing pain to report it and to give a detailed description of it, but to display few emotional responses to it.

The display of the 'conditional screaming' which is qualified by listening to instructions and the stage at which the women came to hospital has a bearing on the way the woman will be supported and cared for by the midwife, that is, these behaviours may contribute to the attitude of the midwife. The argument of 'listening to instructions' is related to a discussion on the psychological preparation of women at the antenatal classes, which helps in minimising fear and anxiety which intensify the emotional experiences of labour pain (category 4.3.2 and data display 1.4.3.2).

4.2.2.3 Category 2.3: Midwives' perception of non-acceptable behaviour of women in relation to labour

In contrast to the previous sub-category and data display, participants also gave an indication of non-acceptable behaviours and reactions to labour pain, including crying and becoming depressed, poor communication, bodily behaviours and frustrations. Data display 11 gives evidence in this regard.

DATA DISPLAY 11
THEME 2: COPING WITH LABOUR PAIN
CATEGORY 2.3: MIDWIVES' PERCEPTION OF NON-ACCEPTABLE BEHAVIOUR
OF WOMEN IN LABOUR PAIN

- Then we do have a problem really, most of the time you find that they do close up their thighs, take off their cloths, and make the birth of the baby a actually a very traumatic experience, and of which I feel *hore naa* if they have gone through those processes as it is (Data unit: 116.1).
 - ... especially sometimes when she is near second stage of labour you find it is difficult to some patient to keep quite, so that you can manage the actual birth, they turn to get up from the beds, really kicking out, just restless (Data unit: 166).
 - The one where the patient is jumping up and down in the bed (she laughs) (Data unit: 168).
 - People react with different behaviours when experiencing pain, others may be uncooperative, others may cry, others may choose to walk around (Data unit: 269).
 - Those ones that screams so load and fights are the ones that really do not have good experiences (Data unit: 166.1).
-

Although the women's reactions to labour pain given as evidence in data display 11 may be viewed as normal, these can get in the way of the midwifery intervention necessary for safe delivery and may thus become sources of frustration to the midwife. Additionally, behaviour such as the crossing of legs may cause obstruction in normal delivery, or at least cause counter-pressure to natural contractions. In combination, these behaviours or reactions could lead to a more traumatic childbirth experience to the mother and can be life-threatening to the baby. Thus it is important to the attending midwife to think critically in order to make a proper judgement to ensure a balance between accommodating the woman's reaction to labour pain and guaranteeing the safety of both the mother and the unborn baby. In most instances the problems emanating from these behaviours result in a breakdown in the communication between the midwife and the patient.

In labour wards communication between the midwife and patient is of the utmost importance. The midwife shares the care-plan activities with the patient and the patient informs the midwife about her needs. It is important that both parties communicate their needs and intentions in order to achieve the common objective, which is the safe delivery of the unborn baby. If communication is broken down by either of the parties, as indicated by evidence in the data display 2.3 (e.g. the patient does not want to listen to instructions), the quality of midwifery care will be compromised. *Communication* is basic to all nursing and other health care services and it contributes to the development of all therapeutic relationships (*Mosby's Medical Nursing and Allied Health Dictionary*

2002:401). Sellers (2004:350) state that it is the midwife who has the greatest contact with the woman in labour, and she is therefore the person to whom the woman will turn in her needs.

Participants stated to have experienced the following unacceptable behaviours: screaming, jumping out of bed at the second stage of labour and rolling on the floor, and not listening to instructions.

No literature was found to support this claim but from common practice it can be accepted that these behaviours can result in the following problems in midwifery practice:

- *Screaming (extreme)*, can cause midwives to panic and disturb proper decision-making.
- *Jumping out of bed and rolling on the floor*, can cause injury to the mother and the baby as well as make the delivery process difficult for the midwife.
- *Not listening to instructions* can have the same consequences as the two points above.

Thus it is important for the attending midwife to make a proper judgement to ensure a balance between accommodation of the woman's reaction to labour pain and guaranteeing the safety of both the mother and the unborn baby. The evidence in the data display indicates the following main consequence of unacceptable behaviour, namely the fact that the baby may be injured and suffer temporary or permanent injury like fractures and epilepsy due to head injury.

In addition to the above discussions on the potential problems that may arise due the unacceptable behaviours of the women during labour, these behaviours could also become sources of frustration to the attending midwives. Since giving birth is emotionally and stress-wise a highly charged moment, it demands concentration and focus from those assisting the mother. If these behaviours are not controllable they may **annoy** midwives (*make a person slightly angry – Oxford School Dictionary 2004:17*) and may cause them to **panic** (*sudden uncontrolled fear – Oxford School Dictionary: 2004:320*). *Panic* is further defined as an intense, sudden, and overwhelming fear or feeling of anxiety that produces terror and immediate physiologic changes that results

in paralyse, immobility, senselessness or hysteria (*Mosby's Medical Nursing and Allied Health Dictionary* 2002:1270).

Tension runs high in a labour ward; it demands critical thinking and good judgement from the midwife. Any behaviour that frustrates her may negatively affect critical thinking and good judgement and thus compromise the achievement of a *safe delivery goal*.

4.2.2.4 Category 2.4: Individual pain threshold and tolerance

Women's behaviour to labour pain depends on their individual pain threshold and experiences, with the latter aspect relating to category 1.4.2: Parity and pain. These two variables are the determining factors for individual women to seek pain medication or medical attention. In midwifery practise, the midwives' previous experiences influence their judgment on the pain experienced by patients as well as their response to women's unique reaction to labour pain. Thus, within the category 'Individual pain threshold and tolerance' we have midwives' perceptions of the uniqueness of individual pain threshold and their reaction to the uniqueness of individual pain thresholds and tolerance. Data display 12 contains evidence of the former and data display 13 of the latter.

The data display below indicates evidence of the uniqueness of each woman as viewed by participating midwives in the study. The evidence contained in this display relates to the literature on individual pain *threshold* and *pain tolerance* (chapter 2, paragraphs 2.3.5 and 2.4.4).

DATA DISPLAY 12
THEME 2: COPING WITH LABOUR PAIN
CATEGORY 2.4: INDIVIDUAL PAIN THRESHOLD AND TOLERANCE

General indicators (2.4.1)

- She will have the sedation and it have effects in her body, she would have to tell you if this is not working, what does that say to you, she has high pain threshold or low pain threshold, because you will find the other one being drowsy and the other one even if she had sedation, she is screaming right way, so what does that say to you, it gives you another view of what type of patient is this, I think you can resort to other means of trying to allaying her anxiety (Data unit: 31: 2).
- Some have a high level, they are very quite, you have trouble to ascertain whether she is definitely having severe labour pains, whereas other patients even from the very first milestone have quite a reaction, sometimes it's a verbal reaction, sometimes it's a physical one. Most of the time I find that patients, especially when the first baby, the labour pain is a surprise experience (Data unit: 157.1).

-
- ... depend on each woman and the threshold of that woman (Data unit: 70.3).
 - So, how she may be in pain, it's different, it's what make it more interesting to see different threshold levels of each patient. Other one can just not tolerate the pain and other ones can tolerate the pain (Data unit: 70.4).
 - I'm expecting the pain to be there and it depends on the threshold of each patient so my perspective is to take each one of him or her individually (Data unit: 106.1).
 - The responses that I have seen, they do not respond the same (Data unit: 112).
 - Patient experience it differently; each individual is different from the next person (Data unit: 157)

Uniqueness relating to analgesics (2.4.2)

- Others if you give them analgesia they respond well and good and they are going to deliver without having any pains, others even if you give them analgesia they keep on making noise, restless, changing position doing everything she wants to do (Data unit: 112.1).

Problem associated with high pain threshold (2.4.3)

- The responses is different, maybe it is because the degree of pain, because some other people you can see whether she is feeling pain she will be quite, but you will only see when the baby comes but some others are screaming, walking up and down the corridors, screaming to the nurses asking for help (Data unit: 248).
- Firstly I would say the threshold of the person- some people have high threshold and others have low threshold the delivery is the same but now how we perceive pain is different as a results the person's reaction will not be the same, if that one has a high pain threshold, she might be able to endure pain and be able to co operate. But the other one might have low threshold might not be able to cooperate, actually it will be a mess" (Data unit: 186.2).

Pillitteri (2003:1114) states that although people may have the same *threshold sensation* (the amount of stimulus that results in pain), their *pain threshold* (the point at which the individual reports that a stimulus is painful) and pain tolerance (the point at which an individual withdraws from a stimulus) varies greatly. Individuals with low pain thresholds experience pain much sooner and faster than those with higher thresholds; individuals' reaction to stimulation of pain receptors vary (*Mosby's Medical Nursing and Allied Health Dictionary* 2002:1264).

Participants acknowledged the fact that people are unique in terms of responding to labour pain and their behaviour is dependent on the different pain thresholds each person has. The participants stressed the fact that each woman's response to labour pain is dependent on her tolerance of labour pain. Again they stated that pain tolerance is dependent on pain threshold.

The different pain thresholds and tolerances influence the effectiveness of pain medication, which implies that the dose and frequency of pain medication given to the woman in labour depend on the individual woman's positive feedback to the midwife.

Furthermore, it was found that pain threshold and tolerance influence a woman's cooperation with the attending midwife. Participants stated that if the woman's pain threshold is low, she does not always listen (cooperate) to instructions, because she is concentrating on the labour pain; hence they regard that response as lack of cooperation from the women.

The participating midwives acknowledge the differences with regards to their reaction to women in labour despite the fact that they have learned about the behaviour of women in labour. They also gave motivations for their attitudes.

4.2.2.5 Category 2.5: Midwives' reaction to their perception of the uniqueness of individual patients

Midwives, as health care professionals, have to take charge and control in the clinical setting. Their reactions and handling of the situation may influence the outcome of the service they render. The data display below indicates midwives' reaction to the women's extreme reaction to labour pain well as the motivations for their views.

DATA DISPLAY 13

THEME 2: COPING WITH LABOUR PAIN

CATEGORY 2. 5: MIDWIVES' PERCEPTIONS OF THE UNIQUENESS OF INDIVIDUAL PATIENTS

Midwives reaction (2.5.1)

- Then, when the patient start to have that extreme reactions then you have to say don't lie down, don't keep still, and its (patient) stretching out, then it becomes difficult, then you battle to keep to your own reactions to yourself and not get angry to your patient, you must still try to manage her, you must think of her she is going through and not what you think she is suppose to do (Data unit: 168).

Midwives' motivation for their reactions (2.5.2)

- We do appreciate the fact that we do differ in response to pain, that's where I say our reaction differs and communications play an important role in management of reaction to pain by patients. The main purpose it to make this experience as bearable as possible (Data unit: 157).
-

Sellers (2004:430) states that if the aim of the midwife is to maintain the woman's attention and confidence and to help the woman towards a normal birth, then the way in which she carries out the physical care of the woman is important. Hattingh (cited in De Kock & Van der Walt 2004:15-1) adds that a woman's perception of the childbirth experience may have a long-term effect on her behaviour as a mother and on the relationship with her partner.

Studies on women’s experiences and perceptions of pregnancy, childbirth and labour pain consistently show that women see supportive maternity care as including good communication, as not only being given information but also being listened to and being able to discuss concerns and options with midwives, being treated as individuals, having a sense of choice and control over what is happening to them, as well as trust and confidence in the competence of professionals (Page & McCandlish 2006:59).

A person’s ability to handle a situation that he/she is confronted with depends on the knowledge, skills and experiences that he/she has acquired in life. In the case of midwifery, it is true that midwives use their professional knowledge, skills and experiences to manage all childbirth processes they come across. It has been stated in the previous discussion (category 5.1 on women’s acceptable behaviour) that labour pain is unique to each woman and that the reaction to it has multi-factorial influences. Sellers (2004:431) suggests that a midwife should be gentle but efficient, kind but firm, understand the woman’s needs but be sure of her own abilities, and always conscientious in her work.

Midwives perception of the uniqueness of individual women is supported by Hattingh’s (cited in De Kock & Van der Walt 2004:15-2) explication of woman’s own perception of “care” experiences during labour that might have a positive or a negative influence on their experience. These are tabulated in table 4.2.

TABLE 4.2: FACTORS INFLUENCEING WOMEN’S EXPERIENCE DURING LABOUR	
Factors that would have a positive influence	Factors that would have a negative influence
<ul style="list-style-type: none"> • Information and education • Self-help skill for coping, such as relaxation techniques, position changes, music and use of water • Informed decision-making • Privacy • Consideration and respect • Encouragement • Feeling of safe and secure • Emotional and physical support during labour (doula) • Timeously administer analgesia if it is a complicated labour • Active participation 	<ul style="list-style-type: none"> • Physical abuse like pinching and slapping • Uncomfortable conditions such as wet and dirty linen • Emotional abuse for example, ignoring her pleas for assistance, shouting at her or telling her that it is her own fault • A sense of helplessness and isolation • Feeling unsafe • Anger when her expectations about trust, power and control were not met; • Long labour and overwhelming pain • Being hungry and thirsty <p>(Hattingh in De Kock & Van der Walt 2004:15-2)</p>

In addition, the participating midwives were selected (as one of the criteria in chapter 3, Research methodology) for the study on the basis that they should be women who had already experienced childbirth and the pain associated with it. Lowdermilk and Perry (2007:467) mention that, although all women expect to experience at least some pain and discomfort during childbirth, it is their culture and religious belief system that determine how they perceive, interpret and respond to and manage pain.

4.2.2.6 Category 2.6: Pain control

Managing the labour process involves managing labour pain to a greater extent than merely managing the patient's reaction to pain and midwives' reactions to their actions, as was discussed in the previous sub-category. Data display 2.4 makes mention of sedation for pain control and consequently, on the control of unacceptable, irritating and even dangerous responses to pain made by patients.

4.2.2.6.1 Category 2.6.1.1: Formal pain control and sedation

Most literature on the practice of midwifery advocates a satisfying childbirth experience for every woman. This objective can be achieved through employing measures that will promote comfort to the labouring woman. The data displayed below indicates the evidence on formal pain control and sedation measures, and reasons or indications of such a need.

DATA DISPLAY. 14
THEME 2: COPING WITH LABOUR PAIN
CATEGORY 2.6: PAIN CONTROL
CATEGORY 2.6.1: FORMAL PAIN CONTROL AND SEDATION

- **General indicators (2.6.1.1)**
 - If her labour process is to be long, you need to sedate her ... (Data unit: 21).
 - you need to sedate her ... (Data unit: 23).
 - ... and I feel that we must do everything in our power to manager that pain effectively (Data unit: 204.1)
 - **Origin of decision on administering analgesics (2.6.1.2)**
 - So with my personal experience, my professional growth I really feel the patient should be sedated for pain (Data unit: 30.2).
 - Ja (yes), I can say, pain medication really needs to be given, because, after giving medication, at least the pain becomes much better, the pain subsides for a while and start again until you deliver a baby (Data unit: 60).
 - What I can emphasise is that the doctor, really should give some analgesia if we request because most of the time you are the one who is with the patient and you are the one who see the patient that is having the pains, if I request the doctor to see the patient, he must respond with immediate effect,
-

for that woman to be comfortable (Data unit: 62).

- **Reasons for administering analgesics (2.6.1.3)**

- We are not the same since I told you that our thresholds are not the same, others used to feel the pain even (when) cervix is 1 centimetre dilated, if you check that this one is going a long way until she is coming to 10 centimetres', they do get treatment at one centimetres (Data unit: 51).
- Any way I prefer it (giving pain medication) when I feel the cervical dilatation is not progressing well even if it is 8cm dilated and she is all the time crying and the pain threshold is so low, I do prefer a sedation for her (Data unit: 81.1).
- The other one who cannot tolerate it (pain) so much that may lead to problem with labour or with the baby I usually ask for sedation (Data unit: 73.1).
- As I indicated previously that I think labour pains really need attention in the sense that if you give sedation it might improve the outcome for the mother and the baby (Data unit: 104.5).
- like I said also, *thanks to the invent of the sedation*, it does play a big role, because at least if you have given some medication, it calms down the situation and you can somehow be sure or positive they will deliver a normal baby (Data unit: 110.1).
- She needs sedation, just to relieve the pain, just to calm her a little bit down (Data unit: 20).

Although the general medical approach to labour pain is that it is severe and that the pain must be alleviated, an alternative view is that labour pain is a natural process, and that women can experience comfort and transcend the discomfort and pain to reach the joyful outcomes of childbirth (Lowdermilk & Perry 2007:467). According to Green and Wilkinson (2004:36), *pain management* involves the alleviation of or a reduction in pain to a level of comfort that is acceptable to the patient. Leap (in Hunter 2001:441) indicates that the way midwives cope with the experience of caring for women having labour pain *vary according to their personal philosophies*. Since the childbirth environment is highly emotive, Smith (in Hunter 2001:441) indicates that some midwives *become task orientated and distance themselves from the women, but others can still be there for their clients*. Singh (Cronjé & Grobler 2003:84) adds that in modern-day medicine it is the responsibility of all concerned with labour that patients be made aware of and be given opportunity to choose from the various forms of labour analgesia available as methods of pain relief in labour.

The different ways of managing labour pain that the participating midwives indicated reflect the different ways or widespread approaches they have acquired during their midwifery practises that include both theoretical knowledge and also, to a greater extent, their individual personal and practical experiences. Midwives' personal experiences and professional growth as evidenced in the data display gives an indication of the empathy and sympathy in their approach to managing labour pain.

These ignite their advocacy role informing doctors about the need to prescribe pain medication in individual cases.

The evidence further reflects the following reasons for administering pain medication: non-progressing cervical dilatation, non-tolerance of pain, improving the outcome for the mother and baby, and calming down the situation. These are factors that influence the physical experiences of labour pain, which contribute to traumatic labour experiences. It can be concluded that the administration of pain medication by attending midwives, based on the reasons advanced in the data display supports the views that the labour/childbirth process should be a satisfying experience for every woman.

Participating midwives acknowledge the fact that the women in labour need sedation (pain medication) to reduce the intensity of labour pain, to improve the outcome for the mother and for them to be comfortable. The midwife's decision to administer pain medicine depends on (1) the labouring woman's request for pain medication, and (2) the attending midwife's assessment of the progress of labour, for example, when the labour process is prolonged, and lastly (3) from personal experiences with labour pain, as indicated in the data display 2.6.1. Most of the participants indicated that the pain medication should be given whenever the woman asks for it. In addition, the evidence in the data display supports the assumption that most authors on midwifery regard the midwife as a companion to women during the childbirth process. According to Page and McCandlish (2006:348), the midwife, as a companion to a woman in labour, should know that women in labour vary in their needs for pain relief, and their choice may change during the course of labour. Effective and satisfactory pain management needs to be individualised for each woman.

Medical staff commonly prefers the abovementioned method of pain management. The method has disadvantages for the unborn baby. Although, as indicated by authors such as Sellers (2004:428), it must be borne in mind that any substances administered to a pregnant woman, no matter what method of administration is used, constitutes an invasion of the woman's body, meaning that either directly or via the placenta these substances can also affect the foetus. The effects of most substances are not wholly known or understood.

There are other non-invasive pain relief methods within the professional midwifery practice that some participants reported they first apply to relief pain before they ask the doctor to prescribe pain medicines. These methods are discussed in the next category.

4.2.2.6.2 *Category 2.6.2: Alternative ways of managing pain*

In this category evidence of alternative ways of managing pain reflect the following interventions: the use of hot baths, food, rubbing the woman's back and encouraging the woman to walk around in the ward.

DATA DISPLAY 15
THEME 2: COPING WITH LABOUR PAIN
CATEGORY 2.6: PAIN CONTROL
CATEGORY 2.6.2: ALTERNATIVE WAYS OF MANAGING PAIN

- **General indicators (2.6.2.1)**

- ... and I feel that we must do **everything** in our power to manager that pain effectively (Data unit: 204.1).

- **Alternative ways of managing pain (2.6.2.2)**

- Expect individuality. In my practice I usually laugh and imitate them to make it (pain) better. The other one who get angry with me, and then I would tell her that I am just making it fun just to make it better (Data unit: 73).
- I normally ask them to take a hot bath, others tolerate it and other doesn't even want to see the bath (Data unit: 75.1).
- and maybe is OK using my experience and what if I have learned, you try and alleviate the pain and all sorts of discomfort, natural methods at first, luckily we have analgesia available, but that is sort of, we try to keep away from that although it got its specific place in labour pains (Data unit: 157.3).
- Ok, first of all especially in early stage of labour, it is better if the patient is ambulant, if she can walk around not lie in bed because walking around, I can't say it take pain away but it can make it tolerable (Data unit: 159).
- We have a practice where if the patient in bed and maybe you are monitoring her with a Cardio Tocogram Machine and she has a pain, you can rub her back, not actually rubbing but pressurised, localised pressure, pressing with your hands on her back, if she, how can I say when you do it, she can tell you that this is helping and you can continue with that (Data unit: 159.1).

Non-invasive relief measures consist of cognitive behavioural strategies and physical modalities that use cutaneous stimulations. These treatments can be used to supplement pharmacological therapy and other modalities to control pain (White & Duncan 2002:298). Hattingh (De Kock & Van der Walt 2004:15-3) states that a number of women express a need to participate fully in a birth experience and they are concerned about the negative effects of medication on them as well as their babies.

This author further states that for these women, as well as those who have little or no access to pharmacological methods of analgesia in childbirth, non-pharmacological pain relief methods seem to be helpful.

Women who choose 'natural childbirth' use a combination of relaxation and breathing techniques along with the support of their family and their coach (http://www.herhealthcare.com/newsletter/hhc_ob_27_28/educ10.htm – accessed 16 September 2002). The evidence in data display 15 supports these techniques.

During the active stage of labour the psychological support used to deal with fear and anxiety is also applicable, with the addition of other intervention methods, as is evidenced in data display 15, namely hot baths, food, rubbing the woman's back and encouraging the woman to walk around in the ward. The application of these methods also depends on the different midwives' preferences; some midwives prefer pharmacological pain relief methods, others non-pharmacological pain relief methods and others a combination of the two.

Sellers (2004:428) states that there is no doubt that the successful relief of pain, by whatever method, appears to shorten the duration of labour, probably by bringing about relaxation of the uterine muscles, and in particular the muscles of the lower segment and the cervix. In this regard, the above website indicates that non-drug pain relief methods may be useful for most women. Such methods include hypnosis (prior to labour), psycho-prophylaxis or Lamaze, a conscious focus of cortical brain activity (e.g. paced breathing), biofeedback, acupuncture, transcutaneous nerve stimulation, hydrotherapy (bath, shower, jacuzzi), music and audio analgesia, aromatherapy, or an injection of sterile water just under the skin of the lower back, which may be effective for lower backache. Of these methods, the ones that are most effective are immersion in water, and position changes and movement (<http://www.midwifeinfo.com/topic-painrelief.php> – accessed 16 September 2002). Other non-pharmacological methods according to Hattingh (De Kock & Van der Walt 2004:15-3 to 15-6) comprise of maternal movement and position changes; counter-pressure; superficial heat and cold; using water during labour for pain relief; touch and massage; intra-cutaneous injection with sterile water; and support for women during childbirth.

4.2.3 Theme 3: Traditional and herbal medicine and the midwife

Since time immemorial, different societies have approached childbearing differently. The preparation of the pregnant woman before giving birth is still approached differently, despite the advanced development in professional midwifery practise. In a further attempt to cope with labour pain, in addition to natural coping mechanisms, women also take traditional and herbal medicines, as was reported by the participating midwives at the hospitals where the study was undertaken. In South Africa, where this study was conducted, the participating midwives gave evidence of a number of traditional and herbal medicines that they came across in their encounter with women in labour. In addition to the evidence, there is an indication that participating midwives held different perceptions of traditional and herbal medicines and also of women who relied on these medicines.

In order to see tradition and herbal medicines in perspective, it must be remembered that the relationship between humans and plants goes back as far as human history itself. Humans have always relied on the plant-world as a source of food and medicine, sustenance and well-being. This reliance and reverence has grown over millennia into the world's well defined systems of traditional and herbal medicines (<http://www.traditionalmedicinals.com/?tittle=traditional+herbal+medicineandprint> – accessed 2 April 2008). It has also paved the way for modern synthetic preparations.

4.2.3.1 Category 3.1: The effects of traditional and herbal medicines on patients

Data display 3.1 contains evidence of participants' experiences of women who took traditional or herbal medicines during pregnancy and/or at the time that contractions started.

DATA DISPLAY 16

THEME 3: TRADITIONAL AND HERBAL MEDICINES AND THE MIDWIFE CATEGORY 3.1: THE EFFECTS OF TRADITIONAL AND HERBAL MEDICINES ON PATIENTS

General indicators (3.1.1)

- Because now we do get patients that are culturally orientated that you would not do anything with her. So this patient comes in having drunk their cultural medication/ herbs (Data unit: 32.1).

Effect of traditional and herbal medicine (3.1.2)

- So the pain becomes severe. They (traditional and herbal healers) will keep on fiddling with the patient until she end in theatre sometimes (Data unit: 86.1).
-

-
- Like those who come in with shlambezo, and only to find out that it is false labour, so after the shlambezo has gone out and maybe she needs sedation and the pain goes off, and the cervix remain closed and then she goes home (Data unit: 88.5).
 - They do respond differently, because you will find the one who has had these traditional and herbal medicines she will be screaming terribly and you find the one who has not had them not showing any sign (Data unit: 134).
 - and others, those that have taken divine water, if you can take the history she tell you that she is having strong contractions, that can even be shown by the Cardiotogogram machine, and when you check pv (per vaginal examination) you find that her os is still closed, so which I think it's a danger for them, but we still accept that it is their culture, there is nothing that we can do (Data unit: 135).
 - They differ with their responses, I think that the others, pertaining to a certain type of herbal treatments, really no one has ever told about that one, *lehe la mpjhe* (ostrich egg) but Elizabeth Ross has taught me that most of them who used *lehe la mpjhe*, I never had a problem at all and those that used St. John divine water. But the other ones that have used another herbal treatment like "letsoku" had problems. There are those who used to drink it, it was even fowl smelling and they end up having complications most of them. Many of them I saw complicated (Data unit: 136).
 - other use to deliver before the right time, and when you ask them they will tell you that I started to take this medication (traditional) at three months of the pregnancy, and some since then I been having some pains (Data unit: 137).
 - I have come to identify the smelling of the liquor, and sometime the shape of the abdomen; I just say; no, even if you say you haven't taken anything (traditional) the shape of your abdomen tells me you had, I know the shape of the abdomen, then they will say yes, (Data unit: 138).
 - Yes, I have seen someone who has just taken "Pitsa", she was having precipitated labour, strong contractions, quick dilatation of the cervix, and everything was just quick (Data unit: 227).
 - Yes, I had one patient who has taken what they call "Kgala", its a traditional and herbal medication and the pain was so severe, severe that she felt like dying, in fact the cervix was not dilating and the pain was severe and we had to call a doctor to suggest a caesarean section because the cervix was not dilating and the patient was complaining of severe pain (Data unit: 255).
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An abstract of the traditional and herbal medication that women take, as experienced by the participating midwives, in both hospitals of the Thabo Mofutsanyana District (North-Eastern region) of the Free State province are summarised in table 4.2, accompanied by their negative effects as perceived by the participants.

TABLE 4.2 TRADITIONAL AND HERBAL AND HERBAL MEDICATION		
Traditional and herbal medication	Therapeutic effects	Possible harmful effects
Isihlambezo	<ul style="list-style-type: none"> • A holistic approach to labour; • Spiritual cleansing • Used for several minor ailments in pregnancy (Gronje & Grobler 2003:674) 	<ul style="list-style-type: none"> • False labour • Foetal meconium passage more frequently in users, but no increase in meconium aspiration has been shown. Preliminary evidence suggests a relationship with low birth weight babies (Gronje & Grobler 2003:674)
Lehe la mptjhe (ostrich egg shell)	Unknown	<ul style="list-style-type: none"> • Intense contractions without cervical dilatation
Devine water	<ul style="list-style-type: none"> • Accelerates cervical dilatation 	<ul style="list-style-type: none"> • Unknown
Letsoku	<ul style="list-style-type: none"> • Unknown 	<ul style="list-style-type: none"> • Foul smelling • Vomiting of a thick yellow liquid
Pitsa (Sesotho) Imbiza (IsiZulu)	<ul style="list-style-type: none"> • Thought to cleanse and prepare the uterus to accept the foetus (Gronje and Grobler 2003:674) 	<ul style="list-style-type: none"> • Precipitated labour • Strong contractions • Quick dilatation of the cervix •
Kgala	<ul style="list-style-type: none"> • Unknown 	<ul style="list-style-type: none"> • Intense contractions without cervical dilatation

The literature, including an Internet search provided the following information on the traditional and herbal medicines mentioned by the participants. According to the evidence contained in data display 3.1, traditional and herbal specific issues of *shlambezo*, *lehe la mptjhe*, *devine water*; *pitsa*, *kgala* and *letsoku* emerged. The following is a list of the traditional and herbal medicines and their English translation or definition:

- *Isihlambezo (Zulu) Sehlapetso (Sesotho)*: A liquid made up of several herbal ingredients, used in pregnancy and labour. May be taken orally or as a vaginal douche(Gronje & Grobler 2003:674); A mixture of different herbs, prepared for a pregnant woman (regime 1, to prepare the pregnancy to term) and for a woman at the 9th month (regime 2, to assist with expulsion of the baby)(explanation by word of mouth).
- *Lehe la Mptjhe*: translated to ostrich eggshell (medication made from eggshell) (explanation by word of mouth).
- Devine water: it is ordinary tap or fountain water prayed for at Saint John Apostolic Church (explanation by word of mouth).

- *Letsoku*: a century old traditional and herbal powder famed as facial makeup for women. They grind these special stones and sieve them into a fine Letsoku powder (<http://www.mmegi.bw/2005/June/Thursday9/4684903619.html> – accessed 5 February 2008).
- *Pitsa? Imbiza*: I want medicine. Blood cleanser (another name for Shlambezo or Sehlapetso, because everything is prepared and kept in clay pots is Pitsa or Imbiza) (explanation by word of mouth).
- *Kgala*: With regard to this medication, the researcher could not obtain specific 'valid' information. A linguistic interpretation of 'kgala' equates to the English word 'bile'.

As indicated in table 4.2 and data display 3.1, participants stated that traditional and herbal medicines influence the labour process. The evidence on participating midwives' perceptions of these traditional and herbal medicines was that they have both negative and positive effects on the labour process. Evidence further suggests that even though participating midwives described what their personal experiences with the women who took traditional and herbal medicines were, such medicines need to be studied scientifically so that every midwife may know their exact effect on the labour process. This knowledge will help midwives to develop future interventions in midwifery practise in such a way that it will accommodate those women who took traditional and herbal medicines.

4.2.3.2 Category 3.2: Midwives' perceptions of traditional and herbal medicines

Traditional and herbal medicines refer to health practices, approaches, knowledge and beliefs incorporating plant, animal and mineral-based medicines, spiritual therapies, manual techniques and exercises, applied alone or in combination to treat, diagnose and prevent illnesses or to maintain wellbeing. (<http://www.who.int/mediacentre/factsheets/fs134/en/print.html> – accessed 4 March 2008).

Data display 17 provides evidence of midwives' perceptions of such practices.

DATA DISPLAY 17
THEME 3: TRADITIONAL AND HERBAL MEDICINES AND THE MIDWIFE
CATEGORY 3.2: MIDWIVES' PERCEPTIONS OF TRADITIONAL AND HERBAL MEDICINES

Acceptance of traditional and herbal interventions (3.2.1)

- So I have to make peace with it and I have to accept it, the people will come in with it, so mine is not to be judgemental (Data unit: 88.4).
- So I am not judgemental about that, because one of my colleagues became angry with me saying that I am encouraging them (Data unit: 88.6).
- Mostly I am not judgemental on herbal medication; I have learnt to accept herbal medication long time ago because I found that you talk to this person that you must not take herbal medication, only to find that she is the one who will be next, it will be another patient and the world is so varied, (Data unit: 152).
- when I studied that time, I was already having exposure at Elizabeth Ross, it gave me that outlook on acceptance, because we were so poor, so we accepted them, it was where I learned about *lehe la mptjhe*, so all of them were good, so they helped me, that's where I learned about St. John, when they came with the St. John one, they believed that the Minister has given them so it gave them strength (referring to Divine water), so I didn't "mind" because it helped my patients, I will just ask where we you in St. John (Data unit:92).

Non-acceptance of traditional and herbal interventions (3.2.2)

- The one that I did not like was the pink or yellow reddish one the *letsoku*. I do not know what they called it, because that one all the patients that come with it vomited it that thick yellow stuff, they ended up at Manapo Regional Hospital (Data unit: 92.1).
- Secretly we feel that this herbal medication has got adverse effects on the baby, on the labour process as well, because like I have mentioned that you find that there are strong contractions and the cervical os is closed, this is my contribution (Data unit: 142).

Origin of midwife's frustrations (3.2.3)

- So that patient will come screaming here, and the midwife who is from a certain ethnic group, who does not know this practice, she is gona mismanage this patient because she will not know why the patient is screaming so much, she might scream at the patient saying; "*you have this bloody muthi of yours*", and not responding to the patient's actual needs (Data unit: 32.3).
- Regarding labour pain I think we should get more information about what other people from other cultures are being told about being in labour, even in this age a lot of people are going back to what they have been told at home, although they are young and up coming people in that situation in labour it seems that you revert to what you have been told at home (she laughed). It is very frustrating, even the nurse they go. I think that should be one of the insert in our training somewhere (Data unit: 179.1).

The World Health Organization estimates that 80% of people worldwide rely on herbal medicines for some aspect of their primary healthcare. (<http://www.umm.edu/altmed/articles/herbal-medicine-000351.htm> – accessed 4 March 2008).

It is clear from the literature reviewed above that the use of traditional and herbal medicines is unavoidable. The support that midwives provide for women in labour

should take into consideration the influence that traditional and herbal medicines might have on the labour process. Part of the evidence in data display 17 reflects the participating midwives' views and reactions on traditional and herbal medicines, accepting the fact that women would come to give birth having taken some form of herbal or traditional medicine. However, concerns were raised about certain traditional medicines. This is based mostly on negative experiences of women who have taken certain of these medications. As one participant stated:

Labour pain becomes severe; creates false labour; causes women to vomit; liquor have a foul smell; women confirm having strong contractions; women deliver the baby before the right time (labour process becomes precipitated); the woman screams from the 1st stage of labour until end of the 3rd stage.

Experiences such as this one generate a negative perception of traditional and herbal medicines. Thus the attitude of midwives towards women who have taken herbal and traditional medicines before coming to the labour ward is often different than to those who have not taken anything.

Data display 3.2 also gives evidence of the positive influence of traditional and herbal medicines, as some seem to accelerate cervical dilatation.

The acceptance of these medicines by midwives during pregnancy and specifically with regard to labour pain indicates serious contradictions with pressing ethical implications. Since the physiological mechanisms of these medicines are not well understood except for the evidence of their reaction on the woman's body, they pose a threat to the outcome of the labour process, which is the safety of the mother and the unborn baby.

Intense contractions without cervical dilatation can lead to uterine rupture or intra-uterine death. This opinion is supported by Sellers (2004:1522) who states that the rupture of the uterus is an extremely serious condition, which may cause shock and collapse in the patients and which often results in the death of the foetus, and if not treated immediately can result in the death of the mother too. This author further confirms the cause of this medical emergency as resulting from strong uterine contractions. According to Green and Wilkinson (2004:410), the aetiology and risk factors to uterine rupture are over-distended and over-stimulation by oxytocin - this is relevant since some of the herbal medicines have an oxytocin-effect on the uterus.

Knowledge and understanding of different cultural practices carries an important element in midwifery practise. Some literature states that traditional herbal medicines encompass extremely diverse preparations that originate from many cultures (<http://www.who.int/bookorders/anglais/detart1.jsp?sesslan=1.andcodlan=1andcodcol=72andc0> – accessed 4 March 2008).

Data display 17 also gives evidence of what creates a frustrating situation for the attending midwives, the reasons being the effect of traditional and herbal medicines on the attending midwife, the extreme reactions of women who have taken these medicines during the labour process. The feeling of frustration on the part of the attending midwives becomes a source and origin of midwives' attitudes towards labour pain.

4.2.3.3 Category 3.3: Midwives' suggestions regarding traditional and herbal medicines

It has been noted from literature that the relationship between humans and plants goes back as far as human history itself. The use of traditional and herbal medicines is gaining impact and is also promoted by different Health Systems throughout the world.

In recent years the preservation of indigenous knowledge systems, the promotion of indigenous health systems in Primary Health Care, and the conservation of biodiversity have become more of a concern to scientists working at the interface of social and natural sciences, especially to ethno-pharmacologists and ethno-botanists (http://www.elsevier.com/wps/find/journaldescription.cws_home/506035/description# – accessed 2 April 2008).

Data display 18 below gives evidence of suggestions from participating midwives regarding traditional and herbal medicines.

DATA DISPLAY 18

THEME 3: TRADITIONAL AND HERBAL MEDICINES AND THE MIDWIFE

CATEGORY 3.3: MIDWIVES' SUGGESTIONS REGARDING TRADITIONAL AND HERBAL MEDICINES

Research (3.3.1)

- Is it now the time that somebody researches it these herbal medicines, rituals, so that we can be informed, accommodate the patient around that what she has drunk (Data unit: 141).
- I 'm venting that because I don't know what does it do, but if we have that information that this eggshell has got oxytocin – *o ya bona* (you see), *e tla mo sututsa* (it will push her), we could accommodate the patient, we can even know that she deliver faster than what we were expecting, so that will safeguard us from having delivery that are unguarded (Data unit: 141.2).
- So they need to do something, just brief information, so that at least we should know what the ostrich eggshell is doing, the squirrel peewee is doing, and even the mercury and battery acid, old record (broken and boiled and the water was drunk. Yes, I think we need that (Data unit: 141.4).
- Although it causes conflict in the sense that we do say that this is what it (herbal medication) has on the pain but we don't have prove that its herbal medication causing that (she laughs). Though (because) it causes that conflict we feel that something must be done about it as well (Data unit: 150.1).
- I think we must really start, or maybe we must have more information to know especially me who is from another culture or background, about what your patient wants in her specific culture, the other day I had a patient who had a big baby and she said she knows if she blows air into a bottle maybe it will help delivering, I was surprised and I say maybe the logic of that is that when you blow air through the bottle you are also pushing the baby" (Data Unit: 179).
- Yes for sure because for me it was a new experience, I did not know of that there is medicines like that, I didn't know that people do take them, you know I am scared what I see the medicine is doing. Really I feel we must get more information about that (Data unit: 183).

Tolerance towards women (3.3.2)

- Not shouting at the patient; "o nwele lehe la mpjhe" (you have drunk ostrich eggshell (Data unit: 141.1).

Knowledge of traditional and herbal medicines is imperative to the field of midwifery because through this knowledge midwives will come to understand their effect on women during labour, as these medicines' effects do not follow known physiological patterns. The scope of the current midwifery body of knowledge does not contain enough information on the effects of traditional and herbal medicines in pregnancy and labour. Many Black South African women use traditional herbal remedies as antenatal medications or to induce or augment labour. Very little is known about the pharmacology and the potential toxicity of the plants used in these herbal remedies (<http://www.ncbi.nih.gov/pubmed/1434676> – accessed 2 April 2008).

The evidence put forward by participants in the current study; indicate a serious need for knowledge on indigenous medicine. Lack of knowledge about these medicines and lack of understanding of its effect may result in the mishandling of women. In the data it

was indicated that in some instances the midwife became intolerant and shouted at a patient who behaved out of bounds because of the traditional and herbal medicine she had taken.

4.2.4 Theme 4: Situational factors that impinge negatively on the perception of labour pain

4.2.4.1 Category 4.1: Factors that impinge negatively on the perception of labour pain

The fourth theme that emerged from the data focuses on 'other' factors that impinge negatively on the midwives' perception of, or reaction to labour pain experienced by women in labour. The data units in data display 19 gives evidence in this regard, namely the shortage of time and staff workload. These factors are interdependent and cannot be discussed in isolation.

DATA DISPLAY 19
THEME 4: QUALITY OF CARE
CATEGORY 4.1: FACTORS THAT IMPINGE NEGATIVELY ON THE QUALITY OF CARE

Time (4.1.1)

- ... and the other issue that I have seen in this life, why there is negative responses and negative management is because at the present juncture there are definite situations that you find that myself as a midwife I cannot respond to the patient who is in labour, complaining of pains is actually now been neglected whilst I'm busy with the next patient labouring with myself being the sole person who must care of these deliveries (Data unit: 104.2).

Workload/Shortage of staff (4.1.2)

- Since we are having shortage, they stress us but, *hee* (even though it happens), and there is nothing that we can do just tell her that please try to behave like this (Data unit: 48.1)
 - so we are in the situation that most of the time the health worker cannot cope with the load of work at hand with the result that there will be the negative response to the patient, that is why you see that you cannot deal with the patient properly (Data unit: 104.3)
 - Like I said you find that most of the time you are alone, when do you deal with her problem, 'cause the next one is labouring (Data unit: 120.2).
 - I think the problem is the shortage the same as us, I think those people are overloaded (Data unit: 131)
 - At times its like people are just lazy, most of the time you will find that we also give drugs, when person is in labour coupled with other analgesics, most of the time people have got burnout syndrome, they are negligent, they are ignorant, is not that she cannot see that a person is having pain, but she just doesn't have time or she not going give it because other manage to do without anything for pain (Data unit: 186.9).
-

Support during delivery, provided by midwives and others, has been shown to create a more positive childbirth experience with a shorter duration of delivery time and lesser pain experienced by the mother (Tarkka, Paunonen & Laippala 2000:184). The presence of professional support in labour has also been shown to be of significant help to labouring women and in managing their pain (<http://www.midwifeinfo.com/topic-painrelief.php> – accessed 16 September 2002). Support is, however, time-consuming and the shortage of midwives is a serious problem. In cases where there is a shortage of staff (midwives) there will be limited time spent by the midwife with the woman in labour, resulting in the woman feeling neglected, raising their anxiety levels and intensifying their experience of labour pain. The attending midwife's role to provide emotional support and pay attention to the mother is eroded (Tarkka et al 2000:184). Due to intense labour pain the women's responses may further be seen as extreme and unacceptable to the midwife, creating a negative self-sustaining spiral.

4.5 CONCLUSION

In this chapter the analysed data units were presented in themes, categories and sub-categories. Data units were presented in the exact words of the participants. These have not been edited. The themes and categories that emerged from the data were all substantiated by relevant literature and were explicated in four major themes, namely labour pain, coping with labour pain, traditional and herbal medicines and the midwife, and factors that impinge negatively on the perception of labour pain.

In the next chapter the conclusions drawn from the data will be presented, as well as recommendations be given.

CHAPTER 5

Summary of findings, conclusions and recommendations

5.1 INTRODUCTION

In this chapter the discussion focuses on the findings, conclusions (implications) and recommendations of the research.

The aim of the study was to explore the perception of midwives of women experiencing labour pain and labour pain as such, as portrayed by midwives' perception of acceptable and unacceptable behaviours of women during childbirth and labour.

Within a generic qualitative research design, an unstructured interview, using an interview schedule indicating the main themes relating to the research topic, was developed and used for both *individual* and *focus-group interviews*. The aim was to elucidate the informants' perception of the research topic in their lived worlds without imposing the researcher's views on it (Polit & Hungler 1997:264).

During the analysis and synthesis of the data, four (4) themes and sixteen (16) categories emerged. These are the following:

Theme 1: Labour pain

Theme 2: Coping with labour pain

Theme 3: Traditional and herbal medicines and the midwife

Theme 4: Situational factors that impinge negatively on the perception of labour pain

The reader is referred to table 4.1 for a summary of the structure of the data (themes, categories and sub-categories).

5.2 FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

The findings and the conclusions, based on the findings, and recommendations are provided according to the main themes and categories that emerged from the data. In some instances findings, conclusions and recommendations are combined and presented as one because of their interdependency as well as the interdependency of some categories.

5.2.1 Theme 1: Labour pain

5.2.1.1 *Category 1.1: Naturalness of labour pain*

- **Finding**

Participants (midwives) viewed labour pain as natural, bearable and manageable; however, it can become unbearable.

- **Conclusion (implication)**

If the natural view does not provide for a view on individual patients, midwives may generalise patients' pain experience.

- **Recommendation**

Special effort needs to be made not to generalise patients' pain experience. This could be done through continued in-service education and routine and formalised discussions among labour ward staff members on individual patients' reaction and behaviour during labour and their own and observed reaction to these behaviours.

- **Guidelines**

- Use general knowledge on labour pain as background to the treatment of labour pain.
- Maintain perspective of the individual client's experience.

- **Finding**

Participants (midwives) viewed the age, parity, and psychological state of the labouring women as factors that impinge negatively on the naturalness, bearableness and manageability of labour pain. Hunger was found to be a unique factor impinging negatively on the experience of labour pain.

- **Conclusion (implication)**

There appears to be naturalness about certain factors impinging on the experience of labour pain. Although primiparity is unavoidable, early teen pregnancy, the psychological state of the patient and hunger can be attended to. The treatment of the latter should be done keeping in mind the possible negative effect of active bowl movements.

- **Recommendation**

Support to a labouring woman should include attention to these factors. Special efforts need to be undertaken to develop a comprehensive midwifery action plan. This could be done through planning for each factor, also considering that patients are unique individuals who will not necessarily fit into planned intervention by the midwife. The influence of hunger as a factor needs to be explored since there is not enough literature to support the findings. The current literature contradicts evidence 4 in the study.

- **Guidelines**

- Maintain a Comprehensive Midwifery Action Plan.
- Conduct research into the alleviation of hunger immediately before and during labour and labour pain (contractions).

5.2.2 Theme 2: Coping with labour pain

5.2.2.1 Category 2.1: Women's natural reactions to labour pain

- **Finding**

Participants (midwives) viewed the reaction of patients (women) to labour pain as natural. Responses to labour pain were considered dependent upon the individual woman's pain threshold and pain tolerance. These two variables appear to be the determining factors for the individual woman to seek pain medication or medical attention. Some of the natural actions taken to counteract labour pain are potentially dangerous to the foetus and may obstruct midwifery interventions, such as closing of the thighs, jumping up and down, not reporting abnormal situations, not cooperating, and the like.

- **Conclusion (implication)**

Some of the natural behaviours women resort to during labour pain are potentially detrimental to the foetus and may obstruct the intervention of the midwife. This may influence the midwife's attitude negatively.

- **Recommendation**

Midwives are to respond to women experiencing labour pain individually. Clear communication needs to be established and maintained between the midwife and the patient. Patients need to be educated during antenatal classes about the implications of certain bodily positions taken during labour in an attempt to relief pain.

- **Guidelines**

- Maintain an individualised pain management intervention though in accordance with pain management protocols.
- Educate the expectant mother on the natural position individuals tend to take to counteract labour pain and the acceptability or non-acceptability of these postures.

- Implement evidence-based practice.

5.2.2.2 Category 2.2: Midwives' perception of acceptable behaviour of women in relation to labour

- **Finding**

Participants (midwives) viewed the reaction to labour pain by labouring women as being natural. These responses or reactions were viewed as acceptable if they were accompanied by 'listening to instruction' from the midwife by the woman in labour, and if they did not endanger the foetus or obstruct the intervention by the midwife in any way.

- **Conclusion (implication)**

The natural responses to labour pain should not endanger the lives of the mother or the unborn baby. The condition put forth to qualifying the woman's behavioural responses as acceptable should not be confused with impatience on the part of the midwife.

- **Recommendation**

The woman's behavioural responses to labour pain should be tolerated. Both the mother and the unborn baby's lives should be taken into consideration when accommodating or tolerating such behaviour. Pain relief methods, like panting during contractions should be stressed during antenatal classes.

- **Guidelines**

- Communicate acceptable behaviours towards pain during antenatal classes and on admission of the patient.
- Gain the cooperation and trust of the patient and establish rapport with patients.
- Where possible a professional relationship should be established between midwives and patients over a period of time prior to the time of delivery.

- Attendance of antenatal classes should be promoted.
- Implement cultural assessment and congruent practice.

5.2.2.3 Category 2.3: Midwives' perception of non-acceptable behaviour of women in relation to labour

- **Finding**

As indicated previously, some reactions to labour pain by labouring women are potentially detrimental and are unacceptable to midwives because they pose a threat to the safe delivery of the baby. The behaviours are: jumping out of bed and rolling on the floor, and tightening the thighs, etc.

- **Conclusion (implication)**

Although these behaviours can be viewed as natural responses to labour pain, they could put the lives of both the mother and the unborn baby in danger. The women can place both their lives in danger by jumping out of bed or rolling on the floor. These behaviours could also interfere with the midwife's execution of her function, and lead to frustration.

- **Recommendation**

- Women should be encouraged to attend antenatal classes.
- Pertinently discourage possible detrimental and dangerous behaviours.
- Pain relief methods like panting during contractions should be stressed in antenatal classes.
- Compulsory attendances of antenatal classes are to be stressed in the media and during community meetings.
- The midwife should administer pain medication when necessary to prevent pain becoming a threat to the mother, the unborn baby and midwifery interventions.

- **Guidelines**

- Develop clear guidelines for expectant mothers on natural pain control.
- Establish clear clinical guidelines for the administration of pain relief medication.

5.2.2.4 Category 2.4: Individual pain threshold and tolerance

- **Finding**

Participants affirmed that pain threshold and pain tolerance influence women's behaviour during labour.

- **Conclusion (implication)**

The woman with a low pain threshold and tolerance does not always cooperate by following instructions, because she will be concentrating on the experience of labour pain; hence she may be seen as not cooperating.

- **Recommendation**

Since the pain threshold and pain tolerance of individual women differ, both the woman and the midwife should determine the timing for the administration of pain relief medication. This approach will guard against neglecting those women who have both high pain thresholds and pain tolerance and will take into account the effect pain relief medication might have on the unborn child.

- **Guidelines**

- Pain management has to be based on both the patient's request and the midwife's assessment.
- Establish clear clinical guidelines for the administration of pain relief medication.

5.2.2.5 Category 2.5: Midwives' reaction on their perception of the uniqueness of individual patients

- **Finding**

Culture, religious belief systems and previous experiences with pain determine how both women and midwives perceive, interpret, respond to and manage labour pain.

- **Conclusion (implication)**

Midwives must guard against relying on a single or even a 'traditional' set of variables when providing support to women experiencing labour pain.

- **Recommendation**

When developing pain management intervention these variables should be taken into consideration. This can be achieved through the inclusion of cultural diversity topics in midwifery curricula, as well as by conducting periodic in-service training programmes for the already practicing midwives on cultural assessment and congruent midwifery care.

- **Guidelines**

- Include transcultural topics in midwifery curricula.
- Provide for in-service training courses on cultural practices relating to pregnancy, labour and labour pain.
- Allow midwives' guided imagery of labour pain during in-service training and education
- Teach cultural assessment frame works.

5.2.2.6 Category 2.6: Pain control

- **Finding**

Participants state that pain relief measures play an important role during labour. The implementations of formal pain control and sedation and/or alternative measures are to be promoted, as well as ensuring a satisfying childbirth experience to every woman.

- **Conclusion (implication)**

It should be borne in mind that every woman has the right to accept or refuse whatever pain relief measures are proposed to her. Pain relief medication should be negotiated even where clear clinical protocols for the administration of such medication exists.

- **Recommendation**

A choice of pain relief methods, including pain relief medication should be discussed and confirmed with the woman concerned.

- **Guidelines**

- Maintain a protocol of pain relief methods at the clinic and in the labour ward.
- Consider the individual woman's cultural perception on the meaning of pain.

5.2.3 Theme 3: Traditional and herbal medicines and the midwife

5.2.3.1 Category 3.1: The effect of traditional and herbal medicines on patients

- **Finding**

Participants indicated that some pregnant women use traditional and herbal medicines to prepare for pregnancy and labour. These medicines induce vomiting, cause extreme

responses, alter normal contraction patterns, and hasten labour. Participants had insufficient knowledge of the pharmacological effect of these medicines.

- **Conclusion (implication)**

Cultural issues relating to pregnancy, labour and labour pain is evidently important. The type of medication and the pharmacological effects of traditional and herbal medicines are not always known.

- **Recommendation**

The effect of these medicines on the mother and the unborn baby need to be known. The physiological outcomes of these medicines should be determined by means of scientific studies.

If the contents of the traditional medication cannot be ascertained, the common linguistic naming of these medications should be promoted so that midwives, through their experience with patients, can learn what outcomes to anticipate when a certain medicine is being used.

Midwives should be updated on the types of traditional medicine administered in the area they are working to the extent that this is feasible taking into consideration the covert nature of such medicines and practices.

- **Guidelines**

- Maintain a register of traditional and herbal medicines used during pregnancy and labour at both the antenatal clinics and labour wards.
- List the effects these medications seem to have on patients who have taken them.
- Involve traditional birth attendants and traditional healers in an effort to establish the effect of traditional medicines.

5.2.3.2 Category 3.2: Midwives' perceptions of traditional and herbal medicines

- **Finding**

Participants had ambiguous views on traditional medicines in midwifery. Some traditional and herbal medicines should be accepted because pregnant women will always use them. They believe in these medicines. Their psycho-cultural effect may have positive effects on women during labour pain. However, these medicines cause some women to respond to labour pain in an extreme manner, resulting in them becoming a source of frustration to the midwives.

- **Conclusion (implication)**

The acceptance of traditional and herbal medicines by midwives during pregnancy and specifically with regard to labour pain indicates a serious contradiction with pressing ethical implications. Since the physiological mechanisms of these medicines are not well understood except the evidence of their reaction on the woman's body, they pose a threat to the outcome of the labour process, which is the safety of the mother and the unborn baby.

- **Recommendation**

Midwives need to accept the fact that pregnant women will continue using these medicines and need to prepare themselves to deal with this issue. Midwives need to acquaint themselves with proper ways in which to treat women who use traditional and herbal medicines.

- **Guidelines**

- Maintain a register of traditional and herbal medicines used in pregnancy and labour at both the antenatal clinics and labour wards.
- Research the ways in which women react to these medications and the treatment alleviating the side effects of these medicines.

5.2.3.3 Category 3.3: Midwives' suggestions regarding traditional and herbal medicines

- **Finding**

Midwives lack knowledge regarding the physiological mechanisms of traditional and herbal medicines except their reactions on the woman's body. These medicines also pose a threat to the outcome of the labour process, which is the safety of the mother and the unborn baby.

- **Conclusion (implication)**

Even though pregnant women inevitably use these medicines, they pose threats to the outcome of the labour processes, which is the safety of the mother and the unborn baby. With insufficient knowledge, their acceptance indicates a serious contradiction with pressing ethical implications in midwifery professional practice.

- **Recommendation**

The traditional and herbal medicines need to be identified and be exposed to scientific investigation.

- **Guideline**

- Maintain a register of traditional and herbal medicines used during pregnancy and labour at both the antenatal clinics and the labour wards.

5.2.4 Theme 4: Situational factors that impinge negatively on the perception of labour pain

- **Finding**

Participants viewed time, staff shortages and workload as situational factors that impinge negatively on how midwives perceived the women's responses to labour pain. These were given as the reasons for delay in responding to the women's needs.

- **Conclusion (implication)**

Poor staffing of the labour wards lead to limited time spent between the midwife and her patient. A big workload negatively affects the midwife's turn-around time.

- **Recommendation**

Labour wards should be sufficiently staffed to prevent midwives spending limited time with labouring women, and midwives being overworked resulted in a delay to respond to women's needs.

- **Guideline**

- Maintain proper staffing of the maternity wards in accordance to internationally accepted ratios.

5.3 ADDITIONAL RECOMMENDATIONS

5.3.1 Recommendations for education, management and research

The findings of this research study generated the following proposals for education and for research within the field of the Health Sciences. Doing work in the labour ward has positive benefits for both the women and the attending midwives; for the midwives it contributes to life-long learning and discovery. The midwives and other roll-players in the midwife professional practice need to take heed of the following considerations:

- Practicing the profession of midwife involves the integration of both theory and practice and goes beyond documented principles of practice, that is, there will always be new discoveries, which will necessitate verification to establish the usefulness of these discoveries. Therefore, midwifery practice should be evidence-based.
- Midwives need opportunities to air their views about their practice environment and to document them. These need to be taken into consideration during the development of midwifery care intervention.

- Include trans-cultural issues within the midwifery curriculum for new midwives and on-the-job training programmes for practicing midwives, to augment the identified gap on trans-cultural issues.
- The maternity environment should be planned in such a way that it prevents situations that could promote frustration for the midwives, which could have a negative effect on the childbirth experience of the mother.

The above recommendations could be achieved by means of increasing the participation role of midwives in the professional practice.

5.3.2 Recommendations for further research

A need was identified for further research studies on

- the relationship of hunger to pain experience in order to understand the practices of some midwives
- the different herbal and traditional medicines used during pregnancy and childbirth and their effects on both the mother and the unborn child
- the views of midwives on their practice, in order to get continuous feedback so as to contribute to the body of midwifery practice

5.4 EVALUATION OF THE STUDY

5.4.1 Research outcomes

The study on registered midwives' responses to women in labour/childbirth in selected Government hospitals highlighted the perception of the midwives on what is viewed as acceptable and non-acceptable behaviour by women during labour/childbirth, and new pain control measures that require being further explored.

The specific objectives of the study were to

- identify the personal perspectives and views (perceptions) of midwives on labour pain

- explore possible reasons for midwives' responses to the behaviour of women experiencing labour pain
- understand what midwives regard as acceptable and as non-acceptable behaviour of women during labour
- determine if midwives acknowledge the uniqueness of individual woman in labour
- recommend interventions with regard to the perceptions of midwives on women in labour pain

As evidenced by the data displays, themes and categories, as well as by the discussion of the findings, implications, recommendations and the guidelines given earlier in this chapter, these objectives were all attained.

Consequently, the research question

- *What are midwives' perceptions on the pain experience of women in labour?*

Alternatively interpreted as

- *What do midwives regard as acceptable and non-acceptable reactions to labour pains?*

has been answered satisfactorily.

The major variables that influence midwives' perceptions of women's experience of labour pain according to the evidence are:

- the midwives' personal experiences of labour/childbirth
- the midwives' formal education in midwifery
- the description of labour pain by the midwife
- the effect that herbal and traditional medicines have on women during labour
- the shortage of staff, workload and time spent with each woman in labour

5.4.2 The researcher's experience of the research

As a novice researcher, this researcher realised that what in everyday practice appears to be 'everyday' and 'easy to understand' within qualitative research quickly evolves into an intricate mesh of subtle nuances in sub-phenomena, as well as in the relationships among them. This realisation paved the way for the researcher to become specifically involved in the perceptions of the midwives.

Thus,

- the research study provided the researcher with an alternative view on the practice of midwifery and how practise shapes the midwife's professional practice and perceptions
- the researcher reconfirmed the necessity for life-long professional learning
- the researcher realised the importance of studies that focus on the health practitioner, studies that allow Health practitioners to express their views on their field of practice

5.4.3 Limitations of the study

Despite some interesting and significant findings and reconfirmations, the study also poses certain limitations. They include:

- The study was conducted in the maternity wards of only two Governmental hospitals. The results of the study can thus not be generalized to the broader population of midwives.
- The administrative and hierarchical position of the researcher (being from the National Department of Health) could have influenced the results. Therefore the researcher had to go to greater lengths to ensure the trustworthiness of the study (see section 3.4.5).
- The fact that the researcher is of male gender, a degree of gender power differential could have been present which might have affected what midwives were prepared to divulge to him.

5.5 CLOSING COMMENTS

This chapter concludes the report on the perception of midwives on women's experience of labour pain. The objectives of the study were attained. The perceptions of the midwives of the women giving birth and their responses to labour pain were explored in two selected Government hospital maternity wards. The researcher realises the uniqueness of the individual midwife in integrating theory with practice. Not every learned theoretical principle appears to fit well into the clinical situation. Midwives seem to have developed their own views about their practice settings, which may be specific to a hospital, creating a unique "labour ward culture." It is exactly this uniqueness that necessitates continuing in-service education and training programmes.

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APPENDIX A

Consent form

APPENDIX B

Interview guide

APPENDIX C

**Letter to request permission from the Head
of the Free State Provincial Department of
Health to collect data**

APPENDIX D

**Letter of permission from the Head of the
Free State Provincial Department of Health**

TABLES

FIGURES