AN INTERPRETIVE PHENOMENOLOGICAL STUDY OF WOMEN'S CHILDBIRTH EXPERIENCES IN ZAMBIA

CONCEPTA NAMUKOLO KWALEYELA

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Abstract

Childbirth holds short and long-term physical and psychological effects for women. Yet, numerous investigations into childbirth have overlooked the delicate interrelated psychological and emotional interplay that women experience, in favour of the physical, such as the outcomes of birth, maternal mortality, and the physical skills of healthcare providers. Although quantitative measures derived from these are important to establish and evaluate maternal health, they are not adequate to explain the complexity of the human experience of childbirth. Without this understanding there is inadequate guidance about how to proceed to achieve the Sustainable Development Goals targeting maternal health.

The aim of this study was to explore childbirth experiences of women giving birth in Zambia, in order to better understand how they experience and give meaning to the phenomenon. The study was guided by an interpretive phenomenology approach. This type of phenomenology was found to be appropriate because the study sought to understand childbirth within the context of everyday lives of women birthing in Zambia. Purposive sampling was utilised to recruit 50 women aged between 16 and 38 years. The women had birthing experiences that occurred between 2005 and 2011. The birthing experiences were from all the ten provinces of Zambia. Data were collected through in-depth unstructured interviews, which were tape recorded. Data analysis was guided by van Manen's six steps of analysis. Seven themes namely: 1) Conforming to societal norms, 2) Clash between traditional and contemporary childbirth practices, 3) Being in a dilemma, 4) Loss of dignity, 5) Feeling insecure, 6) Inadequate service provision, and 7) Being there for the woman, emerged from the analysis. Each theme had several sub-themes that provided a clearer picture of how participants experienced the phenomenon.

The embodied experiences of participants illuminated the complex context of childbirth, whereby, the phenomenon was experienced in private, behind the closed door of secrecy that encompassed difficulties and issues such as, lack of choice, sub-standard care, discrimination, fear and conflicting information. The findings revealed that there was a need for an attitudinal change in maternity care professionals towards a more caring approach, as well as a parallel need to build agency and autonomy in women. For women, the change needs to be addressed at an individual and societal level, beginning with simple things, such as assertiveness training through to educational opportunities, so that they develop economic independence. Macro-reforms (top-down change) need to be combined with micro-reforms (bottom-up change) to challenge existing discriminatory, oppressive and patriarchal attitudes and practices that impact on women's birth experiences. Women's voices need to be heard. Understanding maternal outcomes at a micro level can help inform decisions and influence policy at the larger macro levels of institutions and government. Overlooking this intrinsic level represented an important barrier to utilisation of skilled birth care and constituted a common cause of suffering and human rights violations for birthing women.

The key implications for practice pointed to a need for all maternity care stakeholders in Zambia to have an understanding of how women birthing in Zambia experience and give meaning to the childbirth phenomenon. This could start by re-examining current approaches to improving reproductive health, and addressing the contextual factors and community based issues that have been brought to light in this study. In the absence of such an understanding it is difficult to map out interventions that do not infringe on women's beliefs and practices.

Published papers

Kwaleyela, C. N. & Greatrex-White, S. (2015). Being in a Dilemma: Experiencing Birth in Zambia. *Africa Journal of Nursing and Midwifery*, (Suppl 17), S43-S55.

Dedication

This study is dedicated to my late mother, Mrs Florence Mukela Sianga Kwaleyela

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CHAPTER 1: INTRODUCTION

1.1 Thesis Structure

This thesis is presented in a linear fashion. Chapter 1, which is an introduction to the thesis, provides background information of what the study is about. It highlights insights into what led to the study being conducted. The chapter gives an overview of the safe motherhood campaign, in the context of an international recognition of the importance of identifying women's needs and perceptions about childbirth. It stipulates the purpose of conducting the study.

Chapter 2 reviews existing literature on childbirth in Zambia, the sub-Saharan region as well as other low income countries in other regions. The literature was critiqued in order to highlight how women in Zambia and other low income countries experience and give meaning to the childbirth phenomenon. The review also reveals knowledge gaps in existing literature and portrays the taken-for-granted meanings that contribute towards existing knowledge in this area. The gap in the existing knowledge supported the purpose and objectives of this study.

Chapter 3 relates to the methodology and methods that were used, highlighting the process of how the study was conducted. The basics of phenomenology, the methodology underpinning the study are explored. The philosophical concerns and some of the history of the evolution of phenomenology are examined. In the same chapter, how information from study participants was accessed, the study setting, ethics issues, the decision trail and personal reflexivity while conducting the research are described and discussed. The method used for

data analysis is also described. The process of searching for meaning from the transcribed interviews, and making sense of the findings is presented in Appendices VI, VII and VIII. Care was taken to address the issue of rigour in the conduct and organisation of data.

In chapter 4, the findings of the study are presented through themes and sub-themes supported by key statements from participants' personal accounts of their childbirth experiences, as is methodologically consistent with interpretive phenomenology. The findings outline the experiences and circumstances of the phenomenon that led to participants' interpretations.

In chapter 5, the findings are discussed in relation to the wider literature. The discussion chapter situated the significance of this phenomenological study to existing literature on the phenomenon of childbirth. It highlights the uniqueness of the experience to each woman as well as exhibited the diversities in the way women interpret the phenomenon. The discussion signified that there is no linear interpretation of the phenomenon because in synergy with interpretive phenomenology, every individual is intertwined with his/her observations, thoughts, feelings and experiences.

In Chapter 6, concluding thoughts of this study are presented. Implications of the findings to practice are highlighted. The contributions that this thesis brings to the body of knowledge are illustrated and recommendations with the intention of informing maternity healthcare stakeholders are made. Limitations of the study and areas to assist in future research are also highlighted.

1.2 Motivation for doing the study

I qualified as a midwife in December 1990. During my initial midwifery training I was exposed to a few mortalities resulting from childbirth. At the time, I did not think that it was a problem, until I began attending maternal mortality meetings during my Bachelor's Degree training. However, as each maternal death was discussed, it was startling for me to learn that each one of the deaths could have been prevented. The two main reasons for the deaths were that birthing women had been brought to health facilities when their conditions had deteriorated, or healthcare professionals had failed to act appropriately. I later qualified and was posted to the Lusaka midwifery school. One of my responsibilities at the school was to supervise student midwives during their rural experience exposure. It was during these rural experiences with student midwives that I came face to face with an overwhelming problem of maternal mortality in the country. Being their supervisor, students would come to me with questions that I could not answer because at the time, I understood maternal mortality solely as a medical problem. As I began asking some of the women to share their birthing stories with me, a picture illuminating that women viewed childbirth differently from my focus as a midwife started emerging. I then realised that there were a lot of aspects to childbirth. Beck (2004) in her study on post-traumatic stress, found a similar discord, leading her to conclude that the focus for clinicians was often solely related to clinical efficacy, to the exclusion of, and seemingly oblivious to women's feelings about the birth experience.

Situations that I faced during my clinical practice were dynamic. Thus they offered me a platform to think beyond what was published in midwifery books. The encounters with pregnant and birthing women were so unique that it became clear to me that theoretical knowledge on its own was not sufficient to equip anyone to deal with situations as they are

experienced in real life. Anything could happen at any time and perceptions were diverse. Even though at the time of supervising students I was considered to be competent; in moments where unexpected situations arose, my responsibility as a midwifery educator weighed heavily on me as I tried to make a difference to the students and the women. I found myself being thrown into the midst of responding beyond my theoretical knowledge, clinical experiences and capabilities. Ironically, such encounters of trying to get on top of the dangers and challenges that birthing women were facing in Zambia encouraged me to pursue midwifery at a higher level. When an opportunity was availed, I went to South Africa to undergo training and graduated with a Masters in advanced midwifery and neonatal practice.

After my Master's Degree I got a job as a midwife lecturer at the University of Zambia (UNZA). It is the biggest, oldest and highest institution of learning in Zambia. This position exposed me to the Zambia Demographic Health Surveys (ZDHS) publications by Central Statistical Office (CSO), and a reasonable number of studies on issues pertaining to maternal health, both internationally and nationally. Examples of some local studies were the two by Maimbolwa, Yamba, Diwan and Ransjo-Arvidson (2003); and MacKeith, Chinganya, Ahmed and Murray (2003). The information in the UNZA, CSO and Macro International Inc. (1993); CSO, Ministry of Health and Macro International Inc. (1997); CSO, Central Board of Health (CBoH) and ORC Macro (2003); CSO, Tropical Diseases Research Centre (TDRC), UNZA and Macro International Inc. (2009) publications, and the two studies by Maimbolwa *et al.* (2003) and MacKeith *et al.* (2003) pointed to the fact that homebirths were leading to the high maternal mortality ratios (MMR) in Zambia. Paradoxically, despite this information, homebirths seemed to be the preferred choice of place of delivery for most women. In response to this information the Zambia Ministry of Health (MoH) undertook interventions

such as training health workers, particularly midwives, in the recognition of emergencies (MoH, 2006). The MoH also began building more health facilities close to where women resided (MoH, 2006). The aim of the interventions was to encourage and increase institutional births. Fascinatingly, irrespective of the interventions being in place, the most recent ZDHS (CSO *et al*. 2009) at the time of writing this thesis reported that more women (57%), were still birthing at home; with the number increasing in rural Zambia (70%). Reflections of rural experiences with student midwives strengthened my view that women and midwives understood the childbirth experience differently. In trying to better understand how women experienced childbirth, I decided to ask the women themselves to tell me their birthing stories. That way I was of the opinion that interviewing women birthing in Zambia would enable me access their world.

In addition to the exposure to maternal mortality through my work, my general life experiences in Zambia as a Zambian woman also exposed me to witness a number of deaths resulting from childbirth. The impact of these deaths has always been immense, as many women died when they were young, active and their families were still dependent on them emotionally, economically and socially. I too almost became a maternal mortality statistic during the birth of my first child. More than a decade since the incidence of my first delivery, which ended in a caesarean section, I felt that the impact of that experience still negatively affected me. I began to realise that it was possible for a woman to have a good birth outcome of a live baby, with no complication to mother or infant, yet be troubled by the experience. This personal dimension of childbirth motivated me to conduct a study on childbirth experiences of women birthing in Zambia because I did not see the issue being addressed in the existing literature.

In collaboration with other midwives and researchers, I conducted two qualitative studies that paved the way for this study. The two studies have since been published in the Africa Journal of Midwifery and Women's Health (AJM), which is an international journal based in the United Kingdom (UK). My first study looked at how women in Zambia perceived the midwives' role in the provision of skilled maternity care. The study was conducted following the successful implementation of the Irish Aid funded project that was aimed at reducing the proportion of births occurring at the University Teaching Hospital (UTH), in Zambia's capital city of Lusaka. Before the inception of the Irish Aid project, UTH was attending to both low and high risk pregnant and birthing women. It was also the only designated national referral hospital. Hence the core strategy for implementing the Irish Aid funded project was redeploying of obstetricians to the UTH so that they could attend to high risk clients only. Midwives were thus, left in the urban centres under the supervision of a senior midwife to attend to low risk pregnant and birthing women. The study was successful in decongesting the UTH. However, despite the project's success of decongesting the UTH, women's views regarding autonomous maternity services provided by midwives in the urban centres were not documented. Thus, it was not known whether the increase in births in the Lusaka urban health centres was due to women's personal choices or it was because those with low risk pregnancies were not allowed to deliver at UTH. Data for my study were collected through semi-structured interviews with nine postnatal mothers who had birthed in some of the urban health centres in Lusaka. Grounded theory was used to analyse the data. This approach was found to be appropriate because I was of the view that although more women were birthing from the urban centres, they felt that in the absence of supervision from obstetricians, midwives were neither qualified enough to provide adequate care, nor to make referral decisions if and when the need arose. All the participants in the study reported that they had good birth outcomes. However, they expressed disappointment with the care they received.

But because they had no say in the matter, they had no choice but to continue birthing from the urban health centres. One of the reasons for their disappointment was that midwives did not allow women to see their relatives immediately after giving birth. The women reported that they wanted to talk about their birth and labour experiences immediately after giving birth because it was not easy to talk about the experience at home.

The second study looked at factors that influenced the majority of Zambian women to deliver from home despite the identified risks of homebirths. The research topic was: "Why do women in Zambia prefer to deliver from home: healthcare providers' perspective". This study was supported by the report by CSO *et al.* (2003), which stated that despite the government giving a directive that unless in cases of emergencies, no deliveries were to be conducted in homes, 57% of women in Zambia were having homebirths. Data were collected using four focus group discussions (FGD) with 40 qualified nurses who were pursuing their one year post-basic midwifery training at UTH School of Midwifery. Content analysis method was utilised to analyse the data. The findings from the study revealed that women disapproved of institutional births because:

a) The geography of the labour wards in Zambia's public health facilities did not offer privacy to birthing women.
b) Maternity healthcare workers were not sympathetic and were often rude to birthing women.
c) Women viewed health institutions as places one went to when they were ill. It was reported that women did not view childbirth as an illness and hence, they did not see the need to birth in health facilities.

The two studies provided evidence that women's subjective experiences and perspectives of childbirth had not been addressed adequately in the provision of maternity care in Zambia. The results highlighted significant gaps in health workers and stakeholders' knowledge about how women experienced and interpreted childbirth. Therefore, I was of the view that further research in which the women of Zambia were provided an opportunity to speak out about their birthing experiences in their own way would shade more light on how women experienced the phenomenon. This is in order for the providers of maternity care and all other stakeholders to get a better understanding of how the phenomenon is experienced and thus be able to offer appropriate care. When an opportunity to pursue a PhD at the University of Nottingham was availed to me, I presented my proposal to my supervisors who guided me in choosing the appropriate methodology for the study. I felt that having knowledge and an understanding of how women birthing in Zambia experienced and interpreted the childbirth experience was cardinal if maternity healthcare workers were to provide care that gave priority to the wishes and needs of the consumers of care. The results of such a study not only has the potential to bridge the gap in the existing knowledge but it would provide valuable data to all maternity care stakeholders, especially the ones practicing in Zambia where this study was conducted.

1.3 Background and context of childbirth

Giving birth is a universal physiological process that can be perceived by some women either as a traumatic event (Sawyer and Ayers, 2009) or a transformative experience, with short and long-term outcomes (Kennedy, Shannon, Chuahorm and Kravetz, 2004). According to Beck (2006), a traumatic birth experience can have long-lasting effects on a woman's health and well-being. Grote and Bledsoe (2007) and Callister (2004) describe childbirth as a deeply physiologic, cognitive, cultural, social and spiritual event that heralds an enormous change in

all the systems of a woman's body. Yet, the more delicate interrelated psychological and emotional components that women experience are often overlooked when discussing maternal health in favour of more noticeable physical elements such as maternal mortality measures and interventions (Baker, Choi, Henshaw and Tree, 2005). The emphasis on physical measures alone is such that women's personal experiences of the phenomenon are often marginalised or ignored (Walsh, 2007). Given the high MMR pertaining in countries in the sub-Saharan region, maternity mortality is an important dimension for evaluating maternal health. However, it is not adequate to explain the complexity of human experiences, such as childbirth. Thus, the exclusion of women's subjective experiences and views from maternity service evaluation renders an incomplete and unclear depiction of the childbirth phenomenon. In an attempt to understand the complexity of childbirth, there is an increasing international recognition of the importance of identifying women's needs around the time of delivery, and the centrality of the childbirth experience to women's psychological health (Larkin, Begley and Devane, 2010; Walsh, 2007; Bailham and Joseph, 2003). This has not been replicated in sub-Saharan Africa. In the absence of such information, this study was conducted.

Prior to the 17th century, birthing in most countries was considered within the realm of women. It occurred primarily in homes, and was attended by midwives, female relatives and/or supportive female families (Johanson, Newburn and Macfarlane, 2002). Those who attended the births learned about childbirth from their older female relatives and friends. Thus, birth stories and knowledge on management of birth was passed down from generation to generation (Savage, 2002). This has not been to the advantage of women in Africa. According to the World Health Organisation (WHO), a woman's status in Africa has always been and is still inferior in comparison to her male counterpart (WHO, 2007a). For example,

one of the cultural norms women in Zambia still adhere to is that of compliance to men (MoH, 2003). In keeping to their cultural norms, women in Zambia, particularly those who are not formally educated extend their compliance to midwives who provide care to them during childbirth. This practice has been evidenced in previous studies conducted in Zambia by MacKeith *et al.* (2003) and Maimbolwa *et al.* (2003), as well as in this study in which the majority of participants were not formally educated, not economically independent and hence gave birth in public health institutions. They looked at midwives as being superior to clients. Thus, the participants complied with whatever midwives asked them to do during childbirth. As exemplified in a study by Maimbolwa *et al.* (2003), the type of interaction between maternity care providers and birthing women in Zambia, be it in a home or institutional birth, is compounded by secrecy surrounding the experience of childbirth. This has created a situation where the only people who know what really happens during childbirth are the women and their attendants. Hence, in order to get a better understanding of how women experience childbirth, a phenomenological study exploring Zambian women's lived experience of birthing was essential.

1.4 Shift from homebirths to institutional births in Zambia

Similar to other sub-Saharan African countries, maternity health service provision in Zambia changed from traditional homebirths to scientific institutional births during the 18th century, following the 'Scramble for Africa' (Chintu and Susu, 1994). As the explorers and missionaries settled in their respective colonies, as well as worked with and among indigenous Zambian people, they established and provided basic modern health services, which included maternity care. Between 1924 and 1947, modern health services began to grow throughout the African continent, especially in British colonies (Chintu and Susu, 1994). Companies, such as The British South Africa Company (1878 to 1924) that settled in

south, central and east Africa established the first health services in Zambia (Chintu and Susu, 1994). Explorers and missionaries, such as, Scotsman Dr David Livingstone, with their wives, as well as some Catholic nuns, were among the first known missionaries who established and provided maternity health services in Zambia (Chintu and Susu, 1994).

The introduction of institutional births was accompanied by disapproval and discouragement of traditional homebirth care. As years went by, shifting of maternity care from homes to health institutions focused much on technology-based interventions and prevention of disease (Meleis and Im, 2002; AbouZahr and Wardlaw, 2001). Hence, less attention was paid to understanding women's social backgrounds, gender issues, historical and the cultural contexts in which childbirth was viewed and provided. Consequently, this led to a loss of knowledge as to how women experience childbirth, and whether modern maternity services were meeting women's needs, priorities and preferences. The loss of knowledge of how women experienced and interpreted childbirth could be one of the factors undermining efforts to reduce the country's unacceptably high MMR. Without this knowledge it is difficult for healthcare providers, particularly midwives to understand how women reason when it comes to birthing issues. Therefore, it has not been possible to put in place appropriate programmes targeting women's preferences, as evidenced by the persistent high MMR and homebirths in the country. Even though the MMR in Zambia has reduced from 591 (CSO *et al.* 2009) to 398 per 1,000 live births (CSO *et al.* 2014*)*, this rate is still high. To assist in bringing to light information that is missing when evaluating maternal health, results of this phenomenological study have the potential to answer questions such as: Why are women in Zambia still dying from pregnancy related causes? Why have significant investments in resources failed to

achieve tangible results in combating high MMR in Zambia? Why are more women in Zambia still birthing at home despite the reported risks of homebirths?

Since the mid-20th century, perspectives from midwives have been influencing the knowledge-base of the midwifery profession. This has contributed to the understanding of childbirth as a cultural, social, physiological and psychological phenomenon. Hodnett (2002) indicates that women have profound and vivid memories of the event, as well as very strong feelings about their childbirth experiences, and the people who assisted them. Thus, it has become evident that when evaluating maternity health, psychological aspects of childbirth and not only physical dimensions, are extremely important. According to the Royal College of Midwives (2000) psychological aspects of childbirth play a significant part alongside physical aspects.

1.5 Maternal mortality between high income and low income countries

According to the Maternal Mortality Estimation Inter-Agency Group (MMEIG), which comprises the WHO, the United Nations Children's Fund (UNICEF), the United Nations Population Fund (UNFPA), the United Nations Population Division (UNPD) and The World Bank, an estimated 289,000 women died in 2013 as a result of pregnancy and childbirth (WHO, 2014b). Almost all the deaths (99%) occurred in low income countries (WHO, 2014b), particularly Africa, where unskilled attendants attend to approximately 57% of births, with the proportion generally being higher in rural areas at 70% (WHO, 2006a). A million or more children are left motherless each year when a mother dies from pregnancy related causes (Ellsberg and Heise, 2005). Children who survive their mother's death are ten times

more likely to die within two years than children with two living parents (WHO, 2007b). Hence, in low income countries, where a woman delivers, and how quickly she can be transported to a referral healthcare facility are crucial factors in determining the ability to intervene successfully (Koblinsky, Matthews, Hussein, Mavalankar, Mridha, Anwar, Achadi, Adjei, Padmanabhan, Marchal, De Brouwere and van Lerberghe, 2006; Osubor, Fatusi and Chiwuzie, 2006). Most of the maternal deaths occur during childbirth or within the first 24 hours postpartum (Campbell and Graham, 2006).

In 2013, MMR in high income countries was 16 per 100,000 live births, versus 230 per 100,000 live births in low income countries (WHO, 2014a). More than half of these deaths occurred in countries in the sub-Saharan African region. The region has the highest MMR at an average of 510 per 100,000 live births (WHO, 2014a). Out of the 20 countries worldwide with high MMR, only two (Afghanistan and Haiti) are outside sub-Saharan Africa (WHO, 2014b). Therefore, there is no question that the risk of maternal death is most acute in sub-Saharan Africa. The estimated lifetime risk for maternal death in high income countries is 1 in 3,400 in comparison to low income countries where the risk is 1 in 52 (WHO, 2014b). This makes maternal mortality the most striking health indicator showing the greatest disparity between low and high income countries. The leading causes of maternal deaths in low income countries are complications of haemorrhage, sepsis, hypertensive disorders and obstructed labour (Mushi, Mpembeni and Jahn, 2010; Mbonye, 2007; Lawson, Harrison and Bergstrom, 2001). This is a tragedy because the health care solutions to preventing or managing these complications are well-known. In other words, these deaths are preventable. It is reported that all women need access to antenatal care in pregnancy, skilled care during childbirth, care and support in the weeks after childbirth and emergency obstetric care under

the supervision of skilled health professionals if these deaths are to be prevented (WHO, 2014a; Stephenson, Baschieri, Clements, Hennink and Madise, 2006). It is particularly important that all births are attended by skilled health professionals, as timely management and treatment can make the difference between life and death. According to Chen, Wang and Chang (2001), the ideal image of a skilled attendant should encompass the roles of emotional supporter, comforter, information and advice provider, medical professional, technical skill provider, and advocate for birthing women.

While most countries aspired to achieve the target of Millennium Development Goal (MDG) number 5 by 2015, a lot of countries in sub-Saharan Africa failed to attain the goal (WHO, 2014b). The 11 low income countries that were categorised as being 'on track' because of their MMR of more than 100 per 100,000 live births that declined by 75% between 1990 and 2013 are: Maldives, Bhutan, Cambodia, Equatorial Guinea, Lao People's Democratic Republic, Romania, Timor-Leste, Cabo Verde, Eritrea, Nepal and Rwanda (WHO, 2014b). A number of countries in sub-Saharan Africa halved their levels of maternal mortality since 1990 and thus were categorised as 'making progress' (WHO, 2014b). A further 13 countries were categorised as making 'insufficient progress' (WHO, 2014b). However, although many of the countries in sub-Saharan Africa were categorised as 'making progress' they still have an average MMR of about 400 per 100,000 live births. According to a WHO (2014b) report, MMR figures from some sub-Saharan African countries' latest DHS are as follows:

- Zambia has MMR of 591 per 100,000 live births.
- Tanzania recorded an estimated MMR of 454 per 100,000 live births.
- Uganda has MMR of 438 per 100,000 live births.
- Malawi recorded MMR of 675 per 100,000 live births.

- Namibia has MMR of 446 per 100, 000 live births.
- Mozambique has MMR of 448 per 100, 000 live births.
- Kenya's MMR is 488 per 100, 000 live births.
- Demographic Republic of Congo has MMR of 549 per 100, 000 live births.
- Ethiopia has MMR of 676 per 100, 000 live births.

These figures are unacceptably high. They reveal a startling reality that a woman in sub-Saharan Africa faces a 1 in 16 chance of dying from pregnancy-related causes, in contrast to her sister in a high income country, whose risk is lower than 1 in 3,700 (WHO, 2005a). Between 1990 and 2013, the global MMR declined by only 2.6% per year (WHO, 2014a). This was far from the annual decline of 5.5% that was required to achieve MDG 5 (WHO, 2014a). Globally, three core health-sector strategies have been identified within the maternal health community as critical for reducing maternal deaths. According to Starrs (2007) the core health sector strategies are:

a) Comprehensive reproductive health care.

b) Skilled care for all pregnant women, especially during delivery.

c) Emergency obstetric care for all women with life-threatening complications.

In order to achieve these core health-sector strategies, there is need for women to deliver in an institution where there is a skilled attendant. Institutions where women give birth should be well equipped to allow skilled attendants to recognise and manage complications that may arise (Starrs, 2007). However, it is important to point out that emphasis on skills should not only be physical. As pointed out by Larkin, Begley and Devane (2009), skills should

encompass both physical and psychological aspects of maternity care. In conjunction with improving healthcare workers' skills and equipping health institutions, emphasis should also be on promotion of gender equality and empowerment of women. Thus, all aspects of maternity care should be emphasised and implemented if maternal mortality disparities within and between countries are to be reduced. This will ensure that women, especially in sub-Saharan Africa, who have been marginalised for a long time, develop economic and social independence and be able to challenge oppressive practices. This is because some of the prevailing childbirth practices impinge on women's reproductive rights.

Although, some countries in the sub-Saharan region have made substantial progress towards the vision of providing skilled attendance for all pregnant women, the majority of countries are currently not on target (WHO, 2006a). Zambia is among countries categorised to be 'making progress' towards achieving MDG 5, however, the country has a long way to go to make child-bearing safe (WHO, 2014a). Central Statistical Office, MoH and ICF International (2014) in their ZDHS 2013 – 2014 report stated that 70% of women, especially in the rural areas, continue to deliver at home and assisted by unskilled attendants. World Health Organisation (1999) refers to the TBAs and female relatives, who assist with home deliveries in Zambia, as unskilled attendants because they are not formally trained in the skills needed to manage normal pregnancies, childbirth and the immediate postpartum.

1.6 Global Safe Motherhood campaign

The global campaign to reduce maternal mortality was launched in 1987, when three United Nations (UN) agencies: UNFPA, The World Bank and WHO, sponsored an international safe

motherhood conference in Nairobi, Kenya (Family Care International, 2006). The conference aimed to raise awareness about the numbers of women dying each year from complications of pregnancy and childbirth, as well as to challenge the world to do something. According to the Family Care International (2006) report, the origins of the conference dated from 1985 when two presenters focused the attention of public health specialists on the horrific risks pregnancy posed for women in low income countries. Rosenfield and Maine (1985) pointed out that Maternal and Child Health (MCH) programmes in low income countries were almost exclusively for the benefit of the child, with almost no attention to the factors that were causing mothers to die. This led to the launch of the global safe motherhood initiative, as well as a series of regional and national conferences that made safe motherhood an accepted and understood term in the public health realm (Family Care International, 2006). The action of the safe motherhood initiative encompassed the need to improve women's status, educate communities and strengthen and expand core elements of maternal health, which are: antenatal care, delivery care and postpartum care at the community and referral levels (Starrs, 1998). After the conference, cooperating partners, UN agencies and governments focused on screening women to identify those at risk of complications, and training TBAs to improve delivery care at the community level (Family Care International, 2006). The strategies included providing family planning services and post abortion care, promoting antenatal care, ensuring skilled attendance at delivery, improving essential obstetric care through availability of antibiotics, oxytocics and sedatives, skills for manual removal of the placenta or retained products and assisted vaginal deliveries, as well as addressing the reproductive health needs of adolescents (WHO, 2007b). Despite implementation of these strategies, little progress towards making childbirth safer, particularly in sub-Saharan Africa, was made.

A decade later, delegates at another international conference in Washington DC, on Population and Development, renewed their commitment to the reproductive health needs of both women and men (UNICEF, 1994). By consensus, they adopted a programme of action, which stated that: 'All countries should reduce maternal morbidity and mortality by half of the total 1990 levels by the year 2000, and by a further half by 2015; and that disparities in maternal mortality within and between countries, geographical regions and ethnic groups should be narrowed' (UNICEF, 1994). Although safe motherhood was already firmly entrenched as a core component of reproductive health, governments began de-emphasising large scale training programmes for TBAs. They prioritised health-sector interventions designed to increase women's access to professional medical care, especially for life-threatening complications after implicitly acknowledging the failure of the approaches undertaken during the 1987 conference (Family Care International, 2006). This meeting further acknowledged that there were other strategic decisions that had unforeseen negative consequences to the SMI focus, no matter how well-intended they might have been. One of these strategic decisions was the focus on maternal death as a multi-sectorial problem, with equal emphasis on the range of direct and indirect problems that contribute to poor maternal health (Family Care International, 2006). Women rights advocates and many medical professionals noted that maternal deaths were not just the result of poor or inaccessible medical care, but indicated a chain of problems such as lack of education for girls, early marriages, lack of access to contraception, poor nutrition, and women's low social, economic and legal status (Fathalla, Sinding, Rosenfiel and Fathalla, 2006). These factors individually and collectively contributed to women's poor health before and during pregnancy, thus increasing their vulnerability to life-threatening complications and limiting their ability to seek and receive quality care. Attempting to address these complex and deep-rooted factors resulted in large, complicated and expensive national Action Plans for safe motherhood

(Family Care International, 2006). In addition, unclear leadership guidelines within most sub-Saharan African countries led to cooperating partners such as UNFPA, WHO, UNICEF, UNDP, and The World Bank to be unwilling to support the massive undertakings (Family Care International, 2006). Despite the setbacks, there was a global comprehensive advocacy campaign that substantially increased the support for maternal health (Family Care International, 2006).

The resolutions and achievements made after the 1994 international conference on Population and Development in Washington DC too did not generate the large-scale effect that was hoped for. Therefore, the importance of maternal survival was again reinforced in 2000, when the UN Millennium Declaration was adopted (WHO, 2010). Eight critical goals, called the Millennium Development Goals (MDGs) were launched (Family Care International, 2006). The MDGs were offering an unprecedented chance to redress errors of the past and take advantage of new opportunities. The third MDG, which calls for the promotion of gender equality and empowerment of women at all levels by the year 2015, and the fifth MDG, which calls for a 75% reduction of MMR between 1990 and 2015 (WHO, 2010), are the ones to which this research aligned itself. Alongside the goals of promoting gender equality and reducing maternal mortality, were issues of newborn and child mortality in a continuum of care as a new global consortium. This led to the launch of the Partnership for Maternal, Newborn and Child Health in 2005 (Family Care International, 2006). Critical strategies to achieving MDG three and five's goals by 2015, particularly in sub-Saharan African countries, were elimination of gender disparities in accessing primary, secondary and tertiary education, and promotion of institutional deliveries (UNDP, 2006). The UN Millennium Declaration meeting acknowledged that complications of pregnancy and childbirth can develop at any time. Therefore, every pregnancy should be viewed as being at risk and attended to by a

skilled healthcare provider (Starrs, 2007; Donnay, 2000). World Health Organisation (1999) describes a skilled attendant as an accredited health professional, such as a midwife, doctor or nurse, who has been educated and trained to proficiency in the skills needed to manage uncomplicated pregnancies, childbirth and the immediate postnatal period, and identification, management and referral of complications in women and newborns. Zambia is a signatory to all these declarations.

In UK, the publication of 'Changing Childbirth' report led to development and implementation of initiatives focused on providing maternity care systems, which are responsive to women's needs (Department of Health, 1993). This landmark report recommended a review of maternity services provision, in which women were to be at the centre of their care, both in the intrapartum and postpartum periods. The review was intended to improve both physical and psychological outcomes, as well as optimise women's experiences and satisfaction throughout the childbirth process (Baker *et al*. 2005). Backed by the 'Changing Childbirth' report recommendations, National Health Service (NHS) policies and in particular, the policy around childbirth is focused on the importance of providing choice, continuity and control for all birthing women (Department of Health, 2007). Consequently, the draft National Institute for Health and Clinical Excellence (NICE) guidelines for intrapartum care recommend that women should be offered choice in planning who and where to birth (NICE, 2007). Choice, continuity, involvement in decision making and control in planning who and where to birth are a big challenge to both maternity healthcare providers and birthing women in Zambia because of factors such as, high MMR associated with homebirths, shortage of midwives, lack of decision making powers by women, and long distance to health institutions (CSO *et al.* 2014). According to Fathalla (2015) and Fathalla *et al.* (2006), lack of control over reproduction decisions, women's low

social status, gender discrimination, lack of educational opportunities for girls and patriarchal social constructs contribute to the underpinnings of maternal mortality in low income countries. Improving maternal mortality in low income countries requires not only recognition of multiple and complex factors but action towards realisation of every woman's right to a safe pregnancy and birth (Freedman, 2001).

During the past decade, applying the attributes and concepts of human rights to pregnancy and childbirth have been advocated and described in literature (Fransen, 2003; Cain, 2000). Hence, applying a human rights perspective by focusing on the concerns of women through respect of their beliefs and traditions is essential. This suggests that an improvement in maternal mortality in sub-Saharan Africa could stem from maternity care providers, particularly midwives, and stakeholders' ability to understand the contextual influences on maternal health. To improve maternal health, barriers that limit access to quality maternal health services through choice, continuity, involvement in decision making and control must be identified and addressed at all levels of the health system. As already stated, there is currently very little information available on the psychological and emotional aspects of childbirth in Zambia. One way in which this aspect can be brought to light is by exploring how women in Zambia experience childbirth and give meaning to the phenomenon. Alongside physical aspects of childbirth, not having a clear understanding of how the phenomenon is experienced and interpreted by birthing women could have undermined the country's progress towards attaining MDG 5 by the end of 2015.

One of the objectives stated in the Zambia National Strategic Plan 2001-2005 is the provision of safe and clean deliveries (MoH, 2000). Based on previous studies' findings stating that one

of the factors leading to high homebirths and consequently high MMR was long distance to health institutions, a programme of training TBAs was instituted (CSO *et al.* 2003). The focus of the programme was to provide safe and clean deliveries, thus ultimately reducing MMR in the country. In Zambia and many sub-Saharan countries, TBAs have for a long time played a significant role when it comes to cultural competencies, consolation of birthing women, empathy and psychosocial support at birth, with important benefits for the mother and the newborn (MoH, 2003). Hence, training of TBAs has been an important component of strategies to improving maternal and neonatal outcomes (MoH, 2003). However, an analysis of the impact of training TBAs, in order to reduce MMR in Zambia, concluded that the impact was low (MoH, 2003). The report went on to say that emphasis on large-scale TBA training efforts could be counterproductive, as it held back the training of the necessary numbers of medium level providers, such as midwives. The report therefore, recommended that where TBAs were an important source of delivery care, stakeholders needed to make the best use of them, while simultaneously planning for replacement with skilled attendants (MoH, 2003). At the time of writing this thesis, the MoH was in the process of:

- Increasing the number of students and intakes in existing midwifery schools.
- Opening new midwifery schools offering a direct two-year midwifery course.
- Initiating a straight four-year course that included midwifery training in the fourth year.
- Passing legislature allowing other partners such as private institutions, companies and individuals to open private midwifery training institutions.

Assessing that a lot of countries were far from achieving the MDGs, the countdown to the September's summit on Sustainable Development Goals (SDGs) began in 2015. According

to the International Council for Science (ICSU) and International Social Science Council (ISSC), SDGs are 17, new universal set of goals, targets and indicators that UN member states are expected to use to frame their agendas and political policies over the next 15 years from 2016 (ICSU, ISSC, 2015). They follow and expand on the eight MDGs. The 5th SDG is targeted at achieving gender equality and empowering all women and girls (ICSU, ISSC, 2015). This makes the conducting of this study timely.

1.7 Health Service Provision in Zambia

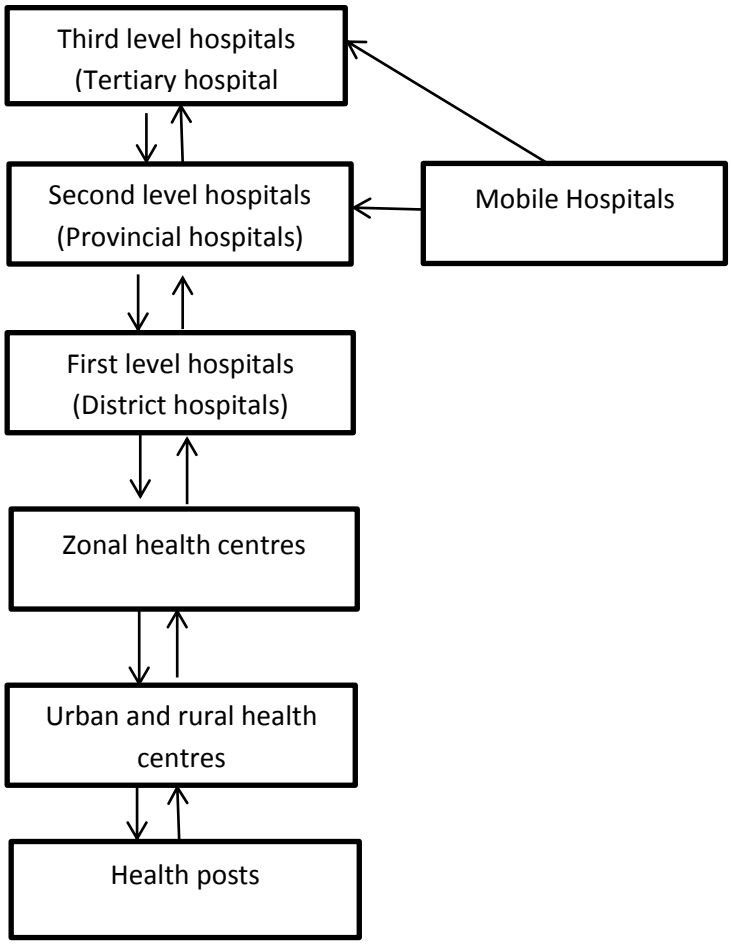
Health services in Zambia are provided by churches, private practitioners, industries and traditional practitioners, although MoH plays a dominant role. Provision of public modern health care services is found at:

- Health posts.
- Rural and urban health centres, popularly known as clinics.
- Zonal health centres.
- First level hospitals (previously known as district hospitals).
- Second level hospitals (previously known as provincial hospitals).
- Third level or tertiary hospitals.

The four public tertiary hospitals are: UTH located in the capital city, Lusaka in Lusaka province; Ndola Central and Arthur Davidson's Children hospitals (ADH) located in Ndola district; and Kitwe Central hospital located in Kitwe district. The latter three tertiary hospitals are all in the Copperbelt province. Supplementation of public health provision, especially in rural areas where health centres are far from where communities reside is through mobile hospitals that were introduced in 2010 (MoH, 2011). The mobile hospitals have the status of

second level hospitals. Maternity care, which is divided into antepartum, intrapartum and postpartum care, is provided in all public health institutions. Although maternity care services in Zambia are termed to be free, some form of payment is requested for things such as syringes, prescribed investigations and drugs. This was a cost-sharing strategy that was implemented with the 1991 health reforms (MoH, 2011). Maternity care in health institutions is provided by obstetricians, midwives and at times clinical officers (CSO *et al.* 2014; MoH, 2001). However, most mothers are attended to by midwives (CSO *et al.* 2014). Public health institutions in Zambia are managed through a unitary system of referral as illustrated in Figure 1.

Figure 1: Health system referral in Zambia



1.8 Antenatal care services

Antenatal care services in Zambia are available both in government and private run clinics and hospitals, and women are encouraged to attend antenatal care services during the first trimester of their pregnancies. The major objective of antenatal care is to achieve the optimal outcome for the mother and her baby (CSO *et al.* 2014). Like many other services, antenatal services in Zambia have for a long time followed the traditional approach of at least 12 antenatal visits before a woman delivered. The assumption was that more visits resulted in better care for the pregnant woman. "The first visit took place during the first trimester and visits continued on a monthly basis through to the 28th week, and every two weeks thereafter up to the 36th week, and then weekly until delivery" (CSO *et al.* 2009, p129). This approach has so far been changed. Zambia now follows WHO Focused Antenatal Care (FANC) approach to promoting safe pregnancies, where a woman without complications can have only four antenatal visits instead of the traditional 12 (CSO *et al.* 2014). Focused Antenatal Care emphasises quality of care during the visits over the quantity of visits, by recommending that each visit be conducted for specific reasons by a skilled attendant. The new schedule of antenatal visits is as follows: the first visit is by the end of 16 weeks of pregnancy, the second visit is at 24 weeks, the third visit is at 32 weeks, and the fourth visit is at 36 weeks (MoH, 2011). Early detection, timely treatment, and referrals in case of special needs are of particular importance in Zambia, given that it is a large and sparsely populated country. Therefore, physical barriers like distance and transport to health centres are a challenge to maternity health care delivery. According to the 2013 – 2014 ZDHS, 99% of women in urban areas receive antenatal care from a skilled provider at least once, compared to 94% in rural areas (CSO *et al.* 2014). Monetary travel costs for the women especially in rural areas are minimal in Zambia as most of them walk to the nearest health centre.

1.9 Labour and delivery services

In 1991, the government of the Republic of Zambia (GRZ) embarked on health reforms that were aimed at increasing the number of deliveries attended by trained health personnel (MoH, 2011). The vision guiding the health reforms was to improve the quality of life for all Zambians through the development of healthcare systems, which provided equity of access to cost effective, quality health care as close to the family as possible (MoH, 2011). One of the most critical interventions for maternal health is to ensure that skilled care is provided in health institutions by skilled healthcare professionals during pregnancy and childbirth (CSO *et al.* 2014). Consequently, since healthcare professionals in Zambia are not allowed to conduct home deliveries, the country's hospitals, especially the UTH, located in the capital city, Lusaka were under severe pressure. Of the estimated 34,000 births a year in Lusaka in the 1980s, 70% were taking place at the UTH, despite the labour and delivery facilities being designated to cater for 8,000 deliveries per year (MacKeith *et al.* 2003).

To decongest the UTH, the Lusaka Urban Maternity Care Project was initiated in 1983 with capital funds provided by the Government of Ireland and running costs met by the Zambia MoH (Nasah and Tyndall, 1994). The project aimed to reduce overcrowding at the UTH by increasing the number of deliveries in Lusaka urban health centres. Women with low risk pregnancies were provided with efficient, safe and convenient services close to their homes by midwives, so that only women with high risk pregnancies were attended to at the UTH (Irish Aid Evaluation and Audit Unit, 1999). According to Nasah and Tyndall (1994), key elements of the project included:

i) Upgrading and extension of existing urban health centres to provide safe delivery services.

ii) Introduction of the partograph to monitor progress of labour.

iii) Provision of emergency transport and radio communications.

iv) Redeploying of obstetricians to UTH.

v) Staffing and running of the urban maternity centres by midwives.

Supervision of the midwives in the urban maternity centres was provided by a senior midwife of the Lusaka District Health Management Team (LDHMT), through regular health-centre visits and audit of activities such as, birth outcomes, referral, and adverse outcomes (Nasah and Tyndall, 1994). As new urban health centres began operating, the number of deliveries at the UTH declined. The number of deliveries in urban health centres increased from 2,000 to 15,000, with an in-labour transfer to UTH rate of 10% (Nasah and Tyndall, 1994). By 1998, there were 32,000 births taking place in the city's urban health centres and 10,500 at the UTH (Irish Aid Evaluation and Audit Unit, 1999). Irish Aid handed over the project to MoH in 1996 and the project was later scaled out to the entire country (MacKeith *et al.* 2003). In an effort to prevent unnecessary delays in relation to childbirth, especially for mothers in rural areas, the Ministry of Community Development, Mother and Child Health and the MoH implemented a birth preparedness package that outlines the steps mothers should take to prepare for birth (MoH, 2011).

1.10 Postnatal services

In order to treat complications to both the mother and/or the infant, arising from delivery, as well as provide the mother with important information on how to care for herself and her infant, postnatal care is an important component of maternity care (CSO *et al.* 2014). According to CSO, *et al.* (2014), there is evidence that a large proportion of maternal deaths

in Zambia occur during the postpartum period, with postpartum haemorrhage being a common cause. Therefore, Zambia's safe motherhood guidelines recommend that women receive at least four postnatal reviews (MoH, 2011). The first postnatal review should take place within six hours of delivery, the second should be on the second day following delivery, the third on the sixth day following delivery, and the fourth within six weeks following delivery. The mothers who deliver without complications and interventions, such as caesarean sections and vacuum extraction, are discharged after six hours of birth. After discharge the mother's next contact with health care services is at the six days postnatal review, then six weeks later (CSO *et al.* 2014). According to the latest ZDHS report, more than 51% of women do not return for postnatal care (CSO *et al.* 2014). This is an area of concern as literature states that most maternal deaths occur during childbirth or within the first 24 hours postpartum (Campbell and Graham, 2006).

1.11 Midwifery training in Zambia

Following independence in 1964, the government of Zambia carried out a national health survey that revealed very high maternal and infant mortality rates (MoH, 1992). Based on the survey results, the MoH in conjunction with international organisations, such as WHO, formulated strategies targeting the integration of MCH services in all health institutions. As it was, and still is a taboo in many parts of the country for a man or young woman to attend to birthing women, older women were recruited and trained in simple aseptic techniques needed for labour and delivery (Chintu and Susu, 1994). These women assisted deliveries under the supervision of expatriate midwives. But due to the evident increase in demand for specialised maternity care, missionary nuns, at Mbereshi mission in Zambia's Luapula province, opened an enrolled midwifery school in 1951, where a few younger women were recruited and trained (Chintu and Susu, 1994). Although these newly-trained enrolled midwives joined the

expatriate ones in provision of maternity services in health institutions, they were still too few to cope with the demand. Therefore, more enrolled nursing and midwifery schools were opened in other parts of the country. Due to the dynamic dimension of midwifery practice, a need to train indigenous midwives at a higher level was identified. The first registered midwifery school in Zambia was opened in 1969 at the UTH, in the capital city, Lusaka (Chintu and Susu, 1994). Gradually, higher nursing and midwifery educational programmes to the level of PhD have since been established.

In an effort to improve the quality of maternity services, the midwifery curriculum in Zambia has undergone numerous reviews, spearheaded by the General Nursing Council (GNC). The review done in 2001 integrated concepts of Primary Health Care (PHC) in order to strengthen community-based midwifery practice, as well as update and incorporate new trends in maternal and neonatal health, such as HIV/AIDS, family planning, gender issues, infection prevention, health management information systems and advocacy (GNC, 2001). During training, midwifery learners are assigned to hospitals, urban and rural health centres, as well as communities, so that they acquire necessary skills to practice autonomously. Training areas comprise both classroom and clinical areas, which are: antenatal wards, labour wards, operating theatres, postnatal wards, gynaecological wards, family planning clinics, communities and neonatal wards.

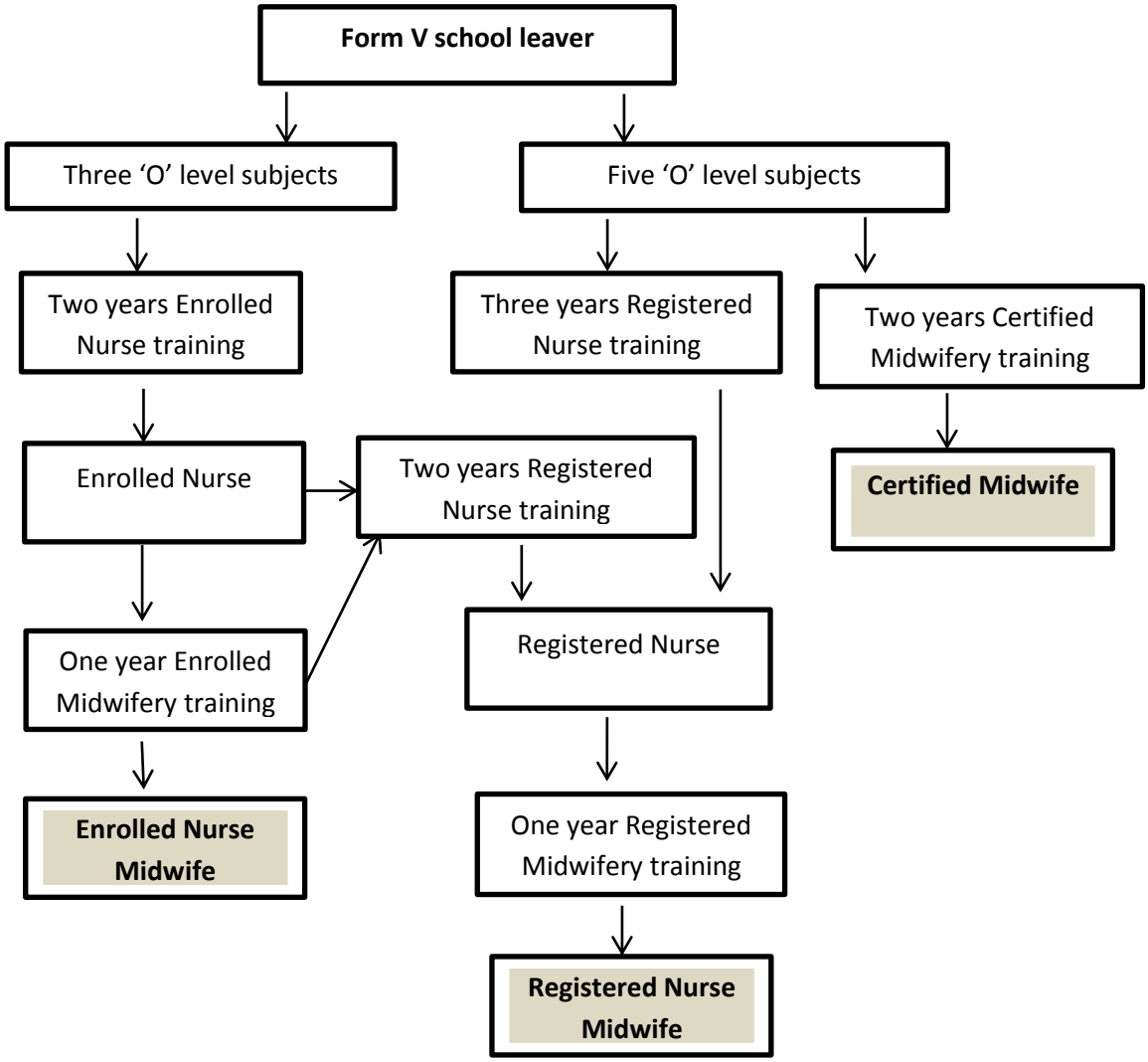
According to the Zambia registered midwifery curriculum, each trainee's practical experience record book has to reflect the following minimum number of experiences: antenatal examinations (20), witnessed low risk deliveries (10), witnessed high risk deliveries (10), vaginal examinations (20), labours monitored (20), deliveries conducted (20), conducted

domiciliary visits (10), information, education and communication (IEC) sessions (10) and family planning procedures conducted (10), as well as pass both theory and practical examinations before a certificate of competence is awarded (GNC, 2001). Trainers in both theory and practice, include qualified midwifery lecturers and tutors, clinical preceptors, obstetricians, gynaecologists, paediatricians and other professionals with relevant specialties (GNC, 2001). At the end of training, midwives in Zambia are expected to practice autonomously. They provide care to low risk antenatal and postnatal mothers and make referral decisions when, and if, they consider it necessary (MacKeith *et al.* 2003). There were three categories of midwives being trained in Zambia at the time of writing this study: Registered nurse-midwives, enrolled nurse-midwives and certified midwives.

According to the GNC (2001), midwifery practice in Zambia is guided by the Midwifery Model of Care. The Model emphasises that pregnancy, labour and childbirth are normal processes of life. Grote and Bledsoe (2007) describe childbirth and consequently the transition to motherhood as a time of great change and altered identity in any woman's life. Hence, the care and support each woman and her newborn receive during labour and childbirth is critical for maintaining their health and minimising or preventing complications. The care providers, who assist women during this critical time, play a vital role, which influences the experience and impacts future reproductive choices (Whitty-Rogers, 2006). The experience exposes women to physical and psychological challenges from which some women derive profound feelings of empowerment and achievement (Lundgren, 2005), while others derive feelings of anger, guilt, violation and depression (Bailham and Joseph, 2003; Mozingo, Davis, Thomas and Droppleman, 2002). Thus, although childbirth is often described as a joyous event, it is associated with challenges for women, babies, families and healthcare providers (Whitty-Rogers, 2006). It is generally a time of both excitement and

anticipation, especially for women going through the experience. Therefore, there is a need to understand how women experience and interpret this phenomenon. A diagrammatic summary of midwifery training is illustrated in Figure 2.

Figure 2: Midwifery training in Zambia



1.12 Statement of the problem

The personal changes that affect the health and general wellbeing of women make childbirth experience, a complex event, as well as an important process with long-term impacts

(Whitty-Rogers, 2006; Nelson, 2003). Therefore, the care that each woman receives during this period of time needs to be tailored carefully to suit the needs of the particular woman, if the experience has to have a positive influence on the woman's life. According to the UNFPA (2011) report, one of the three identified key points relating to challenges and barriers that affect provision of quality maternity care, is that information from women's perspectives of how they experience childbirth has not been given attention. The exclusion of women's subjective experiences from maternity service evaluation has thus, rendered an incomplete and unclear depiction of the childbirth phenomenon in Zambia.

1.13 Research Question

The research question for this study was: 'How do women birthing in Zambia experience and give meaning to the childbirth phenomenon?'

1.14 Study Aim and objectives

The aim of this study was to bring to light childbirth experiences of women giving birth in Zambia, in order to gain a better understanding of how women experience and give meaning to the phenomenon. The study focused on care provided at the time of birth given the intense vulnerability of women during childbirth.

The research objectives were:

1) To explore women birthing in Zambia's personal childbirth experiences.

2) To explore how women in Zambia reasoned and perceived the childbirth phenomenon.

3) To explore factors that contributed to women's decisions of whom and where they birthed.

1.15 Relevance of the study

The social context of each person's life and experience is shaped by social, cultural, spiritual, emotional and psychological factors (Fraser and Cooper, 2009). Irrespective of the context, women expect to have a childbirth experience that encompasses the safe delivery of the baby, as well as the physical and cognitive processes of labour and birth. According to Walsh (2007), when safety relates to physical aspects only, other aspects of the experience, such as psychological safety, may be underestimated. Therefore, the responsibility of a birth attendant is not only to ensure a safe delivery, but to create a positive and satisfying childbirth experience (Chen *et al.* 2001). A phenomenological study such as this is essential in conducting this kind of study because the findings convey knowledge that has potential to aid maternity healthcare stakeholders to better understand childbirth from the perspectives of women they provide care to. According to Bondas (2011), the overall aim of using a phenomenological perspective in caring sciences such as midwifery, is not philosophical. Rather, it is the development of knowledge within the disciplinary interest. Consequently, the knowledge from such a study can assist in the development, implementation and evaluation of interventions that contribute to improvement of the birthing experience, as well as the outcomes for women giving birth in Zambia.

1.16 Summary

This chapter introduced the topic of childbirth experience, which is being explored in this study. The chapter began with providing the thesis structure as well as highlighting the motivation for conducting the study. The purpose of the study, the study question, the significance and the relevance of the study, have also been elaborated. To shed light on available information on childbirth as well as highlight the gaps, the next chapter reviews existing literature on the study topic.

CHAPTER 2: LITERATURE REVIEW

2.1 Introduction

This chapter presented reviewed research literature on childbirth. The review was intended to bring to light current knowledge on women's experiences of childbirth, thus providing context for the study, as well as identifying gaps in the existing literature. The literature included in this review covered issues of childbirth by highlighting core areas that impact on women's experiences namely: cultural and family related issues, gender related issues, educational issues, practical barriers faced by care providers and birthing women, and trauma and abuse experienced by women during childbirth. The search included both qualitative and quantitative studies. During the process of literature search, it was appreciated that a review of all types of women's birthing experiences was an extensive undertaking. Therefore, in order to contextualise the information in relation to the study setting, the review focused on women's birthing experiences from sub-Saharan Africa. To broaden the information, studies from other low income countries in other regions were included.

2.2 Searching for literature

The search engines that were used to access relevant articles were: Cumulative Index to Nursing and Allied Health Literature (CINAHL), PubMed, Scopus, PsychInfo, Midwifery Information and Resource Service (MIDIRS), ASSIA, MEDLINE, BNI, AMED and EMBASE. To ensure that as many articles on childbirth experience as was possible were included, searches of online publications using GOOGLE as well as manual searches of hard copies of journals and research dissertations that were not available online were undertaken. Reference lists of all included studies were hand-searched to identify additional studies. Key words and free-text terms that were used to identify articles were: childbirth experience,

birthing, delivery, sub-Saharan Africa, low income countries, women, maternal mortality, qualitative research, phenomenology and Zambia. The key words and free-text terms were used singularly and in combination.

The review revealed that there were a number of studies on childbirth from the sub-Saharan African region, as well as other low income countries from other regions. However, the studies had little empirical evidence on the childbirth experience. For instance, qualitative studies by Sialubanje, Massar, van der Pijl, Kirch, Hamer and Ruiter, (2015); Some, Sombie and Meda, (2013); and Magoma, Requejo, Campbell, Cousens and Fillipi, (2010) presented findings that indirectly commented on childbirth. Nevertheless, the experience could not be expounded due to methodological limitations. Phenomenological studies such as the ones by Mubuuke, (2014); Nyoni and Serpell, (2012); and Namakando-Phiri, (2004) that were found could not be included in the review because they were not specific to childbirth. Apart from the qualitative studies on childbirth, there were also a number of studies that utilised survey information from DHS reports from different sub-Saharan African countries that were included in the review. The 30 articles included in this study's literature review are summarised in Table I.

Before the decision to focus on studies from the sub-Saharan and other low income countries was reached, a number of phenomenological studies on childbirth from high income countries were found. In contrast to the studies from the sub-Saharan African region and other low income countries, a lot of studies from high income countries utilised qualitative approaches, such as phenomenology to understand the experience. Phenomenological studies

such: Nilsson and Lundgren, (2009); Thomson and Downe, (2008); Beck, (2006); Edwards, (2005); Lundgren, (2004); Gibbins and Thomson, (2001) offered insights on the experience. For example, in the UK, Thomson and Downe (2008) conducted a study to explore the lived experience of, and personal meanings attributed to a traumatic birth. An interpretive phenomenological approach was adopted based on Heideggerian and Gadamerian hermeneutics. Study participants were 14 women who had experienced a self-defined traumatic birth. Data were collected through in-depth interviews. An interpretive analytical approach was utilised to uncover resonant meanings across the participants' birth narratives. The study findings were that trauma was not related to mode of birth, but to fractured interpersonal relationships with caregivers. Three interpretive themes emerged from the analysis: 'being disconnected', 'being helpless' and 'being isolated' (Thomson and Downe, 2008). Synthesis across these themes revealed that for study participants, their self-defined traumatic birth was experienced as violent and abusive. Some described their experience as torture, resulting in a profound sense of being disassociated from the childbirth experience and annihilated from societal regard. Thomson and Downe (2008) concluded that taking a strictly hermeneutic perspective, the findings exposed commonalities between some descriptions of traumatic birth and victims' accounts of violent or abusive criminal offences, even in the case of clinically normal births.

Earlier in Sweden, Lundgren (2004) conducted a qualitative study grounded in phenomenology and hermeneutics that synthesised results from four selected studies focusing on women and midwives' experiences of the encounter during childbirth, as well as experiences of pregnancy from the women's perspective. The setting of the study was the Alternative Birth Care Centre (Sahlgrenska University Hospital, Goteborg) and Karolinska

Hospital (Stockholm, Sweden). Her findings were that the essential structure or key theme of the experience could be conceptualised under the heading: 'Releasing and relieving encounters'. For the woman, it constituted an encounter with herself, as well as with the midwife, and included stillness as well as change. Stillness was expressed as presence and being in one's body. Change was expressed as a transition to the unknown and to motherhood. For the midwife, stillness and change equalled being both anchored and a companion. To be a companion was to be an available person who listened to and followed the woman through the process of childbirth (Lundgren, 2004). To be anchored was to be the person who respected the limits of the woman's ability, as well as her own professional limits in the transition process (Lundgren, 2004). A releasing and relieving encounter implied a sharing of responsibility and participation for women. Key implications were that there was a need to understand the phenomenon as a unique feature, which differed from other caring encounters and should be further studied (Lundgren, 2004).

Table I: Summary of studies included in literature review

Year	Researcher/s	Country	Methodology	Number of participants	Purpose
2015	Bohren *et al.*	34 low, middle and high income countries	Mixed methods systematic review	65 studies	To synthesise qualitative and quantitative evidence on the mistreatment of women during childbirth in health facilities to inform the development of an evidence-based typology of the phenomenon.
2015	Okafor *et al.*	Nigeria	Questionnaire-based, cross-sectional study	446 women	To determine the prevalence and pattern of disrespectful and abusive care during facility-based childbirth in Enugu, south-eastern Nigeria.
2015	Sialubanje *et al.*	Zambia	Qualitative	32 women	To explore women's experiences and beliefs concerning utilisation of MWHs in rural Zambia.
2014	Darteh *et al.*	Ghana	Survey	3124 women	To investigate factors that affect decision making on engaging in sexual intercourse and use of condom among women aged 15–49.
2014	Kruk *et al.*	Tanzania	Quantitative	1779 women (exit survey) 593 five to ten weeks postpartum	To measure the frequency of self-reported abusive experiences of women during a facility exit survey and during a follow-up survey with a sub-sample of the same women five to ten weeks postpartum.
2014	Sando *et al.*	Tanzania	Quantitative		To explore whether women living with HIV were more vulnerable to mistreatment during childbirth in Dar-es-salaam, Tanzania.

2013	Agadjanian *et al.*	Mozambique	Survey	1680 women	To examine both the probability of having an institutional delivery as a function of individual and household characteristics and of location and characteristics of MCH facilities in rural Mozambique.
2013	Ith *et al.*	Cambodia	Qualitative (Naturalistic inquiry approach)	30 women	To investigate women's perceptions and experiences of private and public skilled birth attendants, including midwives, during childbirth in Cambodia.
2013	Ono *et al.*	Kenya	Cross-sectional	303 women	To explore determinants of association between social support and place of delivery.
2013	Shiferaw *et al.*	Ethiopia	Mixed methods	(All participants were women) FGD - 23 Interviews – 8 Questionnaire – 909	To understand why women continue to prefer home delivery even when facility based delivery was available at minimal cost.
2012	Kabakyenga *et al.*	Uganda	Survey	759 postnatal mothers	To assess the influence of birth-preparedness practices and decision-making on place of birth and assistance during labour.
2011	Gabrysch *et al.*	Zambia	Survey	3,682 rural births	To quantify the effects of distance to care and level of care on women's use of health facilities for delivery in rural Zambia.
2011	Some *et al.*	Burkina Faso	Qualitative	30 women	To describe women's perceptions of homebirths in the medical districts of Ouargaye and Diapaga.

2011	Wanjira *et al.*	Kenya	Survey	409 mothers	To establish delivery practices and associated factors among mothers seeking child welfare services at selected health facilities in Nyandarua South district, Kenya.
2010	Magoma *et al.*	Tanzania	Grounded Theory	160 (interviews with 12 key informants; 15 FGDs with women, TBAs, health care providers and community members)	To examine beliefs and behaviours related to antenatal, labour, delivery and postnatal care among the Maasai and Watemi ethnic groups.
2009	Kwaleyela *et al.*	Zambia	Qualitative	40 student midwives	To explore Zambian midwifery students' perceptions of Zambian women's choice of place of delivery; either home or health facility.
2009	Nagahama & Santiago	Brazil	Exploratory and descriptive with a cross-sectional design	569 postnatal women	To characterise hospital care for childbirth in two hospitals affiliated with the Unified National Health System in Maringa, Parana, Brazil, and identify both obstacles and facilitating factors for the implementation of humanised care based on women's perception of the care received.
2008	Bazzano *et al.*	Ghana	Ethnography	2878 women	To examine the social costs of skilled attendance at birth to women in rural Ghana.
2008	Thomson & Downe	United Kingdom	Interpretive phenomenology	14 women	To explore the lived experience of and personal meanings attributed to a traumatic birth.

2007	Brown *et al.*	South Africa	Randomised control trial	1000 women	To pilot a multi-faceted intervention to encourage uptake of childbirth companions in state hospitals, and hypothesised that lay carers would improve the behaviour of health professionals.
2006	Seljeskog *et al.*	Malawi	Qualitative	6 women 2 health workers 2 TBAs	To investigate individual, community and health facility level factors influencing women's choice of place of delivery in Mangochi area.
2006	Stephenson *et al.*	Burkina Faso Ghana Ivory Coast Kenya Malawi Tanzania	Survey	Burkina Faso - 3167 Ghana - 1785 Ivory Coast - 1131 Kenya - 3058 Malawi - 6318 Tanzania – 1710 (All participants were women)	To examine community-level influences on the decision to deliver a child in a health facility across six sub-Saharan African countries.
2006	van Eijk *et al.*	Kenya	Survey	365 women	To assess provision and use of antenatal services and delivery care among women in rural Kenya.
2004	Lundgren	Sweden	Qualitative method grounded in phenomenology and hermeneutics	10 women	To synthesize the results from four selected studies describing women's and midwives' experiences of the encounter during childbirth, as well as experiences of pregnancy from the women's perspective.
2003	Kyomuhendo	Uganda	Qualitative	808 women	To enhance understanding of why, when faced with complications of pregnancy or delivery, women continue to choose high risk options leading to severe morbidity and even their own deaths.

2003	Maimbolwa *et al.*	Zambia	Qualitative	36 women	To explore cultural childbirth practices and beliefs in Zambia as related by women accompanying labouring women to maternity units.
2003	Adamu *et al.*	Nigeria	Qualitative	107 pregnant women	To identify the sociocultural and economic factors that act as barriers to women's use of antenatal care services and hospital delivery in a rural community in Kano State, Northern Nigeria.
2001	Graham *et al.*	-	-	-	To explore the scientific justification for the key action message: *'ensure skilled attendance at delivery'* by examining the historical and epidemiological evidence at both the individual and population levels of analysis.
2000	Magadi *et al.*	Kenya	Survey	Data from Demographic Health Survey	To study the variations in the use of antenatal services in Kenya.
2000	Amooti-Kaguna & Nuwaha	Uganda	Qualitative	FGD - 32 women FGD - 32 men Interviews - 211 women	To understand factors influencing choice of delivery sites in Rakai district of south-western Uganda.

2.3 Cultural and family issues

Callister (2001) asserts that one's healthcare beliefs and behaviours about the childbirth experience are deeply entrenched in a cultural context. Therefore, in as much as certain practices, such as having a social support person, particularly a husband or partner, during labour, have yielded positive birth experiences (Lundgren, 2005; Matthews and Callister, 2004; Mackinnon, McIntyre and Quance, 2003; Gibbins and Thomson, 2001), implementation of such practices may not be consistent with the traditional beliefs of people in sub-Saharan countries, such as Zambia. For example, contrary to practices in most Western countries, Zambian fathers and males in general are excluded from the actual childbirth process during home deliveries (Maimbolwa *et al*. 2003). In collaboration with available global literature (Dodou, Rodrigues, Guerreiro, Guedes, Lago and Mesquita, 2014; Lundgren, 2005; Matthews and Callister, 2004; Mackinnon *et al.* 2003; Gibbins and Thomson, 2001) highlighting the benefits of having a support person during childbirth, birthing women in Zambia are currently being encouraged to have support persons during labour and delivery (MoH, 2003). However, the preferred support persons for women birthing in Zambia are female relatives and friends and not males, even if they are husbands or partners (Maimbolwa *et al.* 2003).

In order to be conversant with cultural practices about labour and childbirth pertaining in Zambia, Maimbolwa *et al.* (2003), conducted a qualitative study, exploring cultural childbirth practices and beliefs. Data were collected by interviewing support persons who had accompanied labouring women to health institutions in Lusaka district. Some of the practices that the study elicited were that a woman in labour was not allowed to shout nor complain of pain. If she did, her baby would die during the birthing process. If labour was observed to be obstructed, birthing women were made to vomit by inserting a cooking stick over the tongue.

If labour was observed to be prolonged, it was believed the labouring woman had been unfaithful to her husband. Hence, she was asked to confess before any further assistance was offered. After confessing, the woman was then given traditional remedies aimed at increasing uterine contractions. Another practice mentioned by the study was asking a mother to sing when the umbilical cord was being cut (Maimbolwa *et al.* 2003).

In Kano State, Northern Nigeria, a study whose objective was to identify the socio-cultural and economic factors that acted as barriers to women's use of antenatal care services and hospital delivery in a rural community was done (Adamu, Salihu, Sathiakumar and Alexander, 2003). Conducted by a trained midwife in the native language of the area, data were collected through interviews with 107 pregnant women. Major barriers that were identified by the study were economic, cultural and those related to the women's perceptions of their condition. The study recommended that poverty reduction and economic empowerment of rural women were prerequisites for any tangible improvement in the utilisation of antenatal care and obstetric delivery services (Adamu *et al.* 2003).

In rural Ghana, an ethnographic study was conducted to examine the social costs of having skilled attendance at birth to women (Bazzano, Kirkwood, Tawiah-Agyemang, Owusu-Agyei and Adongo, 2008). Data obtained through participant observations, interviews, case histories and FGDs were analysed alongside data from a birth cohort of 2878 women in the Kintampo district, between July 2003 and June 2004 (Bazzano *et al.* 2008). The results of the study highlighted that most women had homebirths because, in comparison to having institutional births, homebirths raised a woman’s status in the community, seeking institutional assistance

in childbirth wasted people's time, women valued secrecy in labour, healthcare providers were perceived to have negative attitudes towards birthing women, and institutional births were seen to be expensive because of the number of items that needed to be bought (Bazzano *et al.* 2008).

Stephenson *et al.* (2006) conducted a study in six sub-Saharan African countries of Ivory Coast, Burkina Faso, Ghana, Kenya, Malawi and Tanzania. The aim of the study was to understand the factors that encouraged women to birth in health institutions, thus consequently being attended by trained medical professionals. The background to the study was that, according to WHO (2001), approximately half a million women died each year from complications of pregnancy or childbirth, with maternal mortality being disproportionately high in Africa. Therefore, the presence of trained medical staff could substantially reduce the MMR of 1000 per 1,000,000 live births in the region (Stephenson *et al.* 2006). Demographic and Health Survey data were linked with contextual data. Multilevel models were fitted to identify the determinants of a woman to birth in a health facility. The results revealed that there was a strong community-level influence on a woman's decision to give birth in a health institution. Thus, although demographic and socio-economic factors were key determinants of health-service use, the individual's cultural environment provided a strong influence on the extent to which the factors could lead to the use of health services.

The results from these studies highlighted the major role that culture played in the way a woman perceived, prepared and experienced childbirth. The results exemplified that since each culture had its own values, beliefs and practices related to pregnancy and birth, it was important for healthcare providers to familiarise themselves with the different ideas, rituals

and behavioural restrictions and prescriptions, in order to communicate effectively with birthing women. Even though expecting health care providers to know all the cultural practices of each birthing woman under their care would be impossible, use of open communication and respect when interacting with clients could assist improve the rapport between care providers and women. These findings were very important because they highlighted an integral part of the birthing process, even though they did not elucidate the experience. Thus, in order to develop an understanding of this complex issue of the childbirth experience that could not be implicit in surface responses from participants, there was a need to elucidate the experience through conducting a phenomenological study. The second core area that impacted on women's childbirth experiences was related to issues of gender.

2.4 Gender issues

For many years, the debate and research on women's decision-making in general, and in reproductive health, have been genderised within power relations, with men playing influential roles in women's decision-making (Darteh, Doku and Esia-Donkoh, 2014). In Africa, gender has a considerable impact on women's health because their access to health services, information and decision-making about their health was influenced or controlled by men (MoH, 2003). Hence, they were more vulnerable to abuse, oppression and discrimination because of their subordinate status that is deeply rooted in cultural norms (Hausmann, Tyson and Zahidi, 2008; Bank, 2005). Ministry of Health (2003) reported that 57% of married women in Zambia experience gender-based violence. Gender inequalities deprived women of their rights, autonomy and leadership (Gill and Steward, 2010), hence affecting their life prospects, specifically their reproductive behaviours (Saleem and Bobak, 2005). Information released by CSO *et al.* (2014) and MoH (2003) revealed that Zambia was no exception to the

gender inequality vice. Therefore, the need for women in Zambia to be empowered to make decisions on matters affecting their own lives has been a concern for government and policy makers. However, despite the development of a gender policy, the trends were that men still continue to make decisions for women regarding their lives, by 47% (MoH, 2003).

Some studies done in three sub-Saharan African countries of Uganda and Tanzania highlighted the fact that gender inequalities existed and influenced women's decisions to seek care during labour. Kabakyenga, Óstergren, Turyakira and Pettersson, (2012) conducted a study in south-western Uganda. The aim of the study was to assess the influence of birth-preparedness practices and decision-making on place of birth and assistance during labour. The introduction to the study stated that assistance by skilled birth attendants during childbirth was one of the strategies aimed at reducing maternal morbidity and mortality in low-income countries. Yet, the relationship between birth preparedness and decision-making on location of birth, and assistance by skilled birth attendants in the context of reducing MMR had not been well studied in Uganda (Kabakyenga *et al*. 2012). Community survey methods were used to identify 759 recently delivered women from 120 villages in rural Mbarara district. A safe-motherhood questionnaire, developed by the maternal neonatal programme of Johns Hopkins Program for International Education in Gynecology and Obstetrics (JHPIEGO), an affiliate of John Hopkins University, was used to collect data. Logistic regression analyses were conducted to assess the relationship between birth preparedness, decision-making on location of birth, and assistance by skilled birth attendants. In reference to gender, the study results were that: women's decision-making regarding place of birth was in consultation with the spouse, friends, and/or older relatives. This finding resonated with a factor that was mentioned in an earlier study by Amooti and Kabakyenga (2006). In the study, one of the factors that influenced women's use of delivery care services

in Mbarara district of Uganda was that decisions regarding place of delivery were a husband's role.

In the rural Ngorongoro district of Tanzania, Magoma, Requejo, Campbell, Cousens and Fillipi, (2010) conducted a qualitative study to investigate, among other things, perspectives of healthcare providers and TBAs on childbirth, and the factors determining where women birthed. The key aim of this exploratory study was to gain an understanding of the socio-cultural and health systems factors influencing women's decisions to seek antenatal, skilled delivery and immediate postpartum care in the district. According to Magoma *et al.* (2010), examining the barriers and facilitating factors women experience to access reproductive health services were an important first step towards identifying appropriate interventions aimed at increasing use of institutional deliveries and immediate postpartum care. The principles of Grounded Theory approach were used to elicit and assess the various perspectives of the participants. Tanzania is a sub-Saharan African country with very high and unacceptable MMR, despite a high antenatal attendance (Magoma *et al*. 2010). Only 43% of women utilise health institutions for delivery purposes (National Bureau of Statistics, 2006). Maternal health conditions in Ngorongoro district were described as reflecting the national pattern of high number of homebirths, resulting in high MMR in Tanzania. Data for the study were collected through interviews with 12 key informants, who included male and female TBAs, healthcare providers and community members. Data were also collected through 15 FGDs with Maasai and Watemi women. One finding of the study was that: women's low social status led to their inability to independently make labour and delivery decisions. Culturally, they primarily depended on older women and husbands to decide for them where to birth. Since husbands were described as gatekeepers of women's reproductive health, including decisions about where their wives gave birth, Magoma *et al.* (2010)

recommended that healthcare workers should encourage husbands to participate in reproductive health programmes.

In an earlier study that was influenced by the fact that more women in Uganda birthed at home, leading to the high MMR in the country, Amooti-Kaguna and Nuwaha (2000) conducted a study on factors influencing women's choice of delivery sites in the Rakai district. Data were collected through eight FGDs based on the Attitudes-Social influence-Self efficacy model held with 32 women and 32 men. Semi-structured interviews were held with 211 women from 21 random cluster samples of women, who had a delivery from 2 June 1997. The results were that 44% of the participants had delivered at home, 17% at TBAs' places; 32% at public health institutions and 7% at private clinics. One of the factors that were identified to influence women's choice of delivery sites was: social influences from spouses, relatives, TBAs and health workers. Amooti-Kaguna and Nuwaha (2000) thus, recommended that in order to make delivery safer for women, there was need to improve their access to maternity services, train and equip TBAs, and involve men in education about safe delivery.

The four reviewed studies highlighted an important aspect of childbirth, which is the influence of gender issues on women's reproductive health and choices. Nonetheless, although the findings are important, the childbirth experience was not expounded because of methodological limitations. The third core area in the literature review was educational issues.

2.5 Educational issues

A number of studies from sub-Saharan Africa state that the most consistent determinant of use of reproductive health services is a woman's level of education (Darteh *et al.* 2014; Stephenson *et al.* 2006; Magadi, Madise and Rodrigues, 2000). The studies mention that although demographic and socio-economic determinants' use of reproductive health care were mediated by cultural influences on health-seeking behaviour that shaped the way individuals perceived their own health, and available health services; formal education had an impact on the way a woman thought. In other words, increasing the education level of a woman increased her decision-making power, thereby influencing her use of maternity services.

Despite the study not being specific to childbirth, in Ghana, Darteh *et al.* (2014) conducted a study investigating factors that affect decision making on engaging in sexual intercourse and use of condom by women aged 15 to 49 years. The study was influenced by the fact that in many sub-Saharan African countries, women's reproductive health decision-making and choices, including engaging in sexual intercourse, use of condoms and childbirth were shrouded in secrecy (Darteh *et al.* 2014). A sample of 3124 women from the 2008 Ghana DHS data was used. Multivariate logistic regression was used to study the association between women's economic and socio-demographic characteristics and their decision-making. The study results showed that one out of five women reported they could not refuse their partners' request for sexual intercourse. One out of four indicated they could not demand the use of condoms by their partners. Women aged 35–49 were more likely to make decision on engaging in sexual intercourse compared to those aged 15–24. One of the main factors that affected women's decision making was education. The higher a woman's education status was, the more likely she was to make the decision to use or not use a

condom during sexual intercourse (Darteh *et al.* 2014). If a woman had primary or secondary education, she was more likely to make the decisions regarding engaging in sexual intercourse, compared to a woman who had no formal education. Furthermore, women who were in the richest, rich and middle-wealth index categories were more likely to make the decision regarding engaging in sexual intercourse, as well as condom use, compared to the poorest (Darteh *et al.* 2014). The conclusion of the study was that interventions and policies geared to empowering women to take charge of their reproductive health, should focus particularly on women from less wealthy backgrounds and those with low educational attainments (Darteh *et al.* 2014). The findings of Darteh *et al.* (2014) were in agreement with the statement from Stephenson *et al.* (2006) that education was one determinant that could influence a woman's decision-making irrespective of her traditional beliefs or cultural environment.

In Kenya, Magadi *et al.* (2000) did a study on the frequency and timing of antenatal care, in order to explain the variations between women of different socio-demographic characteristics. The background to the study was that although appropriate antenatal care was important in identifying and mitigating risk factors in pregnancy, many mothers in low income countries did not receive such care, hence leading to high MMR. The study used data from the 1993 Kenya DHS. Analysis was based on modelling the frequency and timing of antenatal visits, using three-level linear regression models. The results showed that the use of antenatal care in Kenya was associated with a range of socio-economic, cultural and reproductive factors. However, the level of a woman's education had a major impact on her decision to attend antenatal care (Magadi *et al.* 2000). Educated women were reported to have a pragmatic attitude to traditional practices and hence, they may not be interested in following the practices, while those without may consider it important to adhere to traditional

pregnancy and childbirth practices. The fourth core area was practical barriers that care providers and birthing women face.

2.6 Practical barriers faced by care providers and birthing women

Review of literature revealed that care providers and birthing women faced practical barriers in the provision and access of acceptable standard maternity care, respectively. The place of delivery was consistently identified to be a major factor impacting high MMR and morbidity in sub-Saharan Africa (CSO *et al.* 2014; National Bureau of Statistics, 2006; Government of Malawi, 2000). Homebirths were said to contribute to the persistently high MMR, whereas, health institutional births attended by skilled attendants were associated with lower MMR (Bell, Hussein, Jentsch, Scotland, Bullough and Graham, 2003). With this in mind, one would have expected more women to choose to birth in health institutions. Ironically, according to the findings of Abeje, Azage and Setegn (2014); Shiferaw, Spigt, Godefrooij, Melkamu and Tekie (2013); Magoma *et al* (2010); CSO *et al.* (2014); Seljeskog *et al* (2006); Amooti-Kaguna and Nuwaha (2000); Government of Malawi (2000); and Maimbolwa, Ransjo-Arvidson, Ng'andu, Sikazwe and Diwan (1997), homes were the favoured choice of place of delivery for most women birthing in sub-Saharan Africa.

A cross-sectional study was conducted from September to November 2011 at Sosiot Health Centre, Kericho West District, Kenya by Ono, Matsuyama and Karama (2013). The aim of the study was to explore determinants of association between social support and place of delivery. Participants were 303 mothers who brought their babies to the health centre for immunisation within their first year of life (Ono *et al.* 2013). Background to the study was that an estimated 358,000 maternal deaths still occurred worldwide each year (Ono *et al.*

2013). Most of these deaths occurred in sub-Saharan African region where the place of delivery was of great significance to the reduction of maternal mortality. Socio-economic factors, cultural traits and local customs were associated with health-seeking behaviours (Ono *et al*. 2013). Study participants underwent structured interviews using a questionnaire on demographic characteristics and their experiences of delivery, including place of delivery and social support. The results of the study highlighted that:

a) The proportion of deliveries in health facilities was significantly higher among unmarried women.
b) Unmarried women whose mothers supported them in housework and whose sisters helped them fetch water were more likely to deliver at health facilities than those without this support.
c) In contrast, married women whose husbands supported them in farming and whose neighbours helped them fetch water were less likely to deliver at health facilities.
d) Married women who were advised to deliver at a health facility by their mothers-in-law or health staff were more likely to deliver at health facilities than those who did not receive this advice.
e) Married women were more likely to deliver at health facilities if they were highly educated, had financial capability, had medical insurance, were primiparous, did not have the support of sisters-in-law for fetching water or were advised to deliver at a health facility by family members or neighbours.

From a town (name of the town is not mentioned) in rural southern Mozambique, Agadjanian, Yao and Hayford (2013) used longitudinal data to examine both the probability of having an institutional delivery as a function of individual and household characteristics and of location, and characteristics of MCH facilities. The aim of the study was to develop an

explanation for non-health institutional deliveries that took into account women's household socio-economic characteristics of age, parity, education, involvement with organised religion, characteristics of their marital unions and the material conditions of their households. Women's reproductive backgrounds and experiences in utilising MCH services in the event of reproductive mishaps such as miscarriages or stillbirths, prior to the focal pregnancy, the number of antenatal consultations during the focal pregnancy, exposure to the expanding HIV services in the study area, and characteristics of MCH clinics, were taken into consideration. In addition, environmental aspects of the services, such as distance from women's residences to nearest health facility, village distance from the nearest town, and seasonal factors, such as pregnancies and deliveries occurring during the dry season, and those during the rainy season when travelling is difficult, were looked into (Agadjanian *et al.* 2013). The results of the study showed that educated women and women from affluent households were more likely to deliver at a health facility, irrespective of the effects of environmental factors or previous experiences of reproductive mishaps. This result was similar to results from studies by: Darteh *et al.* (2014); Onah, Ikeako and Iloabachie (2006); Stephenson *et al.* (2006); MacKeith *et al.* (2003); and Magadi *et al.* (2000).

Background to an explorative study on factors influencing women's choices of place of delivery in rural Malawi, was that more than 500,000 maternal deaths were occurring worldwide (Seljeskog *et al.* 2006). The majority of the deaths were divided between the continents of Africa and Asia. Despite the enhanced focus and awareness of high MMR in the two continents the past decades, the situation had not improved (Seljeskog *et al.* 2006). The aim of this exploratory study was to identify individual, community and health facility level factors that were influencing women's choice of place of delivery in the rural district of Mangochi. Data were collected through semi-structured in-depth interviews with six women

who had recently given birth. Three of the women had homebirths. The other three had institutional deliveries. Two health workers and two TBAs were included as key informants. The profession of the two healthcare workers included in the study was not mentioned. In addition to the interview, non-participant observations and FGDs were conducted. The interviews focused on:

i) Women's experiences and preferences for delivery care, and their ideas about barriers to use of professional maternity care.

ii) Women's perceptions and interpretations of danger signs during pregnancy.

iii) Influencing factors and decision-makers in families and local communities.

The results of the study were that, many women delivered from home because of:

a) Sub-optimal quality of care related to poor communication between healthcare providers and women.

b) Negative staff attitudes and inadequate equipment in health institutions.

c) Choice of place of delivery, which was influenced by decision-makers, who were either spouses or older female relatives.

d) Long distance to health centres.

e) Lack of transport to health centres, and

f) Lack of privacy during childbirth.

Therefore, even if a woman viewed or experienced something she thought could be a danger sign based on the information given to her by healthcare professionals during antenatal care, traditional views superseded the woman's preference. Provision of privacy to birthing women was reportedly difficult to achieve during an institutional delivery because all women delivered in one room on beds separated only by curtains (Seljeskog *et al* (2006). In Malawi only 41% of deliveries occurred in health institutions (Government of Malawi, 2000).

In an earlier study, conducted in a western district of Uganda, by Kyomuhendo (2003), the barriers that led to women not utilising health institutions for birthing services were:

a) Lack of skilled staff in health institutions.

b) Abuse and neglect by health professionals in health institutions, and

c) Poorly understood procedures in health institutions.

In Uganda, lack of resources and skilled staff to improve quality and delivery of maternity services are mentioned as factors that have led to a decrease in utilisation of maternity care services by women. This is despite good policies and concerted efforts to put in place interventions to reduce the high ratio of maternal deaths in the country (Kyomuhendo, 2003). This study was conducted in Hoima, a rural district in western Uganda. The aim of the study was to enhance understanding of why, when faced with complications of pregnancy or delivery, women continued to choose high-risk options, leading to severe morbidity and even their own deaths. The findings demonstrated that women's utilisation of health institutions for birthing was considered only as a last resort. Complaints of abuse, neglect and poor treatment in health facilities, and poorly understood reasons for procedures, plus health

workers' views that women were ignorant, also explained the unwillingness of women neither to deliver in health facilities nor to seek care for complications (Kyomuhendo, 2003). Adherence to traditional birthing practices and beliefs that, pregnancy was a test of endurance, while maternal death was viewed as a sad but normal event, were other important practical factors that were associated with women's choice of place of birth (Kyomuhendo, 2003).

A qualitative study done in Zambia by Kwaleyela, Gottval, Maimbolwa, and Ransjo-Arvidson (2009) looked at the situation of low utilisation of health institutions for childbirth services. The researchers studied the phenomenon from the perspective of nurses. Data were collected through four FGDs with 40 nurses pursuing midwifery training at the UTH School of midwifery. Background information was that, in Zambia, 57% of births occurred at home, under the supervision of unskilled attendants, thus posing danger to the lives of birthing mothers and their infants. With reference to statistics from the 2001-2002 ZDHS (CSO *et al.* 2003), which stated that nearly two thirds of mothers who died in childbirth had delivered at home, and most of the maternal deaths reported in health facilities were as a result of late referrals from homebirths; the purpose of the study was to explore Zambian nurses' perceptions of women's choices of place of delivery. In addition to the findings from Malawi by Seljeskog *et al.* (2006), from Tanzania by Magoma *et al.* (2010), and from Uganda by Kabakyenga *et al.* (2012); Kwaleyela *et al.* (2009) reported that lack of privacy during institutional births contributed to women's preference for homebirths. The study participants explained that it was difficult to maintain privacy during an institutional birth because of the geographical layouts of public health institutions' labour wards. Similar to the situation in Malawi (Seljeskog *et al*. 2006), birthing women in the Zambian study were attended to in one room divided by curtains only. This practice was in contrast to the traditional aspect that

stipulates that birth should be conducted in seclusion and secrecy (Maimbolwa *et al.* 2003). The participants stated that midwives had inadequate powers to control programmes, such as the provision of privacy to birthing women. What the study could not expound was how the women interpreted their experiences of birthing in an environment that did not provide privacy. The recommendation of the study was that, in order for midwives to offer maternity services that were fulfilling to women, they needed to perceive themselves as change agents for women, and not victims of external factors over which they had no influence (Kwaleyela *et al.* 2009). One way that this could be done would be by having a clear understanding of how women experienced and interpreted childbirth.

In Burkina Faso, Some *et al.* (2011) conducted a qualitative study describing women's perceptions of homebirths in two rural medical districts of Ouargaye and Diapaga. The background to the study was that in developing countries, childbirth mostly occurred at home assisted by unskilled attendants (Some *et al*. 2011). The situation thus, increased the risk of morbidity and mortality of mothers and infants. Data were collected by using FGDs and individual interviews with 30 women. The findings showed that homebirths in Burkina Faso were frequent because of prohibitive distance to health facilities, fast and/or easy labours, financial constraints and lack of decision making power to go to health facilities (Some *et al*. 2011). The researchers echoed the need for stakeholders to make health facilities easily available to rural inhabitants in anticipation of maternal and child deaths in the two districts.

A study whose aim was to establish delivery practices and associated factors among mothers seeking child welfare services was done at selected health facilities in Nyandarua South district, in Kenya, by Wanjira, Mwangi, Mathenge, Mbugua and Ng'ang'a (2011). The study

was conducted to determine whether mothers were receiving appropriate delivery care. A hospital-based cross-sectional survey among women, who had recently delivered in the study area, was carried out between August and October 2009. Binary Logistic regression was used to identify factors that predicted mothers' delivery practices. Study results were that utilisation of skilled delivery attendance services was low with a high number of deliveries being attended in homes by unqualified persons. Recommendation from the study was that there was a need to implement cost-effective and sustainable measures, to improve the quality of maternal health services with the aim of promoting safe delivery, hence reducing maternal mortality (Wanjira *et al.* 2011).

A study utilising a mixed-methods design, employing a cross-sectional household survey, combined with in-depth interviews and FGD, among 15 to 49 year old women, explored why women in Ethiopia preferred homebirths (Shiferaw *et al.* 2013). The reasons for women's preference for homebirths over institutional ones were:

a) Women perceived TBAs who assist in homebirths to be culturally acceptable and competent workers.

b) Influence of perceived poor quality of care by midwives.

c) Previous negative experiences with health workers.

d) Women's lack of awareness on the advantages of skilled attendance at delivery.

e) Little role in decision-making, for example to birth in a health institution if a woman wanted to.

f) Women's lack of economic power in homes.

Apart from revealing factors that influenced women's choice of place of delivery, the results highlighted why women in sub-Saharan Africa chose to have homebirths rather than health institutional births, even though the outcomes appeared not to be good. Results from studies, conducted in sub-Saharan Africa, were similar to those done in low income countries from other regions. For example, in Cambodia, a low income country located in South East Asia, Ith, Dawson and Homer (2013) conducted a study to investigate women's perceptions and experiences of private and public skilled birth attendants, including midwives, during childbirth. Background to the study was that, despite available information that consideration of the needs of pregnant women and their ability and willingness to attend maternity services and pay for them, was central to the provision of accessible and acceptable care, women's satisfaction with maternity services was poorly understood in many low income countries. A qualitative design, using a naturalistic inquiry approach, was the methodology utilised for the study. Thirty individual in-depth interviews were conducted with women who had recently given birth at private and public health facilities, in one province in Cambodia. Data were analysed using a thematic approach. The findings of the study were that women's choices of health facilities were influenced by their perceptions of safety and staff attitudes. Reported barriers to the effective utilisation of public maternity services were: costs associated with the birth, staff attitudes, and a lack of supportive care during labour and in the postpartum period (Ith *et al*. 2013). Although private health care was more expensive than public health care, some women reported a preference for private birth attendants. They perceived them as providing safer and more supportive care in labour. The conclusion of the study was that although women expected to receive humane, professional, supportive and respectful treatment from public skilled birth attendants, their expectations were not always met (Ith *et al.* 2013). While removal of unexpected costs and geographical barriers were important to increasing public maternity care and service utilisation, improvements in maternity services

should also focus on addressing provider-attitudes and enhancing communication skills during labour, birth and the immediate postpartum period.

The issue of skilled attendance having an impact on reduction of MMR in low income countries was very evident in the literature. Earlier, Graham, Bell and Bullough (2001) asked whether skilled attendance deliveries alone could reduce maternal mortality in low income countries. This study by Graham *et al.* (2001), explored the scientific justification for the key action message: 'Ensure skilled attendance at delivery'. They examined the historical and epidemiological evidence at both the individual and population levels of analysis. The focus of the study was that the lack of a clear definition of a skilled attendant has, and continues to be the cause of much confusion over the role, and thus, the potential of skilled attendants (Graham *et al.* 2001). Although recent initiatives to specify minimum and additional skills had improved understanding, not only of training requirements but of the wider environment that was required for skilled attendants to function effectively, it was proposed that skilled attendance should be tailored in such a way that it encompassed a partnership of skilled attendants and an enabling environment of equipment, supplies, drugs, and transport for referral.

According to Gabrysch, Cousens, Cox and Campbell (2011) maternal mortality, in sub-Saharan Africa could be reduced if all women delivered in settings where skilled attendants could provide emergency obstetric care (EmOC) in the event that a complication arose The researchers pointed out that studies in Zambia had typically focused on household and individual factors, neglecting the influence of the health service environment on choice of delivery place. Backed with this information, Gabrysch *et al.* (2011) conducted a study in

rural Zambia, to quantify the effects of distance on care, and level of care on women's use of health facilities for birthing. The researchers compared the population's impact to that of other important determinants, such as the influence of distance on care and level of care on place of delivery, whether in health institutions or homes. Using a geographic information system (GIS), the researchers linked national household data from the 2007 ZDHS, with national facility data from the 2005 Zambian Health Facility Census. They calculated straight-line distances between women's villages and health facilities. The results of the study were that only a third of births in rural Zambia occurred at health facilities, despite having attended antenatal care. Half of all mothers giving birth in Zambia lived more than 25 km from a health facility that provided basic emergency obstetric services (Gabrysch *et al.* 2011). The researchers estimated that the impact of poor geographic access to emergency obstetric services was of similar magnitude as that of low maternal education, household poverty, or lack of female autonomy. Hence, the likelihood of a woman giving birth in a health facility under the care of a skilled birth attendant depended on factors that included, characteristics of the mother and her family, such as education level and household wealth, and aspects of the health service environment, which encompassed distance to the nearest health facility, and the quality of care provided at the health facility.

Using a population-based cross-sectional survey among women who had recently delivered, van Eijk, Bles, Odhiambo, Ayisi, Blokland, Rosen, Adazu, Slutsker and Lindblade (2006), assessed provision, use of antenatal services, and delivery care among women in rural Kenya, to determine whether women were receiving appropriate care. The background to the study was that improving maternal health was one of the UN MDGs. In Kenya, homebirths without a skilled attendant were chosen by most women, despite information that the practice in the absence of skilled professional attendants was associated with adverse infant and maternal

outcomes (van Eijk *et al.* 2006). The results of the study showed that although usage of antenatal care was high, the opportunity for healthcare workers to provide delivery services was not fully utilised, due to low use. Almost one out of five women in the study had births that were not assisted by health professionals (van Eijk *et al.* 2006).

In an attempt to respond to the findings of such studies and thus, overcome physical and logistical barriers, such as long distance and high transportation costs to healthcare facilities faced by women living in rural areas, maternity waiting homes have been established in many sub-Saharan countries, including Zambia (Stekelenburg, Lonkhuijzen, Spaans and Roosmalen, 2006). The aim of constructing maternity waiting homes is to improve women's utilisation, as well as improving their access to health facility-based skilled delivery services. Sialubanje *et al.* (2015) conducted a study that explored women's experiences and beliefs concerning utilisation of maternity waiting homes in rural Zambia. The results were that most women appreciated the important role maternity waiting homes played in improving access to skilled birth attendance and improving maternal health outcomes. However, several factors such as, lack of decision-making autonomy, prevalent gender inequalities, low socio-economic status and socio-cultural norms prevented many women from utilising the maternity waiting homes (Sialubanje *et al.* 2015).

Antenatal care visits constitute one of the few times that women in low income countries seek care for their health. The visits present maternity healthcare providers with an opportunity to help women prepare for birth, and inform them about pregnancy-related complications, as well as advantages of skilled delivery care (Campbell and Graham, 2006; Carroli, Rooney and Villar, 2001). Efforts to understand the complex factors underlying the discrepancy

between high utilisation of antenatal care and low use of institutional deliveries, has been a research topic for a number of studies from the region (Agadjanian *et al.* 2013; Magoma *et al.* 2010; Amooti and Kabakyenga, 2006; Seljeskog *et al.* 2006; Maimbolwa *et al.* 2003). The following are examples of antenatal care attendances in some sub-Saharan countries: Uganda, 94% (Uganda Bureau of Statistics and Macro, 2001); Malawi, more than 95% (Government of Malawi, 2000); Tanzania, more than 90% (Bureau of Statistics, 2006) and Zambia, more than 96% (CSO *et al.* 2014). Inconsistently, at least 20% of pregnant women who attend antenatal do not seek health institutional care for birth (WHO, 2003). In studies conducted in sub-Saharan Africa by Magoma *et al.* (2010); Amooti and Kabakyenga (2006); Seljeskog *et al.* (2006); and Maimbolwa *et al.* (2003), the reasons given by women for attending antenatal care services were to:

a) Establish the size of pregnancy by dates and gestational age of the foetus.

b) Find out whether the foetus is lying in a proper position.

c) Establish whether pregnancy is progressing well.

d) Receive treatment for various ailments.

e) Seek advice on how a pregnant woman should look after herself.

f) Obtain an antenatal attendance card because it guaranteed free institutional health care in the event that a problem arose during a homebirth.

From the physical perspective, there are clinical reasons for believing that the risk of maternal death could be reduced by skilled attendance, particularly since the causal pathways could be specified. A measure of the proportion of deliveries assisted by skilled attendants

was one of the indicators of progress towards achieving MDG 5, which aimed at improving maternal health. However, the theory of how skilled attendance in sub-Saharan Africa could work in reducing MMR has not yet been rigorously tested because how women experience childbirth has not been explored. Hence, the available empirical evidence seems flawed, owing either to study designs that fail to explicate key factors that determine birthing women's decision making powers regarding choice of place of delivery, and/or their interpretation of a skilled attendant. The lack of this information could be associated to the reasons why many women in sub-Saharan Africa have enthusiastically embraced antenatal care services, and not birthing services. Increasing the proportion of women delivering in health facilities is challenging as it requires comprehensive efforts to overcome socio-cultural, economical, geographical and infrastructural obstacles (Amnesty International, 2006). Although the findings from these studies are essential, they cannot expound the experience. The fifth core area of this literature review tackled the issues of trauma and abuse experienced by women during labour and childbirth.

2.7 Trauma and abuse experienced by women during childbirth

Every woman has the right to dignified and respectful sexual and reproductive health care, including during childbirth (Cottingham, Kismodi, Hilber, Lincetto, Stahlhofer and Gruskin, 2010), as highlighted by the Universal Rights of Childbearing Women charter (Cook, Dickens and Fathalla, 2003). Therefore, mistreatment of women during childbirth represents a violation of women's fundamental human rights (d'Ambruoso, Abbey and Hussein, 2005; d'Oliveira, Pires, Diniz and Schraiber, 2002; Ezedinachi, Ross, Meremiku, Essien, Edem, Ekure and Ita, 2002) and can serve as a powerful disincentive for women to seek care in facilities for their subsequent births (Family Care International, 2010). World Health Organisation is calling for research, action, advocacy, and dialogue on this important public

health issue, in order to ensure safe, timely, and respectful care during childbirth for all women (Behruzi, Hatem, Fraser, Goulet, Ii and Misago (2010). Likewise, respectful care is a key component of both the mother-baby friendly birthing facilities initiative and the WHO vision for quality of care for childbearing women and newborns (Family Care International (2007). Freedman and Kruk (2014) define disrespect and abuse during childbirth, as an interaction of facility condition that local consensus deem to be humiliating or undignified, as well as, interactions or conditions that are experienced as or intended to be humiliating or undignified.

Bohren, Vogel, Hunter, Lutsiv, Makh, Souza, Agular, Coneglian, Diniz, Tuncalp, Javadi, Oladapo, Khosia, Hindin and Gulmezoglu (2015) conducted a mixed-methods systematic review on the mistreatment of women during childbirth in health facilities globally. Background information for the review was that despite growing recognition of neglectful, abusive and disrespectful treatment of women during childbirth in health institutions, there was no consensus at a global level on how these occurrences were defined and measured. The aim of the review was to synthesise qualitative and quantitative evidence on the mistreatment of women during childbirth in health facilities, to inform the development of an evidence-based typology of the phenomenon (Bohren *et al.* 2015). A total of 65 studies from 34 countries on the mistreatment of women during childbirth across all geographical and income-level settings were included in the review. Qualitative findings were organised under seven domains: 1) 'Physical abuse', 2) 'Sexual abuse', 3) 'Verbal abuse', 4) 'Stigma and discrimination', 5) 'Failure to meet professional standards of care', 6) 'Poor rapport between women and providers', and 7) 'Health system conditions and constraints' (Bohren *et al.* 2015). Physical abuse (McMahon, George, Chebet, Mosha, Mpembeni and Winch, 2014; Crissman, Engmann, Adanu, Nimako, Crespo and Moyer, 2013) during childbirth was

reported to be perpetuated by nurses (Moyer, Adongo, Aborigo, Hodgson and Engmann, 2014; Kruger and Schoombee, 2010), by midwives (Ith and Dawson, 2013; Mselle, Moland, Mvungi, Evjen-Olsen and Kohi, 2013; Rahmani and Brekke, 2013), and by doctors (Rahmani and Brekke, 2013; Miller, Cordero, Coleman, Figueroa, Brito-Anderson, Dabagh, Calderon, Caceres, Fernandez and Nunez, 2003). Women sometimes reported specific acts of violence, but often referred to the experiences more generally, describing beatings, aggression and the use of extreme force (El-Nemer, Downe and Small, 2006; Grossman-Kendall, Fillipi, De Koninck and Kanhonou, 2001). Hitting and slapping with an open hand or an instrument were most commonly reported specific acts of physical abuse (Rahmani and Brekke, 2013). Women also reported being pinched, particularly on the thighs (Human Rights Watch, 2011) and kicked (Moyer *et al.* 2014). Some women were physically restrained during labour with bed restraints (Teixeira and Pereira, 2006) and mouth gags (Mselle, Kohi, Mvungi, Evjen-Olsen and Moland, 2011).

A quantitative study by Kruk, Kujawski, Mbaruku, Ramsey, Moyo and Freedman (2014) explored mistreatment among women in rural Tanzania. It was based on women's self-reported experiences during a facility exit survey and during a follow-up survey with a sub-sample of the same women, five to ten weeks postpartum. The proportion of women who reported experiencing any mistreatment during childbirth was 19.5% in the facility exit survey, and 28.2% in the follow-up survey (Kurk *et al.* 2014). Common specific experiences included 'non-dignified care', 'shouting or scolding', 'neglect', and 'physical abuse' (Kurk *et al.* 2014).

In Dar-es-salaam, Tanzania, a quantitative study by Sando, Kendall, Lyatuu, Ratcliffe, McDonald, Mwanyika-Sando, Emil, Chalamilla and Langer, 2014) explored whether women living with HIV were more vulnerable to mistreatment during childbirth. It was based on interviews with women at three to six hours postpartum, and direct observations of labour. The proportion of women who reported experiencing any form of mistreatment was 12.2% in HIV positive women, and 15% in HIV negative women (Sando *et al.* 2014). The direct observations of labour recorded the following types of mistreatment: 'partitions did not provide privacy' to women during childbirth and 'women were not asked for consent during vaginal examination' (Sando *et al.* 2014).

Okafor, Ugwu and Obi (2015) explored mistreatment in a teaching hospital in south-eastern Nigeria. Data were collected through interviews with a convenience sample of women accessing newborn services at an immunisation clinic. Almost all of the women reported at least one type of mistreatment during childbirth (Okafor *et al.* 2015). Women reported experiencing physical abuse during childbirth that included being: 'restrained or tied down during labour', 'beaten, slapped or pinched', and 'sexually abused by health workers' (Okafor *et al.* 2015). The results were similar to studies from other low income countries. In a randomised controlled trial in South Africa, 84.5% of women were reported not to have been allowed companionship during childbirth, and 4.3% reported being slapped or struck (Brown, Hofmeyr, Nikodem, Smith and Garner, 2007). A cross-sectional study from Brazil showed that companions were often not allowed in the labour or delivery ward, and women were shouted at or slapped during childbirth (Nagahama and Santiago, 2008). Despite the agreed importance among maternal health and human rights stakeholders of achieving respectful, non-abusive care for all women, there has been a relative lack of formal research around the topic (Bowser and Hill, 2010).

2.8 Summary

The body of evidence reviewed in this chapter suggests that there is a plethora of studies about childbirth that have been conducted in sub-Saharan Africa, and other low income countries from other regions. However, the global burden of pregnancy related deaths in low-income countries, particularly in sub-Saharan Africa has not changed despite extensive programme approaches. The studies suggest underlying cultural complexities and an understanding of childbirth that fails to fit the biomedical paradigm of the medicalisation of childbirth. An unfortunate aspect of the biomedical paradigm is the lack of contextual information. Many women in low income countries prefer to birth at home in the care of TBAs or relatives who understand the norms and practices associated with childbearing in their cultures. How childbirth at individual level is influenced by the broader socio-economic, cultural and political spectrum is not explicated because the studies have only been able to answer the 'what and why' aspects of childbirth. Due to methodological limitations, the reviewed studies have not been able to explicate the 'how' aspect, which is the aim of this study. Nevertheless, the findings of the reviewed studies highlighted important targets for interventions and suggest a need to provide women with skills and resources to ensure decision-making autonomy and address the prevalent gender and cultural norms that debase their social status. Thus, in order to provide starting points for the design of public health interventions that focus on promoting women's access to skilled birth attendance services, insight is needed into women's experiences of childbirth. The gaps identified in the literature review supported the aim of this study, which was to gain a better understanding of childbirth experiences of women birthing in Zambia. The next chapter describes the methodology and methods that were utilised to conduct this study.

CHAPTER 3: METHODOLOGY AND METHODS

3.1 Introduction

In this chapter the methodology and methods that were utilised to conduct this study are presented. This qualitative study utilised interpretive phenomenology to provide an understanding of the meaning of childbirth through the lens of 50 women who gave birth in Zambia between 2005 and 2011. Selection of the methodology was driven by the research question: "How do women birthing in Zambia experience and give meaning to the childbirth phenomenon?"

According to Polit and Beck (2012) the pioneers of phenomenology are Edmund Husserl (1858 – 1938) and his student, follower, and later a leader in his own right, Martin Heidegger (1889 – 1976). The works of these two philosophers in relation to the development of phenomenology were examined to give an overview of the theoretical underpinning of the study. Also included in the chapter are the researcher's personal thoughts and a brief critique of phenomenology. Information on participants' demographic characteristics, how participants were recruited to the study, the study setting, data collection techniques, ethics issues, and how data were analysed are also discussed in this chapter.

3.2 Choosing the methodology

Before settling to utilise interpretive phenomenology, time was spent trying to find a methodology that would appropriately answer the research question. Two other qualitative methodologies that were considered were: grounded theory and ethnography. After a lot of searching, interpretive phenomenology was found to be more appropriate for the study

because it had a greater perspective that could lead to a better understanding of the phenomenon being studied. Polit and Beck (2012) mention that phenomenology was a qualitative research methodology with roots in philosophy that focuses on the lived experiences of human beings. The term phenomenology was derived from the Greek word *"phainoemn"* meaning *"*appearance*"* (Holloway and Wheeler, 2010, p170). Greatrex-White (2008) mentions that phenomenology is the study of experience or phenomena. It aims at gaining a deeper understanding of the nature of human beings' everyday experiences. Thus, it helps to understand the lived experiences of people. In the case of this study, how do women birthing in Zambia experience and interpret childbirth?" Through the concept of 'Dasein,' loosely translated 'Being-there', Heidegger (1998) provides meaningful insights into an individual's ontological lifeworld, in the sense that the way an individual experiences phenomena is influenced by the whole context of her or his own life. According to McLeod (2001), phenomenology is partly about the epistemological question regarding the theory of knowledge - how we know, as well as the ontological question - how things really are. In other words, epistemology is about the way we know things, whereas ontology is about what things are. Hence, phenomenology tries to discover the relationship of the person who knows, and what can be known in relation to the nature of reality and our knowledge about it (Merleau-Ponty, 1995/1945).

Discussions on phenomenology have their origins in the philosophy championed by Edmund Husserl, a Germany philosopher and mathematician (Greatrex-White, 2004). According to Ehrich, (2005), phenomenology emerged in the late 19th century as a challenge to the then dominant positivist view of philosophy and psychology. Whereas, positivistic studies gave valuable information and played a part in the attainment of knowledge, they however, were

unable to interpret experiences of people as they were encountered (Thomson, 2011). This was the appeal and contribution of the phenomenological approach to this study.

Grounded theory, which was one of the qualitative methodologies that was considered for use in this study, has its origins in symbolic interactionism. This paradigm embraces the view that individuals engage in a world that requires reflexive interaction as averse to environmental response (Goulding, 2005). As the name suggests, this qualitative methodology reflects theory that is grounded in the words and actions of the individuals under study (Fletcher-Watson, 2013). The other distinguishing aspect between phenomenology and grounded theory is that, grounded theory relies on a constant comparative analysis process to find out patterns and commonalities within human experience (Gelling, 2011). In the case of this study, the aim was not to develop theory, nor to find out patterns and commonalities of how childbirth was experienced in Zambia. Rather, the purpose was to get a better understanding of how childbirth was experienced and interpreted by women birthing in Zambia. In other words, it was not only the patterns and commonalities that were important, but rather the experiences of women, both individually and collectively.

The roots of ethnography, which was another qualitative methodology that was considered, lay in cultural anthropology, with focus on small-scale societies. The distinguishing aspect between phenomenology and ethnography is that the original central concept of ethnographic studies is a concern with the nature, construction and maintenance of culture (Goulding, 2005). According to Goulding (2005), ethnographic studies aim to look beyond what people say to understand the shared system of meanings in a given culture. In the case of this study, the aim was to understand the meaning of the experience from the interpretation of each

individual participant, and not the shared system of meanings. In other words although the journey of having a baby may be similar for all women in terms of physiological explanations, its personal aspect makes its meaning to each woman unique. van Manen (2002) is of the opinion that it is an individual's focus on the phenomenon, which distinguishes phenomenology from other frequently used qualitative research methodologies, such as grounded theory and ethnography. Heidegger (1962/1927), the founder of interpretive phenomenology asserts that humans are embedded in their world to such an extent that subjective experiences are inextricable linked with social, cultural and political contexts. As will be revealed in the next chapter, the use of phenomenology led to the understanding that culture was just one aspect that impacts how birthing women give meaning to the childbirth experience.

3.3 Historical development of phenomenology

Since the time of Rene Descartes (1596–1650) and the introduction of the enlightenment sciences during the 17th century, a positivist epistemology dominated scientific research (Ironside, 2005). According to Thomson (2011), the basis of positivist epistemology is that there is a truth which can be objectively measured through the deconstruction and statistical measurement of discrete variables. Emmanuel Kant (1724-1804) was the philosopher who helped to create an environment wherein phenomenology could seed and blossom. He distinguished between two forms of reality: 'noumenal reality' and 'phenomenal reality' (Cerbone, 2006). Noumenal reality or noumena are the (presumed) things themselves, whereas, phenomenal reality or phenomena are the appearances, which constitute our experience (Cerbone, 2006). Thus the instant a human being observes or engages with an event or an object, it becomes a phenomenon. According to van Manen (2002), anything that

presents itself to consciousness is potentially of interest to phenomenology, be it real, imagined, empirically measured or subjectively felt. Thus, according to Kant's view, the most fundamental laws of nature are knowable, precisely because they make no effort to describe the world as it really is but rather prescribe the structure of the world as we experience it (Cerbone, 2006).

Smythe (2011) advises that to choose to do interpretive phenomenology, one needed to understand and demonstrate skills of interpretation. Hence, in the case of this study, I consolidated my understanding of phenomenology by reading the original text of Heidegger's (1995) 'Being and Time'. I learnt that within the roots of phenomenology were the ideas of epistemology and ontology that were important to both Husserl and Heidegger. However, despite this commonality, the philosophy of phenomenology as developed by Husserl and Heidegger is upheld by the transcendental/eidetic (descriptive) and hermeneutic (interpretive) ideologies, respectively (Chen, 2000). Examples of the proponents of these ideologies are Van Kaam and Colaizzi (descriptive/Husserlian phenomenology), and van Manen (interpretive/Heideggerian phenomenology).

3.4 Descriptive (Husserlian) phenomenology

Phenomenology as a philosophical movement began with Husserl's extensive writings (Giorgi, 2006). He developed phenomenology to counteract positivism and the way it was applied to human concerns (Giorgi, 2006). Positivistic studies addressed the observance of external reality, but Husserl wanted a science that observed individuals in their natural context, not as part of artificial situations (Giorgi, 2006). He criticised psychology as a science that had gone wrong, by attempting to apply methods of the natural sciences to

human issues. He charged that these pursuits ignored the fact that psychology dealt with living subjects who were not simply reacting automatically to external stimuli, but rather were responding to their own perception of what these stimuli meant (Laverty, 2003). For Husserl, the attraction of the phenomenological method was in its promise as a new science of 'Being' (Husserl, 1970). Husserl (1952/1980) argued that researchers who attended only to external physical stimuli that could not be isolated and correlated with other isolated responses not only missed important variables, but ignored context.

According to Thompson (1990), Husserlian phenomenology began as a search for the philosophical foundations of logic and then evolved into a study of the logical structures of consciousness. A characteristic of descriptive phenomenology is its focus on the structure of the phenomenon under scrutiny, in order to reveal what is common to the different ways the phenomenon presents itself (Hein and Austin, 2001). With this approach, the researcher stepped out of their 'natural attitude' and bracketed part of their world from consciousness. The 'natural attitude' was Husserl's attempt to describe the relationship of consciousness to our life experiences. Thus Husserl (1960) asserted that it was possible to approach consciousness from a standpoint that was different from the one held prior to the experience.

'Intentionality', which is having a clear intention to observe a phenomenon with as pure a mind as possible, and 'bracketing' or removing from an observation, one's own preconceived ideas, were the methods of achieving conscious recognition and therefore, pure description or 'essence' of a phenomenon (Dowling, 2011). Intentionality, according to Crotty (1996, p42) relates to the "union of object and subject". It is based on the principle that every mental act is related to some object (Moran, 2000), and implies that all perceptions have meaning

(Owen, 1994). Husserl believed that consciousness was always intentional because it was consciousness of something. It was a process where the mind was directed towards objects of study (Laverty, 2003). Thus human beings created meaning through interacting with the world and one another. Husserl (1960) proposed that one could attempt to suspend or bracket his or her presuppositions by intentionally directing one's focus on the phenomenon. In order to achieve this, Husserl (1960) believed that the essence of phenomenon could be seen and felt clearly if it was freed from all the clutter of factors, such as culture. He called this suspension 'epoche' or 'phenomenological reduction' (Giorgi, 2006). His pronouncement for this was 'Zu den Sachen selbst' or 'To the facts or things themselves' (Husserl, 1952/1980). Thus, the lifeworld is understood as what we experience pre-reflectively. It often included what was taken-for-granted or those things that were common sense (Husserl, 1970). Husserl called such common themes 'essences' (Gerrish and Lacey, 2006). Hence, "it is not our experience after we have developed or applied ways of understanding and explaining it. It is experience as it was before we thought about it" (Crotty, 1996, p53). He created his own three-step approach that involved looking at a phenomenon (Anschanng), being conscious of the phenomenon (Intentionality), and separating the phenomenon from one's beliefs and experiences (bracketing). He was concerned with looking for a truth that could be carried across time and not bound to an individual, time and place. He preferred to have the researcher detached from the research so that they could observe and study the phenomenon without preconceived ideas and theories. For example, from Husserl's standpoint, the findings of this study would entail the meaning of childbirth experience regardless of the participating women's unique and individual circumstances.

Husserl was a mathematician before he became a philosopher. He took the mathematical method of brackets in an equation being the part one attends to first. He applied this to his

philosophy. The term now meant to hold back preconceived ideas, beliefs, feelings and traditions. To bracket out information and suspending beliefs eventually uncovered the essence of an experience (Chen, 2000). This position differed from that of Heidegger.

3.5 Interpretive (Heideggerian) phenomenology

Heidegger is famous for developing interpretive phenomenology (Ehrich, 2005). Despite extending Husserl's ideas, Heidegger's work: 'Being and Time' (Heidegger, 1962/1927) was significantly different. He was sceptical about Husserl's 'phenomenological reduction', and argued that one could not begin an analysis of the self or the world around from an isolated 'I' of pure consciousness, or from the bracketed out purely rational self. Thus, he did not approve of the idea of the Cartesian subject who was separate, and who could distance herself or himself from the world and its objects. Heidegger saw the world as indivisible from being human. A person was intertwined with his/her observations, thoughts, feelings and experiences. Therefore, separating one from them was impossible. He observed that bracketing and standing back from a phenomenon could not succeed because the self was involved in the world. This involvement was part of a conscious experience and knowing. In fact, according to Heidegger (1962/1927), we awake to find ourselves thrust into this world. He referred to this as 'thrownness' (Heidegger, 1962/1927). Thrownness relates to how human beings are thrown into a world of understanding their traditions (Thomson, 2011). It provided the primordial basis through which human beings are able to engage with and make meaning of their world (Heidegger, 1962/1927). Where Husserl emphasised "a consciousness-of-the-world", Heidegger viewed it as a "being-in-the-world" (Kearney, 1994, p30). Heidegger's philosophy departs from the need to maintain objectivity. It includes background practices and one's natural standpoints as part of 'Being'. Heidegger declared that there could be no such thing as an un-interpreted fact. Facts spoke for themselves, but

through the lens of interpretation. The lenses vary depending on the viewer and her or his experiences. Thus, in the case of this study, the findings are based on the study participants' interpretations of their reflections of their individual birth experiences in response to the question: "Could you tell me how you experienced childbirth, the last time you gave birth?" While Husserl wanted a phenomenology clear of interpretations, Heidegger's phenomenology is interpretive.

Clarity or understanding of phenomenon to Heidegger comes not by being separate from the world. It instead comes by 'Being-in-the-world' or 'Dasein', and examining the modes of 'Being' (Greatrex-White, 2008). 'Being' is a central concept to Heidegger's interpretive phenomenology. Thus, 'Being-in-the-world' or 'Dasein' is vital to human interests. It therefore, cannot be pursued through traditional Cartesian objectification. According to Heidegger (1962/1927, p27), 'Dasein' involves: "looking at something, understanding, conceiving and choosing access to it". All these ways are constitutive for enquiry. In the case of this study, since it was not possible for the participants to literally get back to their personal experiences, it is acknowledged that what were narrated were individual experiences as they were remembered. Nonetheless, the birthing stories provided a platform on which someone else could understand their world. In this instance, my experiences as a Zambian woman, mother, wife and midwife educator, familiar with birthing in Zambia, enabled me to engage with the accounts in such a way that I obtained an insider's perspective of what birthing meant to each individual participant. This echoes the Heideggerian view that states that researchers use their foreknowledge or preconceptions to uncover meanings about what it is to be (Greatrex-White, 2007).

The concept of 'Being' for Heidegger (1962/1927) is a characteristic of each individual 'Dasein' as an "existential constituent of Being-in-the-world" (p163). Heidegger's work, 'Being and Time' looked at the need for an analytical reconstruction of 'Being' as exemplified by 'Dasein' (Greatrex-White, 2008). He examined ways of 'Being' called 'existentials', producing concepts such as 'Fallenness'. 'Fallenness' describes how acculturation and learned modes of 'Being' can divert one from his or her own self, truth and purpose. As long as one behaves according to his or her cultural orientation, he or she is said to be 'Fallen'. For example during the interviews, participants showed their 'Fallenness' through the sub-theme: "Compliance". One of the participants (Mrs LN) narrated how she let her aunt take her to a health facility that was not her preferred place for birthing. When prompted to clarify why she let her aunt make the decision regarding her place of delivery, the participant replied:

> *"…culture is culture and it has to be followed no matter how it makes you feel…of course I felt bad that my aunt made me do things her way, but I had no say, or control over her decision…that is culture…"*

After turning to the writings of researchers such as: Mackey (2005), Dowling (2004), Greatrex-White (2004), and van Manen (2002), who offer their own interpretation of phenomenology, I too found out that it was impossible to 'bracket' my interpretations of the childbirth phenomenon. For instance one of the participants (Mrs MN) narrated how she was in labour for more than 24 hours. Health personnel who were taking care of her eventually decided to take her for caesarean section. As she was being prepared for theatre, a White doctor passed through the ward. After checking on the patient and diagnosing the reasons why she was being taken to theatre for, the doctor advised the midwives to give the woman a

bit of time. In the meantime he prepared a cup full of concentrated sugar solution and gave it to the woman to drink. Shortly after, the woman regained her strength and managed to deliver vaginally. The participant's interpretation was that the doctor possessed magical powers because he was White. Using my foreknowledge of how most Zambians, especially the ones living in rural areas perceive White people; I understood that her interpretation was based on Zambia being a former colony of Britain. During the colonial era, White people were viewed as being superior and in possession of supernatural powers. This assertion was backed by the participant's reference to the behaviour of some healthcare providers:

> *"There are some nurses who have too much pride and think of themselves too much: one would think they are White people."*

The post-colonial mentality of being regarded as second class citizens was intrinsically embedded in this sentiment. However, based on my education and experience as a midwife; my interpretation of the incidence was that the woman's prolonged labour was because of her hypoglycaemic state and exhaustion, which led to inefficient uterine contractions. The concentrated sugar solution she was given by the doctor raised her sugar levels and that was how the contractions became stronger, and she eventually gave birth. The essence in this account was not whether I was right and the participant was wrong, but rather it revealed a misinterpretation of the encounter by the participant. The pursuit of interpretive phenomenology was to seek to recapture the perspective from which the participant made her statement. Given the situation where the woman already had preconceived ideas about White people being superior beings; in her world she believed that the White doctor possessed magical powers, too. This was the participant's unique 'Being-there' of how she interpreted and gave meaning to her childbirth experience. Acknowledging the participant's 'Dasein'

aided me to recognise the individuality of the participant. However, my background of being born and bred in Zambia, influenced me to see beyond what the participant was saying, making Husserl's descriptive phenomenology inappropriate for this study. As an interpretive phenomenologist researcher I was interested in uncovering the meaning of how women birthing in Zambia experienced and gave meaning to the childbirth experience rather than describing the experience. In the case of this study, the theme for the participant's experience was conceptualised under the heading: "Inadequate service provision". The sub-theme was "Unable to notice deviation from normal processes".

Heidegger is also famous for promoting hermeneutic phenomenology. The word hermeneutics is derived from the Greek word, 'hermenuin', which means 'to interpret' (Eberhart and Pieper, 1994). The Greek god Hermes, in mythology is a winged messenger and interpreter for the mythological gods of ancient. Hermes was thought to be responsible for changing not-understood information into a form that humans could understand. What was a scholarly method for dealing with sacred texts when the meaning was obscure in the Bible became known as 'hermeneutics' (Walsh, 1996). Now it is known as a philosophy, as well as a method of interpretation. According to van Manen (1997), it seems that the existence of man in Heidegger's realm of 'Being' is unavoidably hermeneutical. Hence, during the interviews close attention was paid to the women's stories. The stories were listened to without being judgemental because what they were presenting were interpretations of their experiences based on their life experiences, pre-suppositions, projections of their personal values and expectations, background practices, and their standpoints as part of 'Being'.

The flow of each conversation was encouraged by prompts. Sometimes the stories appeared a little inaccurate to my trained ear, as perceptions of what happened and why, could be distorted due to women's lack of understanding of physiological childbirth processes. I attempted to interpret the meanings of each story individually and then collectively. This was part of the intersubjectivity and the role of the researcher in interpretive phenomenological studies. The process of the method of inquiry was circular and adhered to the basic principles of the Hermeneutic circle, which highlights the relatedness of the phenomenon under investigation to its surroundings. Unlike descriptive phenomenology; interpretive phenomenology is a philosophy that aims to achieve understanding through interpretation. The process of interpretation is circular rather than linear. Interpretation that occurs in a circle is dynamic in nature. It has no bottom, top, beginning or end and no subject-object distinctions. It is called the 'Hermeneutic Circle' (Schmidt, 2006). The hermeneutic circle is defined as a theory of interpretation and understanding that no observation or description is free from the effects of the observer's experiences, pre-suppositions and projections of his or her personal values and expectations (Schmidt, 2006). It is proposed that interpretation in the human sciences takes place within the hermeneutic circle in order to avoid a possible loss of meaning (Greatrex-White, 2004). An example of how this concept was applied to this study is highlighted within the 50 interviews that were undertaken. The participants' stories were not linear. They were contextual and circular. The participants moved back and forth in time, from antepartum to postpartum periods, tying off some stories, introducing others, telling me what happened to their friends and relatives, introducing other aspects of the experience and discarding others. They moved from the whole of the subject of childbirth that was being discussed to the part of childbirth experience that was being studied. Thus, within the hermeneutic circle, the whole could be understood through the study of the particular aspects, and the particular aspects with reference to the whole. This is to say that in this study, the

hermeneutic circle applied to all the participants' accounts. I studied the childbirth phenomenon by moving between the experiences of individual participants, and developing interpretations of the experience as a whole, by looking at the shared experiences of the individuals.

3.6 Phenomenology and Midwifery

Phenomenology is a popular approach being used for midwifery research. This could be because midwifery practice values the meaning women ascribe to their experiences of pregnancy and birth (Thomson, Dykes and Downe, 2011). Midwifery being as much an art as it is a science is a unique discipline deeply involved in the human side of pregnancy and childbirth. It is the midwife who is by the woman's side during the most vulnerable time of birthing, and who is likely to hear the woman's deepest thoughts, fears and feelings. Consequently, the midwife is often the first one to see the woman's newborn baby, even before the mother sees her infant. It seems this could be the reason behind why phenomenology is a commonly used approach for midwifery research when examining women's childbirth experiences.

According to Morse and Field (1996), the outcome of phenomenological research is new information. The researcher does not let existing theory drive the research (Morse, 1991). Even though phenomenology does not have theory development as its intention or purpose, the outcome of new information is intended to inform theory. Thus, theory that arises from phenomenological research, allows for what is learned, and what arises from the study, rather than proving an existing idea. Emerging understandings of an experience when applied to midwifery can theoretically inform practice. This substantiates the prime intent of this

phenomenological study that was conducted in order to better understand childbirth experiences of women birthing in Zambia.

3.7 The Recruitment process

3.7.1 Study Setting

The setting for this study was the country of Zambia. The participants were recruited from the districts of Mumbwa in central province and Lusaka in Lusaka province. Convenient sampling was used to select the two districts. Mumbwa is a rural district located 106 kilometres away from Lusaka. Therefore, transport costs, as well as geographical barriers, such as impassable roads were minimal when collecting data, as the researcher was a Lusaka resident. Zambia is one of the most urbanised countries in sub-Saharan Africa (CSO, MoH, ICF International, 2014). The capital city, Lusaka, is home to one fifth of the population (Atkinson, Ngwengwe, Macwang'i, Ngulube, Harpham and O'Connell, 1999). Hence, although the study participants were recruited from the two districts; through the use of purposive sampling, it was possible to recruit participants with birthing experiences from all the ten provinces of the country. Recruiting participants with a variety of birthing experiences was essential to better understand how women in Zambia experience and give meaning to the phenomenon. According to Smythe (2011) and Woodgate (2006), a variety of experiences sparks thinking in a researcher, as well as provides a platform for a deeper understanding of the phenomenon under study.

Zambia is a landlocked sub-Saharan African country covering an area of 752,612 kilometres (km), which is about 2.5% of Africa (CSO *et al.* 2014). For administrative purposes the

country is divided into ten provinces and 74 districts (CSO *et al.* 2014). There were some changes in the administrative divisions of the country at the time of writing this thesis. Among the current ten provinces, the Copperbelt and Lusaka provinces are predominantly urban, whereas, Central, Eastern, Muchinga, Luapula, North-Western, Northern, Southern and Western, are predominantly rural (CSO *et al.* 2014). The population increased from 5.8 million people in 1980 to 13.1 million in 2010 (CSO, 2012). Thus, the population density increased from 8 people per square kilometre in 1980 to 17 in 2010 (CSO, 2012). Compared to the vastness of the country, Zambia is still sparsely populated. The estimated total fertility rate of 7.2 births per woman declined steadily to 5.9 births per woman in 2010 (CSO, 2012). Though fertility rates have declined, the population growth rate is still too high for Zambia's young growing economy. Overall, the population of Zambia is young, with 69% of the population below the age of 25 years (CSO *et al.* 2014). Women of reproductive age represent about 22% of the total population (CSO *et al.* 2014). Demographic factors and emerging issues, such as rapid urbanisation, gender inequalities, brain drain to high income countries, Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS) have immensely constituted major obstacles to ensuring improved quality of life for the Zambian population, particularly women (CSO *et al.* 2014).

3.7.2 Contacting key people and participants

Once the administrative procedures of ethics clearance were completed, appointments with the District Directors of health in Lusaka and Mumbwa, respectively, were made. I was invited to attend both districts' annual planning meetings. It was during these meetings (one in Lusaka and one in Mumbwa) that I was given a platform to inform health institutional in-charges about the planned study. After sensitising healthcare administrators, dates when I

could go to health institutions to give information about the purpose of the study to the wider communities were agreed upon. In order to widen the scope of people getting to know about the study, general Out Patients Departments (OPDs) were found to be appropriate venues. To avoid inconveniencing or delaying anybody, brief talks were given without interrupting or disturbing the processes of the services that people had come to the health facilities for. Most of the people who listened to the dissemination talks were relatives and patients who were waiting to collect their healthcare files. Care was taken to ensure that the healthcare files collection process was not disturbed. After the first brief talk, which took place in one of the health facilities in Lusaka, the telephone number on which I could be contacted, as well as the physical location of where I could be found were given. I registered my phone for the 'call collect' service so that potential participants did not bear any financial costs when calling. The same process was repeated in Mumbwa district. The response was overwhelming in both districts. Women began getting in touch shortly after listening to the talks. Some prospective participants rang, others came to my residence, and others sent relatives to come and ask me to meet them in places of their choice.

According to Harman (2007), thinking is the interpretative act which brings understanding. Heidegger (1998) suggests that thinking has a mood. Thus, as humans, we are perplexed, anxious, curious or dismissive when drawn to a particular phenomenon. Based on my knowledge of the secretiveness of the issues surrounding childbirth in Zambia, I was anxious that it was going to be difficult to get participants for the study. Therefore, the eagerness to participate that the women with the support of their families portrayed was perplexing to me. Darteh *et al.* (2014); CSO *et al.* (2009); Hausmann *et al.* (2008); Bank (2005); and MoH (2003) state that men in Africa play influential roles in women's decision making, especially around the issues of pregnancy and childbirth. Therefore, the large number of women who

contacted me with the desire to participate in the study gave me the impression that decision makers for women were interested in the study too. Hence, I was thus drawn to thinking that in Zambia, childbirth was not an issue that was important to maternity healthcare stakeholders and women only, it was important to the Zambian community at large. The large number of people who contacted me influenced me not to continue with the recruitment talks. This was in order to avoid collecting too much data, which was going to be impossible to analyse.

3.8 Data Collection

Data were collected between, 25th February to 20th July 2011. Due to the sensitive nature of the information that was sought from participants, one-on-one interviews were used. In order to obtain enough information that would enable an understanding of the richness and complexity of the childbirth experience, data were obtained through in-depth interviews.

3.8.1 Participants

This study was about understanding a lived experience, and hence, the number and the ages of participants were not pre-determined. According to Smythe (2011), the number of participants in a phenomenological study depends on the time available to conduct the research. She states that in her experience, a Masters study (one year, full time), five to eight participants are likely to yield adequate data, but for a doctoral study the number may increase. Greatrex-White (2004), in her PhD phenomenological study recruited 26 participants. Li-Hung (2009) interviewed 30 participants. Lori (2009) interviewed 54 participants. In this study, 50 participants were interviewed. It became clear during the process of conducting the study that fewer participants could not have provided additional

knowledge that was possible with this number. For the purpose of describing the 50 study participants, their socio-demographic characteristics are presented in Table II.

Understanding phenomenon can only be undertaken in terms of relation to time (Heidegger, 1962/1927). According to Smythe (2011), there is no right time from which one can gain a definitive meaning of a woman's experience of birth. It is likely to be recounted in a different manner immediately after the baby is born, to the next day, the next week or the next year. Years later, the story would still be the same, but the perspective would have altered. In other words, the meaning of a lived experience is neither fixed nor static. Rather, it is contextual and historical (Dahlberg *et al.* 2008). Smythe (2011) thus, advises that the researcher simply needs to consider the point of perspective that is likely to have the most relevance. In the case of this study, participants were women who gave birth between 2005 and 2011. This was in cognisance of the fourth in the series of the health sector reforms that the Zambian government had been implementing since 1992 (MoH, 2011). Purposive sampling was used to choose study participants from all the ten provinces of the country. Participants were aged between 16 and 38 years. Twenty-five participants were interviewed in the rural district of Mumbwa in Central province. The other 25 were interviewed in the capital city of Lusaka, in Lusaka province. Synonym identification for participants interviewed in Mumbwa began with the letter M, while those interviewed in Lusaka began with the letter L.

As clarified by Hein and Austin (2001), the concept of data saturation was not possible in deciding the number of participants in the study because each participant had her own story. This echoed the theoretical underpinnings of interpretive phenomenological studies. Understanding 'Dasein' (Heidegger, 1998) was fundamental to grasping the nature of this

study. The point being that participants were not narrating their exact birth stories per se, instead, they were verbalising the memories of their reflections of the experience. 'Dasein' always 'is' (Smythe, 2011). In so being, one is always open to things, thoughts, feelings, people that come to one's memory, and forgetful or ignorant of all else that was there, but did not claim one's attention. Phenomenology accepts that: not only can we not escape context, but that the 'there' of 'Being' makes the experience what it 'is' (Smythe, 2011). This means that even though all the 50 women in this study experienced birthing in Zambia, their interpretation of the phenomenon were different depending on what presented to their consciousness during the time of data collection.

3.8.2 Interview technique

According to Greatrex-White (2008), conducting a good interpretive phenomenological interview requires skill, awareness and dedication. This was not the first time I was conducting interviews, thus I thought I had the skills of interviewing with an interpretive phenomenological lens. This proved not to be the case. After sending the first three interviews to my supervisors, I was advised that although the transcripts contained important information, they were not very helpful for phenomenological analysis. The next four interviews were not any better. The lengths of the first seven interviews were between 06 minutes 39 seconds and 25 minutes 40 seconds. However, despite the interviews not being in-depth enough for phenomenological analysis, they could not be discarded. Discarding the interviews would have been unethical because the seven participants spent their time narrating their accounts in accordance with the information that was provided during recruitment. Hence, though not in-depth enough, the information from the first seven interviews too contributed to the understanding of the phenomenon under study.

Later, during the data collection period, I attended a seminar on how to conduct phenomenological interviewing, which was organised and presented by one of my supervisors. After the training, the remaining 43 interviews lasted longer as participants were skilfully drawn into the conversations and encouraged to express their feelings, thoughts and actions during the process. The shortest interview lasted 30 minutes 43 seconds, and the longest lasted 1 hour 20 minutes and 30 seconds. To lessen the risk of inconsistencies arising during the data collection process, I personally conducted all the interviews. It was a labourious but interesting process. The maximum number of interviews I could do in a day was three. As the topic of this study was about a distinct event in a woman's life, one interview with each participant was enough. Conducting more than one interview with less participants was not in itself going to present good interview data because as explained by Smythe (2011), there is no right time from which to gain the perfect perspective of a woman's experience of birth, because it is likely to be recounted in a different manner every time. Smythe (2011) further states that it is only when participants are asked to talk about experiences that occur regularly in their everyday lives, that more than one interview become necessary. For instance asking a midwife who works in an antenatal clinic about her experiences of conducting antenatal assessments. She may struggle to distinguish one assessment from the other because she does several in a day.

As a number of days had passed between recruitment and interview dates, I again briefly explained the purpose of the study to ensure that each participant was still willing to participate. Before the beginning of an interview, each participant was thanked for agreeing to participate and tell her story. To avoid participants becoming overwhelmed by the intensity of a one-on-one interview, each participant was asked how she felt and urged to be at ease. This was important in building trust and rapport, because even though women were eager to

narrate their experiences, I was a stranger in their lives. Each participant was made aware that the interview was going to be audio recorded. All the participants were agreeable to the use of the audio tape. Interviewing began after assessing that the participant was comfortable and ready for the conversation. Taking cognisance that some of the information the participants were going to provide, would be on their thoughts about maternity care providers, I felt that introducing myself as a midwife educator and clinical practitioner would be inappropriate and hence, influence their openness. Smythe (2011), a phenomenological researcher, is of the view that the researcher influences the openness of participants. However, in order to adhere to the fundamental ethical principles based on protection against the violation of human rights, correct self-introduction to participants was vital. I introduced myself as a Zambian student studying for a PhD at the University of Nottingham, in UK, because I was collecting data for this study primarily as a PhD student and not as a midwife educator or clinical practitioner.

Participants were asked whether they had time to participate in the interview. This was with the view that although phenomenological interviews were similar to other types of non-structured, open-ended interviews, they were different in that they tended to be longer (Greatrex-White, 2004). Each participant was reassured that if she felt that she could not go ahead, she was free to withdraw without any threat to her accessing health services. None of the women opted to withdraw from the study. After noticing that a participant was at ease a broad, open-ended question: "Could you tell me how you experienced childbirth, the last time you gave birth?" was asked. Many of the participants kept quiet for a brief moment before starting to narrate their accounts. This reaction signified that the question prompted participants to reflect back on how they experienced the phenomenon. Some participants began narrating their accounts from the time they were growing up as young girls; some after

they got married; some when they were in labour and then went back to the time they were pregnant; and others began their stories from the time they discovered they were pregnant. This highlighted the going back and forth of interpretation in the hermeneutic circle.

As recommended by Willig (2001), the content and structure of the interviews were non-directive, unstructured and open-ended. Each participant was allowed to narrate her story in whichever way she wished. The interviews were allowed to flow in a conversational manner. However, in order to stay close to the experience that was being studied, there was need in some instances to use open-ended unstructured prompts like: "Would you mind explaining what you mean by that?", "What happened then?", "In what way?", "How did you feel about that?", "What did you think?", "What did this experience mean to you?" Many of the participants spoke openly and freely. As a way of encouraging a participant to continue talking, at times, I kept quiet while looking at the participant, or I repeated their last sentence in a questioning tone. I was patient and did not rush participants in telling their stories. If a participant said something that was unclear, she was asked to either, give some examples or give a more detailed description. When a participant began digressing, she was encouraged to describe her own experience and not those of others. Thus, it was not enough for the participants in this study to merely have general opinions or views about childbirth because the focus lay in the account of a phenomenon, which is an object as a person experiences it. The object or phenomenon of this study was childbirth. Thus, understanding of the phenomenon could only come through exposure to the phenomenon described by women who have personally lived the experience (Dahlberg, Dahlberg and Nystrom, 2008; Gerrish and Lacey, 2006; Woodgate, 2006; Todres, 2005; Lopez and Willis, 2004; Caelli, 2000; 2001). According to Smythe (2011), personal data brings a much richer potential for analysis in a phenomenological study.

Where and with whom I was interviewing dictated the way I dressed. For instance when conducting interviews with participants' living in villages, I wrapped myself in a cloth locally known as 'chitenge'. This is a wrapper that adult Zambian females tie on top of whatever they are wearing, as a sign of respect. The normal practice in Zambia is that women sit on mats while men and visitors are offered chairs. This indirectly exposes the status of women in comparison to that of men. To avoid this power imbalance, I politely declined any chair that was offered to me if the participant sat on the mat or floor. If the woman did not have chairs, I sat on the floor with her. If she had chairs, we both sat on chairs. I listened and observed participants closely. I noted the body language and tone of voice during the interviews. If a participant became distressed during an interview because of recalling traumatic memories, as was the case with a few participants, the interview was discontinued for some time to give her chance to gain her composure. After the participant was composed and ready to continue, the interview resumed.

Thapar-Bjorkert and Henry (2004) note that the interview location should be considered because it can influence a participant's perception of power. In an effort to avoid exerting power over participants, the location, day and time of each interview was chosen by each participant. Participants were encouraged to choose locations that would make them feel free, as well as accord us safety and privacy. Too (1996) suggests that home interviews could be a good choice for addressing the power balance between the interviewer and the interviewee, because being in familiar surroundings gives a person confidence. This was important for this study because the information that was sought was very personal and at times secretive. Apart from one participant who chose to be interviewed in her office and six who preferred to be interviewed in my home, the rest chose to be interviewed in their homes. Through the stories, a glimpse of how each individual participant's values, vested interests, culture, roles,

and past experiences shaped the way she understood and experienced childbirth began to emerge. At the end of the interviews most participants said that they felt happy and relieved to have taken part in the study. This corroborated the notion of Gibbins *et al*. (2001) that women want to tell stories of their childbirth experiences because it was therapeutic.

Interviews were conducted in five languages (Lozi, Nyanja, Bemba, Tonga and English), depending on which one the participant was conversant with. Since I was conversant in the five languages, I did not utilise an interpreter. According to Sandelowski (2004), information that a researcher obtained from an interpreter was not a narration of a lived experience, but rather, it was reported speech influenced by the interpreter's interpretation.

3.8.3 Organisation of data

To avoid loss of information, all the interviews were audio recorded. I used two audio recorders as back-up for moments when the attention of the participant and I could be caught up in the story-telling, and the recorder stopped unnoticed. According to Too (1996), two advantages of tape-recording interviews are that it allows the interviewer to interact with the participant, as well as audit the collected data, later. Each interview was transcribed verbatim immediately after. Interviews that were in the four indigenous Zambian languages were translated into English while transcribing. Smythe (2011) recommends that if the researcher has time to transcribe the interviews, he or she should do it because it is a useful way of becoming familiar with the data. Transcribing the interviews lightened the burden of analysing because I could easily identify statements with the participants who said them. In order to eliminate translation-related problems, Birbili (2000) advises that a researcher can consult other people. I conducted a check on the accuracy of my translation by letting a

fellow doctoral student listen to parts of two interviews that did not have any names mentioned. He translated them independently. I then compared his translations to mine and checked for consistency. There were no inconsistencies. To enable recalling the whole interview process during transcription and data analysis, field-notes were recorded as soon as was possible after each interview. The field notes included observations about participants' verbal and non-verbal behaviours such as gestures, frowning, expressions of anger, hurt, happiness, general surrounding, laughing, crying, outlook of each participant and my thoughts about each story. As part of the decision trail for the study, a reflective diary was kept, from the beginning of the research up to the end of the writing up process. I was conscious of my own ideas about what it might be like to experience birthing in Zambia. Diarising these ideas helped me to be aware of biases when analysing the data.

3.8.4 Inclusion criteria

Women were eligible for inclusion to the study if they:

- Had a childbirth story to tell.
- Experienced birthing in Zambia between 2005 and 2011.
- Had time to tell their story.

3.8.5 Exclusion Criteria

Women were excluded from participating in the study if they:

- Had never experienced childbirth.
- Had given birth earlier than 2005.

Table II: Socio-demographic characteristics of participants

Synonym	Age	Parity	Marital status	Location	Education	Occupation	Birth year	Interview length	Date of interview	Place of delivery
LA	18	2	Married	Lusaka	Primary	Housewife	2007	25:40	02/03/11	Hospital
LB	31	2	Married	Lusaka	Secondary	Teacher	2011	06:39	01/03/11	Hospital
LC	31	1	Married	Lusaka	University	University lecturer	2009	10:02	25/02/11	Hospital
LD	38	2	Married	Lusaka	University	College lecturer	2008	37:20	10/06/11	Hospital
LE	22	3	Married	Lusaka	Primary	Housewife	2011	50	30/05/11	Hospital
LF	23	3	Married	Lusaka	Primary	Housewife	2009	50:20	10/06/11	Hospital
LG	29	2	Married	Lusaka	Nil	Housewife	2009	1:08:25	09/06/11	Home
LH	27	2	Married	Lusaka	Nil	Housewife	2007	39:55	10/06/11	Home
LI	27	2	Married	Lusaka	Primary	Housewife	2007	1:10:15	09/06/11	Home
LJ	27	5	Married	Lusaka	Secondary	Housewife	2007	36:13	09/06/11	Hospital
LK	25	2	Married	Lusaka	Secondary	Housewife	2011	31:52	14/06/11	Hospital
LL	19	2	Married	Lusaka	Primary	Housewife	2011	1:10:07	17/0611	Hospital
LM	24	3	Married	Lusaka	Primary	Housewife	2006	30:43	14/06/11	Hospital

LN	20	1	Married	Lusaka	Secondary	Housewife	2011	1:20:30	17/06/11	Hospital
LO	22	3	Married	Lusaka	Secondary	Housewife	2007	44:33	14/06/11	Hospital
LP	25	2	Married	Lusaka	Nil	Housewife	2005	1:10:23	17/06/11	Hospital
LQ	32	6	Separation	Lusaka	Primary	Nil	2011	1:07:45	21/06/11	Hospital
LR	22	4	Married	Lusaka	Nil	Housewife	2006	39:37	21/06/11	Hospital
LS	21	2	Married	Lusaka	Nil	Housewife	2008	50:32	21/06/11	Hospital
LT	18	1	Single	Lusaka	Primary	Nil	2009	38:41	20/06/11	Hospital
LU	20	2	Married	Lusaka	Primary	Housewife	2011	40:50	20/06/11	Hospital
LV	19	1	Single	Lusaka	Secondary	Nil	2011	1:01:50	22/06/11	Hospital
LW	25	2	Married	Lusaka	Primary	Housewife	2007	36:07	22/06/11	Hospital
LX	23	2	Married	Lusaka	Secondary	Housewife	2008	38:35	22/06/11	Hospital
LY	23	1	Divorced	Lusaka	College	Accountant	2006	1:40:20	20/06/11	Home
MA	19	2	Single	Mumbwa	Secondary	None	2006	15:08	05/03/11	Hospital
MB	38	2	Married	Mumbwa	College	Banker	2008	10:45	04/03/11	Hospital
MC	24	1	Single	Mumbwa	Secondary	None	2011	20:03	28/02/11	Home
MD	30	1	Married	Mumbwa	College	Secretary	2007	07:20	04/03/11	Hospital

ME	29	3	Married	Mumbwa	Primary	Housewife	2009	48:26	05/07/11	Home
MF	20	2	Married	Mumbwa	Primary	Housewife	2008	34:31	20/07/11	Hospital
MG	24	3	Married	Mumbwa	Nil	Housewife	2009	39:37	20/07/11	Hospital
MH	23	4	Married	Mumbwa	Nil	Housewife	2009	35:42	20/07/11	Home
MI	26	3	Widowed	Mumbwa	Nil	Nil	2010	48:20	14/07/11	Hospital
MJ	21	1	Married	Mumbwa	Nil	Housewife	2009	42.43	14/07/11	Hospital
MK	29	3	Married	Mumbwa	Primary	Housewife	2005	38:03	14/07/11	Hospital
ML	20	1	Married	Mumbwa	Primary	Housewife	2007	39:24	07/07/11	Home
MM	28	2	Married	Mumbwa	Primary	Housewife	2009	46:37	01/07/11	Hospital
MN	30	2	Married	Mumbwa	Primary	Housewife	2007	48:21	28/06/11	Home
MO	26	4	Married	Mumbwa	Primary	Housewife	2009	49:05	28/06/11	Home
MP	21	1	Married	Mumbwa	Nil	Housewife	2007	42:50	28/06/11	Hospital
MQ	19	1	Married	Mumbwa	Primary	Housewife	2009	41:22	05/07/11	Hospital
MR	24	2	Married	Mumbwa	Primary	Housewife	2009	39:07	05/07/11	Hospital
MS	16	1	Married	Mumbwa	Secondary	Housewife	2010	33:49	01/07/11	Hospital
MT	21	2	Married	Mumbwa	Primary	Housewife	2007	39:12	01/07/11	Home

MU	25	3	Married	Mumbwa	Secondary	Housewife	2008	1:05:36	07/07/11	Hospital
MV	23	1	Married	Mumbwa	Primary	Housewife	2008	1:02:40	07/07/11	Hospital
MW	25	3	Married	Mumbwa	Primary	Housewife	2011	1:05:23	11/07/11	Hospital
MX	22	1	Married	Mumbwa	Secondary	Housewife	2009	58:26	11/07/11	Hospital
MY	19	1	Married	Mumbwa	Primary	Housewife	2010	1:20:05	11/07/11	Hospital

3.9 Ethics clearance

According to Brink, Van der Walt and Van Rensburg (2012), it is imperative to adequately address ethics concerns during the design phase of any research that involves human subjects. This is because the fundamental ethical principles are based on protection against the violation of human rights (Brink *et al.* 2012). This study's proposal review was passed by the University of Nottingham and ethics approval was sought and obtained from The University of Zambia Biomedical Research Ethics Committee, before commencement of data collection. A copy of the ethics clearance is provided as Appendix II. Brink *et al.* (2012) emphasise that it is unethical to commence studies without ethics approval. As this study was concerned with the effects of a personal experience, it was essential that the participants did not suffer any pain or discomfort through the process. Thus, every effort, such as choosing interview location, was made to ensure that each participant was not put at risk of being traumatised by sharing her emotional pain, if any. I sensitively listened to the women's stories and provided them with names of counsellors, in case they would need their services. None of the participants needed the services of a counsellor during or immediately after the interviews.

In consideration of participants' human rights, I ensured that each individual who participated in this study, made an informed judgement on whether to participate or not. I had discussions with each participant and availed each one of them with comprehensive, plain and clear information, in a language they understood, about their participation well in advance of the interview. A copy of the Information sheet (English version) is presented as Appendix III. The information sheet was translated for participants who did not understand English.

Each participant's demographic data sheet (Appendix IV) was completed to ensure that there was no mix-up of participants. Participants had the right to withdraw from the study even after the process of recruitment had commenced. They were informed of their right to withdraw and stop the interview at any time they chose. All concerns and questions were answered in full. No participant was coerced to participate. To reaffirm participants' rights as volunteers in the study, a consent form (Appendix V) was signed. Participants who did not know how to write were asked to endorse left and right thumb prints. An informed consent is a "legal written agreement between a researcher and a participant, giving the researcher authority to proceed with the study" (Neuman, 1994, p450). Participants' right to privacy was observed at all times. The identity of each participant as well as, when and where each interview would take place was not revealed to anybody, other than the researcher and the participant. Respect for human privacy was also observed both in the conduct of the interviews and in the writing up of results, by removing all identifying materials. The participants had the issues of confidentiality and anonymity discussed with them before the data collection began. Where names were mentioned during the interviews, they were omitted in the transcription. Synonyms beginning with the letters L or M were used to identify each participant. In addition, the audio tapes and field notes were kept locked in a drawer in my office and the data for analysis was stored on my personal password-protected computer. Participants were informed that all the data would be kept confidential. All identifying materials in the thesis, for example, names of institutions or homes where participants birthed were not mentioned. In case of future queries from participants, the audio tapes were kept securely and confidentially in accordance with the regulations of the University of Nottingham.

3.10 Data analysis

Interpretive phenomenological analysis is only as good as the data it is derived from. In writing this section, I make it look as though I did the interviews and then moved on to data analysis. However, that was not the case. I conducted one interview, transcribed it, wrote the initial analysis and summarised the story into a one to two page document, before moving on to the next. An example of this process is presented with Mrs LN's interview (Appendices VI and VII). Identifying key statements, meaning units, sub-themes and themes are presented as Appendix VIII. A preliminary analysis of Mrs LN's interview is presented as Appendix VI. To help conceptually interpret the data as a whole, as well as transform the raw data into a new and coherent depiction of the phenomenon that was being studied, data analysis also occurred as an explicit step, using specific analytic strategies by van Manen (1997).

According to Patton (2002), phenomenological analysis seeks to grasp and make clear the meaning, structure and essence of a lived experience of a phenomenon for a person or a group of people, and then transforms their data into findings. Thorne (2000), states that the theoretical lens from which a researcher approaches a phenomenon, the strategies that a researcher uses to collect data and the understanding that a researcher has about what might count as relevant data in answering the research question are all data analysis processes. Hence, there is no universally accepted method for data analysis in interpretive phenomenological research. Steps for analysis differ between researchers. Greatrex-White (2007) explains that there are many qualitative data analyses computer programmes currently available on the market. However, they are essentially aids to sorting and organising sets of qualitative data, as none of them is capable of intellectual or conceptualising processes required to transform data into meaningful findings. Thus, guided by the writings of Greatrex-White (2007; 2004), I decided to do the data analysis without the aid of any

computer programme. Although labourious, this aided me to stay close to my data throughout my doctoral journey.

Sandelowski (2004) suggests that a researcher can utilise personal and methodical steps. However, he advises that the steps that are utilised need to be congruent with the philosophical position that underpins the study (Sandelowski, 2004). In this case, the philosophical position underpinning the study was interpretive phenomenology. Therefore, it was appropriate to utilise van Manen's (1997) six steps of analysis:

1. Turning to a phenomenon of interest.
2. Investigating experience as we live it.
3. Reflecting on the essential themes, which characterise the phenomenon.
4. Describing the phenomenon (The art of writing and re-writing).
5. Maintaining a strong and oriented relation to the phenomenon.
6. Balancing the research context by considering the parts and the whole.

The steps were found to be a useful guide when dealing with the phenomenon under study, because they are neither absolute nor fixed. They thus provided a workable overview of a study of this nature because they were broad. van Manen (1997) observes that it is important to avoid fixed procedures when analysing data as they do not support the flexible philosophy of interpretive phenomenology. Although, there is a logical process to van Manen's steps of analysis, there was a backwards and forwards motion that occurred as I immersed myself in the data. As I wrote my findings, I considered my position in relation to the phenomenon, considered the parts and the whole of participants' accounts, and then considered my position. This was a backward and forward, pendular and circular motion that is involved in

the hermeneutic circle. At the centre of my thinking, I kept Patton's (2002, p433) words: "Do your very best with your full intellect to fairly represent the data and communicate what the data reveal, given the purpose of your study." This was achieved by reading and re-reading the collected data to make sure that the interpretations and conclusions accurately represented the information provided by participants. Reading is compared to digging the soil before preparing a garden (Williamson, 2005). In my case, it was like loosening the soil so that it was possible for the seeds of my analysis to have roots and grow. I may already have had a few ideas and preconceptions on childbirth, but the information from the data provided in the participants' accounts was slow to emerge. As I read and re-read the transcripts, the information being relayed became clearer. My ideas about the meaning of childbirth from the women's perspective began to seed during the data collection period, and strengthened through the reading and re-reading process during data analysis. The meanings and ideas changed and altered shape many times. Thus, analysis included the dynamic and circular nature of the process of interpretation, which is portrayed in the hermeneutic circle. This concept was illuminated in conducting the 50 interviews, thinking about them, and analysing them afterwards. I found myself moving from the parts of each interview to the whole of the interview. I then gathered all 50 analysed interviews and brought together key statements, sub-themes and themes. The outcome of the analysis remains unique to me as I related to the participants' stories. I was aware of my own prior knowledge of the experience of childbirth. I used my prior knowledge when dialoguing with the text, within the hermeneutic circle. I made notes of my ideas and measured them against the text as I worked. Many times, I discarded my old ideas based on the new information from the texts. Heidegger (1962/1927, p195) says: "Our first, last, and constant task in interpreting is never to allow our…fore-conceptions to be presented to us by fancies and popular conceptions, but rather to make the scientific theme secure by working out the fore-structures in terms of the things themselves".

I re-examined my own ideas in the light of what I found in the texts. For example, in interpreting the meanings in Mrs LD's transcript, I found the phrase: *"I am an African"* to be a significant representation of her childbirth experience.

> *"Well I just needed some kind of support from an older lady on the basis that my husband and I were young…so I told myself that let me consult somebody who is elderly before I go to the hospital. In spite that I had read a lot about pregnancy and childbirth I thought I might be mistaken…I was not really in labour. So I wanted an opinion from someone who had given birth to a number of children. You know* ***I am an African*** *so there is a part of me that always says that the old people know a lot of things…"* **(LD, p2)**

Mrs LD was one of the four highly educated participants in the study. In introducing herself she said: *"…I have this background of health nutrition, so I have some basic knowledge of what is needed when a woman is pregnant…I am a holder of a Master's Degree in Psychology and work as a lecturer…"* With such an academic background I was of the opinion that Mrs LD would be more inclined to conventional aspects of childbirth. Thus, I was surprised when she referred to herself as being "an African". As I kept on reading and listening to her interview, it came to light that indirectly, she was referring to her being African as an intrinsic aspect that influenced the way she viewed childbirth. In this instance, it was the aspect of the meaning of the childbirth experience in relation to the role older women's opinions played. "*I am an African*" brought to mind Heidegger's (1962/1927) concept of "thrownness" (p174). According to Healy (2011), 'thrownness' is a basic characteristic of Dasein, and refers to the certainty that human beings find themselves thrown into a context, which is culturally and/or historically significant, without having a choice. In

other words it is our heritage of thrownness and enculturation into a shared community at a specific historical period. In her interpretation of the childbirth experience, Mrs LD was first and foremost an African, thus despite her education; her being an African also played a part in her interpretation of the childbirth experience. In Mrs LD's case, she valued the role that older women played in matters of childbirth.

The process of cutting and pasting quotes (key statements) from different interviews and then putting them together under sub-themes and then themes was very long and involving. At one point my whole room was filled with piles of data being sorted out. After the analysis, I found myself reflecting on the research question, checking whether I had answered it. From the beginning to the end of this process I was moving backwards and forwards through the data.

3.10.1 How van Manen's six steps were applied to the analysis

3.10.1.1 Turning to a phenomenon of interest

The first step involved making sense of some aspect of human experience. van Manen (1997) describes phenomenological research as a deep questioning of something, and that it does not exist in a disembodied fashion. Thus, it is a project of someone or an individual who sets out to explore an aspect of human existence. In the case of this research process, turning to a phenomenon of interest involved deciding upon the topic and the research question. The phenomenon of interest was 'childbirth experience'. At the beginning of my engagement with my supervisors I thought I could study the phenomenon by investigating the reasons why more women in Zambia birthed at home instead of health institutions. Looking at the phenomenon from this angle pointed to aspects of childbirth in Zambia that were already

available in literature, such as: long distance to health facilities and midwives' perceived bad attitudes. What was lacking in the available literature was information on the childbirth experience itself. The absence of this information led to the research question: "How do women birthing in Zambia experience and give meaning to the childbirth phenomenon?"

3.10.1.2 Investigating experience as we live it

Phenomenological research aims at establishing renewed contact with the original experience (van Manen, 1997). To ensure this, I explored the lived experience of childbirth in all its modalities and aspects by conducting unstructured, face-to-face, in-depth interviews with 50 women who had experienced childbirth from different parts of Zambia. The participants narrated their accounts in their own way. This added depth and breadth to my understanding of the lived experience of birthing in Zambia, as I could physically note participants' expressions, which could have been missed had the interviews been via the telephone. For instance, if a participant smiled, the expression was observed before a laugh could be heard on the audio tape. If a participant cried softly or her eyes misted, this expression could not be observed unless the interviewer was physically there. In the case of this study, while interviewing one participant, who was a para 1 and gravida 4, her eyes misted when narrating the birth experience of her third pregnancy, which ended in the death of her infant. She was pregnant with her fourth child during the time of this study's data collection period. The misty eyes could not be picked on audio. Thus, during analysis, one element that brought the totality of the interview to mind clearly was the notes written immediately after, in the reflexive diary. van Manen (2002) remarked that any depiction of a lived experience was an appropriate source for uncovering thematic aspects of the phenomenon it described. While conducting the research, I attempted to re-learn the nature of the participants' experiences as

they had related them to me, by repeatedly listening to the audio recording, reading the scripts and consulting my reflexive diary. This helped my interpretation.

3.10.1.3 Reflecting on the essential themes, which characterise the phenomenon

van Manen (2002) says that a true reflection of lived experience is a reflective and thoughtful grasping of what renders an experience its special significance. This involved a bringing into focus what tended to be obscure and evading the intelligibility of my preconceptions. It involved reflecting on both the implicit and explicit themes that characterised the phenomenon under study. In seeking key words/statements, sub-themes and themes, I was guided by van Manen's (1997) suggested process for isolating thematic statements. He says that generally one can use three methods towards uncovering thematic aspects of a phenomenon in a text. The three methods are: a) The detailed or line-by-line approach, b) The selective or highlighting approach, and c) The wholistic or sententious approach. van Manen's suggested processes for isolating thematic statements echoed Sheehan's (2001) suggested interpretation of 'Dasein' or openness. In other words, as one reads a text, some bits may cause one to mark them, while other bits may not cause one to mark them. In openness, one is always open to some things while other things pass one by, almost or entirely unnoticed (Smythe, 2011). We notice what matters to us. Such resonance is at the heart of interpretive thinking. I utilised the detailed or line by line approach. In doing so, I looked at every single sentence or cluster of sentences, and asked what they were revealing about the childbirth phenomenon. I searched through each transcript and picked out key words, sentences or cluster of sentences containing new ideas. This involved reading each text and listening to each interview several times and inquiring, which statements or phrases appeared to be revealing the phenomenon of birthing. The identified statements were highlighted, copied from the transcript and tabulated. An example of what I did is as follows:

"She insulted me and angrily walked away…as I was struggling to turn she slapped me hard on my face…shouting and asking why I was acting like it was my first delivery…she pinched me on the thigh saying that I was stupid…she sneered at me saying that I should have thought of the childbirth pain while I was feeling good with my husband…The nurse started cursing that she did not understand why we poor people without well-to-do relatives liked giving birth a lot…I am a married woman and having children dignifies me…Having children is important for me to avoid being divorced…" **(LL, p3)**

This quote from Mrs LL's account was highlighted, cut and pasted into a new document, using the cut and paste properties of Microsoft Word. At times, the meaning of a word only became clear when seen in the context of the whole sentence. For instance *"…pinched…"* became clear in the sentence: *"…she pinched me on the thigh."* The sentence revealed that it was a healthcare provider who pinched the birthing woman. At the same time, the meaning of the sentence depends upon the cumulative meanings of the individual words. For example the meaning of Mrs LL's reflections of her childbirth experience was understood by listening to the audio tape, reading the paragraph that was highlighted, going through the notes I took while conducting the interview, and revisiting my reflexive diary. The interpretation of this piece of text was seen within the context of my preconceptions of childbirth. However, my preconceptions of birthing women not being treated well by healthcare providers were changed by the encounter with this new piece of information. The sub-theme put forward by the participant was: "disrespectful treatment". However, intrinsically intertwined in the paragraph were the feelings of "loss of dignity" and "physical abuse", as the participant believed that as a married woman, giving birth was a dignified process that she was expected to undergo. Therefore, there was no need for the midwife to inflict pain on her. Interpretation

of the texts involved referring to each transcript as a whole, and then asking what critical phrases captured the fundamental meanings or the significance of the text. In the case of this study, the constitutive theme that fit this essence was: "Experiencing physical and verbal abuse".

3.10.1.4 Describing the phenomenon (The art of writing and re-writing)

van Manen (2002) said that writing is an important aspect of phenomenological research. Hence, language and thinking are hard to separate in phenomenological research. Phenomenology can therefore, be described as the application of language and thought to an aspect of lived experience. Reading and re-reading the transcripts of the 50 participants and replaying the audio tapes allowed the participants' thoughts, feelings and stories to filter through my mind. I began the written analysis process by writing and analysing all 50 individual stories, considering the "parts". I summarised each interview. Then I gathered together the 50 stories and considered the "whole", moved backwards and forwards in a hermeneutic circle, attempting to make sense of the childbirth phenomenon. Through writing and re-writing, I made visible the feelings, thoughts and attitudes of the 50 participants. I sent copies of what I was doing to my supervisors from time to time. The process of reading and re-reading also involved checking and re-checking to ensure all textual extracts were correctly labelled. It involved extracting and tabulating words or statements of ideas by participants into sections, which were grouped under key words/statements, sub-themes and themes. During this process of continuously interacting with the data I kept asking myself: "who", "what", "when", "where", "how", and "why" of everything. The statements and phrases were the beginning of sub-themes that represented the meaning of the childbirth experience, which was the phenomenon that was being studied. I learnt that it was a good idea to understand the meaning of a phenomenon in terms of key statements. I lifted

appropriate phrases and captured them in simple statements that constituted sub-themes. Sometimes the extracts contained differences. But when looked at in light of the whole developing picture, they were linked. For example two participants, Mrs MR and Mrs MS said:

> *"…at times when you want things to go your way, you just comply with everything that the nurses tell you to do even if you do not agree with them…the nurse advised us to eat eggs…At home my grandmother forbade me from eating eggs while pregnant…in my culture I am not supposed to question anything said or done by an older person…you are expected to comply…"* **(MR, p7)**

> *"…when an adult or superior does something bad to me, I am not supposed to respond because traditionally that is considered being rude on my part…I need to be compliant to customs…when nurses were abusing me I kept quiet because I needed to comply…back home nobody is allowed to be rude to a woman in labour…this was problematic to me…"* **(MS, p5)**

These statements were said in reference to participants' experiences with healthcare professionals and older women. Although expressed differently, the sub-theme from both statements bordered on women's compliance. It became clear to me that there was often a hidden meaning behind the large volumes of text that emerged after I sifted the "parts" from the "whole". The meanings were not necessarily obvious during the initial reading of the text. Once all data were collected using the cut and paste function, the new documents were collated and separate files created. These were then re-read, to check for similar or different

ideas, and to check that all the words, concepts and ideas that stood out as being significant or meaningful to the participants during the reading of the transcripts were included. This was an involving process, taking considerable time to complete. However, it was a process that enabled me to identify meaningful data and set the stage for interpretation. With data reduced into sub-themes, I was able to retrieve segments of textual data that shared similar meanings. For instance when analysing the two statements from Mrs MR and Mrs MS's accounts, I interpreted that the constitutive theme that was being expressed was: "Clash between traditional and contemporary childbirth practices". van Manen (2002) describes a theme as an attempt to capture the phenomenon we are trying to understand.

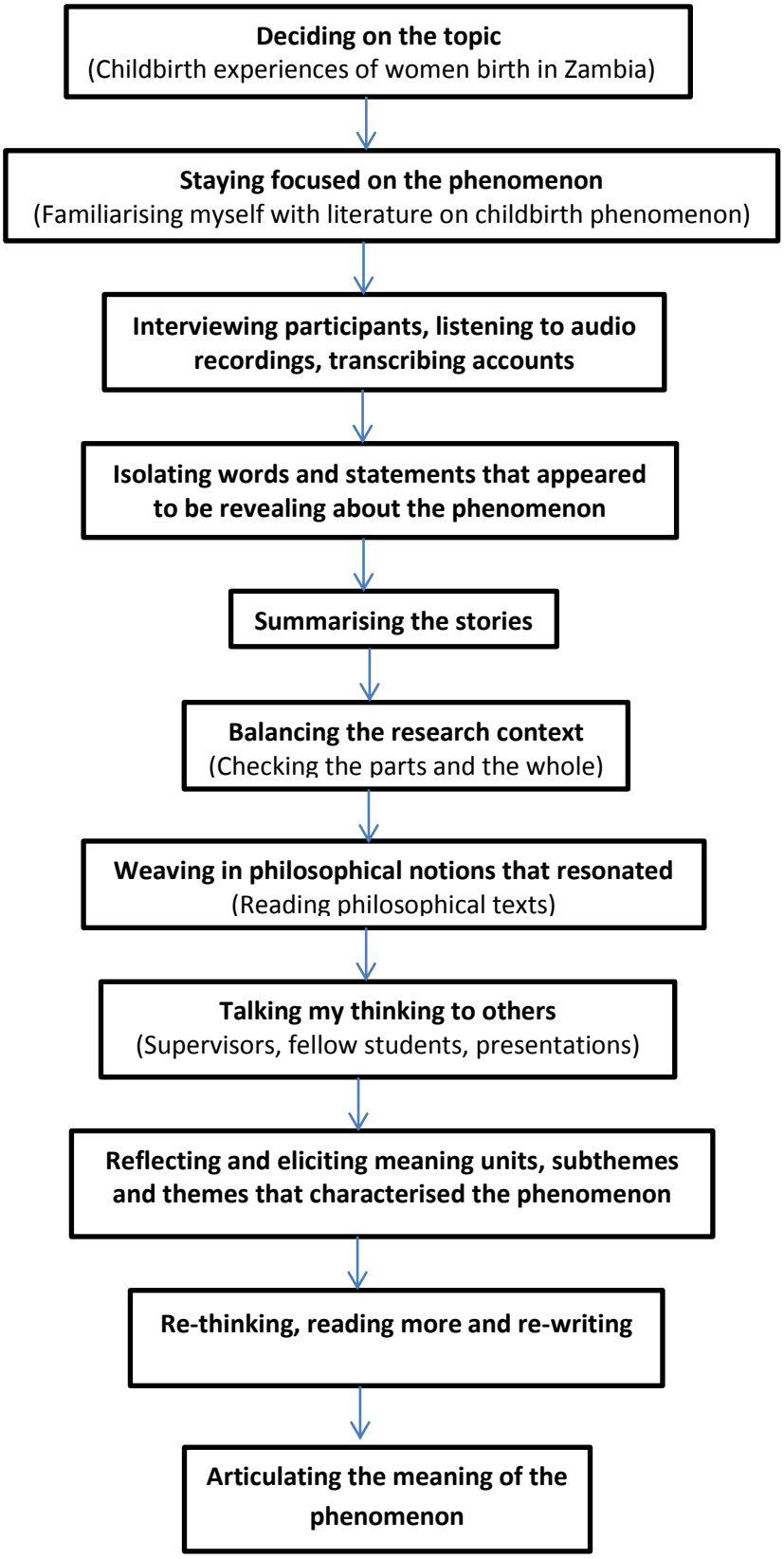
3.10.1.5 Maintaining a strong and oriented relation to the phenomenon

Phenomenology is an approach that is very demanding of the researcher in the sense that one must remain devoted to the fundamental question and avoid being side-tracked (Greatrex-White, 2008). van Manen (2002) advises that it is important to approach the task of doing a phenomenological study with integrity and be animated by the phenomenon in a full human sense, and not to settle for superficialities or falsities. I maintained a strong and oriented relationship to the phenomenon under investigation throughout the research process, by being aware of my preconceived opinions, notions, ideas, memories and experiences. To help being aware of the differences between my preconceived notions and those of the participants, I recorded my opinions, memories and experiences in the reflexive diary. I kept referring to the diary during my interpretation of what participants were saying to ensure that my personal notions of childbirth were not side-tracking my thinking. This was in constant flow as I carried out this study.

3.10.1.6 Balancing the research context by considering the parts and the whole

This step matched the hermeneutic circle. van Manen (1997), explains that to construct a text, a circular process involving continual dialogue between seemingly meaningful words, phrases and concepts, and questioning these segments of the text, to ask: "What is really being said here?" is part of the analysis process. Initially, this involved individual participants' stories. Once emerging words and meaning units developed from the individual parts, they were reviewed in light of the whole perspective. Questions such as: "Is this sub-theme shared or different from other perspectives?", "What does this mean in relation to the phenomenon?" were asked. I constantly measured the overall design of the study against the significance that the parts played, in terms of the theme of the text. At times I moved from studying the parts and looked at the whole, and at how each part contributed to the whole. The six steps of van Manen flowed one into another, and backwards in a spiral; with the sixth step searching into the first step, as I went back to the research question. A summary of the interpretive phenomenological data analysis process that I undertook is illustrated in Figure 3.

Figure 3: Summary of the interpretive phenomenological data analysis process (Not a linear process as the arrows show, always going back and forth and around)



3.11 Rigour of the study

Rigour refers to the thoroughness of the study (Yardley, 2008). de Witt and Ploeg (2006) reminds qualitative researchers that to match the research question and also to be reasonably homogeneous on the basis that the participants can grant the researcher access to a particular perspective on the phenomenon under study, the appropriateness of the sample and participants need to be selected quite carefully. Thus, data was obtained through unstructured in-depth interviews with 50 women who had experienced childbirth in Zambia between 2005 and 2011. I chose Yardley's (2008) four broad principles for establishing quality of this qualitative research. The suggested criteria are broad ranging and offer a variety of ways of establishing quality. The approach also attempts to offer criteria which can be applied irrespective of the particular theoretical orientation of a qualitative study. The four broad principles are:

1. Sensitivity to context.
2. Commitment and rigour.
3. Transparency and coherence.
4. Impact and Importance.

3.11.1 Sensitivity to context

Interpretive phenomenology researchers start demonstrating sensitivity to context in the very early stages of the research process (Yardley, 2008). In this study sensitivity to context was demonstrated by showing the socio-cultural milieu in which the study was situated. This was intended to orient readers to the context of where the study was done, so that as they went through the text, they related and understood the 'Dasein' of the participants' reflections. The existing literature on the topic and how data were obtained from the participants has also

been discussed to orient the reader to what was pertaining regarding the topic under study. Awareness of the existing literature was substantive and related to the topic under study to help orient the study. It was theoretical and related to the underpinnings of the study methodology itself. The very choice of interpretive phenomenology as a methodology and the rationale given for the adoption of the methodology was centred upon the perceived need for sensitivity to context through close engagement with existing literature. Sensitivity to context was also demonstrated through an appreciation of the interactional nature of data collection within the interview situation.

Obtaining good data requires close awareness of the interview process. To ensure free flow of conversation and making sure each participant felt at ease throughout the interview process, I showed empathy by placing myself at the level of each individual participant. I recognised the interactional difficulties and negotiated the intricate power-play by asking each participant to choose the time, place, date and the language the interview was to be conducted. I introduced myself as a student because that was who I was when interacting with the participants during the research process. I was coming to the participants as a PhD student and not as a midwifery care provider and educator. Hence, the women in this study are referred to as participants and not samples, because the knowledge they had on childbirth complemented mine. Making sense of how a participant was making sense of their experience required immersive and disciplined attention to the unfolding account of the participant and what could be gleaned from it. Sensitivity to context was also manifest explicitly in the sense that a considerable number of verbatim extracts from the participants' transcripts to support the arguments being made have been presented. These gave participants a voice in the project, thus allowing the reader the opportunity to check the interpretations made. The findings were later related to relevant existing literature in the discussion chapter.

3.11.2 Commitment and rigour

Demonstration of commitment was in most instances synonymous with the demonstration of sensitivity to context. I kept the balance between commitment and separateness by maintaining consistency in probing, picking up on important cues from the participants' accounts and digging deeper. The analysis was conducted thoroughly and systematically with sufficient idiographic engagement, moving beyond a simple description of what was there to an interpretation of what it meant. An example of this process is presented in appendices VI, VII and VIII, with an illustration from the interview with Mrs LN. I have presented an example with only one interview because there was not going to be enough space in this study to provide extracts from each of the 50 participants, taking into consideration the required number of words for the study.

Commitment and rigour were also maintained by checking and re-checking the memos written after each interview. The memos recorded such things as my own beliefs, the responses and emotional state of the respondents and my thoughts and ideas as a result of the interview. I then measured my conclusions against this and the participants' stories at every phase of the analysis. I reviewed each theme thoroughly and worked through it by dialoguing with the sub-theme and text, and did not allow it to be finalised, until after I was convinced by re-reading and checking that it was a faithful representation of my perception of what was expressed in the text by a participant. Truth-value is subject-oriented and is not decided in advance by the researcher (Morse and Field, 1996). As I took notes and memoranda in the reflexive diary after each interview, I also took special notes of the participants' emotional reactions during the interview, particularly if they became distressed or if their mood lightened at any time.

3.11.3 Transparency and coherence

Transparency refers to how clearly the stages of the research process are described in the write-up of the study (Yardley, 2008). Transparency was enhanced by describing how participants were selected, how the interview schedules were constructed, how the interviews were conducted, and what steps were used in the analysis. A number of draft theses were sent and discussed with my supervisors and necessary amendments were made. This was done to assess whether my write-ups were presenting coherent arguments, were the sub-themes hanging logically together with constitutive themes, and whether ambiguities or contradictions were dealt with clearly. Yardley (2008) suggests that coherence refers to the degree of fit between the research which has been done and the underlying theoretical assumptions of the approach implemented. This was ensured by giving the historical background of phenomenology and the theoretical underpinning of the approach, and showing how they were utilised in the study.

3.11.4 Impact and Importance

Yardley (2008) makes the point that however well a piece of research is conducted, a test of its real quality lies in its impact and importance. I aspired to provide the impact and importance of this study by highlighting the reasons why I decided to conduct the study and gave background information on the phenomenon being studied. I provided literature regarding what is known about the phenomenon. In order to confront the problem of establishing rigour in interpretive phenomenological research, Koch (2006) recommends the inclusion of a decision trail as an essential part of a study.

3.12 The Decision Trail

As part of the decision trail, examples of data and how it was analysed are presented in appendices VI, VII and VIII. Whitehead (2004) recommends that one must understand data within a holistic context, which naturally includes events, actions, communication and otherwise relevant contextual and environmental factors. The decision trail of this study consisted of filing all the data in such a way that my supervisors could follow the chain of events that led from the initial documentation through to the final report. It consisted of initial notes on the research question, the research proposal, the interview schedules, audio tapes, annotated transcripts, tables of themes, draft reports and this final report. Rodgers and Cowles (1993) identified areas where documentation ought to occur and thought that orderly and dated field notes were important to place interviews within context. Hence, field notes which were dated or at times scribbled in the margin of a transcript at the correct point with such information were very important during analysis. Most of my transcripts either had detailed notes as a separate file in a diary or notes in the margins. If an expression of emotion was very clear or relevant, it was included in the data that was quoted during data analysis. Changes in approach to data collection technique have been explained in the data collection section. This was in reference to the first seven interviews together with the rationale. While transcribing the interviews I wrote thorough descriptions of what happened in memoranda. My engagement with the subject matter was complex and prolonged and lasted several months.

3.13 Reflexivity

The process of reflexivity, which entailed reflecting continuously on how my background and experience as a midwife educator influenced the interpretation of this research took place throughout the process of conducting this research. I made known my preconceptions and

experiences that I came with when conducting this study at the beginning of the study, while demonstrating a commitment to closely attend to the phenomenon under study. That way the readers of this study are made aware that they are positioned as attempting to make sense of my making sense of the participants' experiences. During the process of conducting this study, I highlighted how I questioned the effect my role as a midwife educator and clinical practitioner could have influenced the interpretation of the study outcomes.

In order to understand how childbirth was experienced in Zambia, a total of 50 women who experienced birthing from different parts of all the ten provinces of the country provided the sample for the study. Purposive sampling of study participants provided me with the opportunity to acquire insights on birthing and learn from women from various parts of the country. A wide sample of individuals with experience and knowledge of the childbirth phenomenon were directly interviewed, consequently, providing a rich context to the study. Practices, beliefs and traditions that impacted women's interpretations of the childbirth experience were explored.

Authors, such as Johnson (2004) and Fulbrook (2003), advocate that in order to show reflexivity, there was need to use the first person, 'I' in academic work. When conducting this interpretive phenomenological study, wherever possible, I used the first person "I" to describe how the study was conducted and how birthing in Zambia was interpreted and experienced by women. Since the methodology required my reflexivity to be reflected throughout the research process, I described my actions when conducting this study, how data were collected, analysed and interpreted, as well as the data outcome. I should point out that this whole thesis has been a reflexive journey, in the sense that as part of using interpretive phenomenological approach, I continuously questioned everything at every stage of the

process. Interpretation of the data dealt with the meanings I made from the data and how they were translated through this process into findings. Sandelowski (2004) indicates that interpretation is the step of working with forms of analysed information so that statements can be made about what they mean in the light of the intentions, methods and processes of the research. Therefore, qualitative research findings such as this one are open to multiple interpretations because of the context-dependent and relative features of qualitative research approaches. For example, different researchers and participants could place importance on other aspects of the phenomenon. The decision trail which evolved from the description of the analysis process included here is intended to help the reader to follow the rationale for the interpretations, and that is why particular words or phrases such as "dilemma" and "I am an African" were selected. The decision trail also makes clear how I linked the words and phrases together, and what I understood them to mean for the women in the study.

Analysis generally precedes interpretation, although in a phenomenological study the process of searching for meaning is often intuitive and begins with data collection and is blended through the analysis phase in a spiral and integrative process (Sandelowski, 2004). This was my experience while conducting this study. As language is the basis of phenomenological research and words are the main source of interpretation, the approach I used required a high degree of familiarity with the text and that was why I read and re-read the scripts, as well as, belaboured analysing the scripts without the assistance of a computer programme. It was also important to keep reminding myself of the research aim and question. This re-orientation was necessary in the transition from analysis to interpretation in order to stay focussed when checking for congruency between the findings and the original aim, objectives, methods and processes of this study. The hermeneutic circle was used in the interpretation phase of this study by moving forward and backward with the data. First the text was read carefully to

ensure familiarity and then I read and re-read each transcript, and simultaneously played the audio tapes over and over. This step involved dwelling with the data. Important ideas, words and phrase were highlighted on each transcript. According to van Manen (1997) one must be aware of the parts and the whole. Therefore, in choosing significant phrases or words within a particular transcript, I maintained a mental picture of the mass of data. Thus the whole process was indeed circular and spiral from the first step of van Manen's steps of analysis to the last.

3.14 Summary

In this chapter the methodology and methods of data collection, recruitment process, the study setting, the participants and ethical issues have been discussed. Data analysis and interpretation have also been described. As the study was underpinned by interpretive phenomenology, it was worth revisiting some of the ideas of the methodology and highlight how they were applied to the study. Care was taken to address the issue of rigour, the organisation of the data and the decision trail with reference to the appendices which are included in the thesis. I explicitly highlighted the interpretive phenomenological lens by showing that there was no linear progression to an end point, but rather a lived experience of dwelling with the possibilities of what childbirth could mean to a woman birthing in Zambia. I have also explained and given reasons why interpretive phenomenology was found to be an appropriate methodology for this study. The aim of the rigour section in this chapter was not to produce a single report which claims to represent the truth nor necessarily to reach a consensus. Instead this section allows for the possibility of a number of legitimate accounts. The concern therefore, was with how systematically and transparently this particular study has been produced. The next chapter presents findings of the study.

CHAPTER 4: FINDINGS

4.1 Introduction

This phenomenological study was focused on understanding the childbirth phenomenon through the lens of women birthing in Zambia. The findings are contextual and should be interpreted as yielding an understanding of Zambian women's childbirth experiences without ignoring the uniqueness of the individuals involved. They depict childbirth experiences of 50 women aged between 16 and 38 years who gave birth in Zambia, between 2005 and 2011. According to Lundgren (2011) phenomenological studies must always be interpreted in relation to their context and time. However, although the findings are contextual, it does not imply that they would be inapplicable and have no meaning in other contexts (Lundgren, 2011). Quotes from participants' accounts are presented in italics, followed by participants' pseudonyms and the text page-number where each quote was, in the transcriptions. All the quotes are in participants' own words. To allow for a better understanding of the context of the 50 women who participated in this study, this chapter beings by presenting their socio-demographic characteristics, followed by themes and sub-themes that emerged.

4.2 Socio-demographic characteristics of participants

The socio-demographic characteristics of the participants included: age, marital status, educational background, occupation, parity, place and year of birth, as well as, the location of each interview. In accordance with the inclusion criteria for this phenomenological study, the core requisite from the participants was that they were women who had experienced childbirth in Zambia. This was irrespective of their marital status, age, educational background, outcome of the birth or whether the birth took place at home or at a health institution. Age and parity emerged to be the two most telling demographic characteristics of

the childbirth experience. Most of the participants were in their twenties with parity of more than one, giving an indication that childbirth in Zambia begins at an early age; before or at the age of 20. Only four participants were in their thirties at the time of data collection. Another aspect to this was that the age at which participants began having children was related to their level of education. The four highly educated participants were the ones who were in their thirties during the time of data collection:

- Mrs LC, a lecturer was 31 years and para 1.
- Mrs LD, a lecturer was 38 years old and para 2.
- Mrs MB, a banker was 38 years and para 2.
- Mrs MD, a secretary was 30 years old and para 1.

The four participants with tertiary education started having children at a much later age compared to the other 46 participants with secondary level of formal education or less. To avoid a mix up of experiences, since many of the participants had given birth to more than one child, each participant was asked to give an account of her last birth. Irrespective of the participants' younger ages, more than three-quarters were married, divorced or separated. Only four participants had never been married. All the participants narrated their childbirth experiences in relation to their marital status. This was despite the initial question being non-directional. Some examples of responses to the initial question, "Could you tell me how you experienced childbirth, the last time you gave birth?" were:

> *"Childbirth ehee…I was a married woman when I got pregnant and later gave birth to my second child…As a married woman I could not stop having children after having only one child…"* **(LI, p10)**

Mrs LI was a 19 year old para 2 lady who gave birth to her second child in 2011. Mrs MX, a 22 year old para 1, who gave birth in 2009 responded:

> *"I got pregnant before I got married…childbirth for me therefore began on a wrong note…I mean traditionally, no single girl should experience childbirth…"* **(MX, p1)**

Mrs LX, a 23 year old para 2 who gave birth to her second child in 2008, also related childbirth to her marital status. She began her account by saying:

> *"It was during…the time…that I met a man who proposed to marry me, and I got married…that was when I got pregnant…childbirth for me began after I got married…"* **(LX, p2)**

4.3 Themes and sub-themes

According to Gill (2014), themes are patterns of meaning, ideas, thoughts and feelings that identify and convey something of the meaning of the phenomenon under investigation for the participants. They emerge from information in the texts. Analysis of the data uncovered seven themes or meanings that gave a picture and interpretations of the childbirth experience through the lens of the 50 women who participated in the study. The themes were: 1) Conforming to societal expectations, 2) Clash between traditional and contemporary childbirth practices, 3) Being in a dilemma, 4) Loss of dignity, 5) Feeling insecure, 6) Inadequate service provision, and 7) Being there for the woman. The seven themes had several sub-themes, which were in-vivo quotes from transcripts (Table III).

Table III: Childbirth experience: Key statements, Themes and Sub-themes

Key statements	**Sub-themes**	**Themes**
*"We grow up knowing that a single girl or woman is not supposed to get pregnant and thus consequently give birth. If she does, she brings **shame and embarrassment** to her family…Society expects childbirth to be for married women only…"* (LD, p1) *"I could not eat or concentrate on anything anymore because of **fear** for my aunt… My mind just kept on thinking of how my aunt was going to react if she heard that I was pregnant. I thought she was going to kill me…I even thought of leaving town and going to … where I had a grandmother…"* (LN, p1) *"When I got pregnant with my first child…I was very **excited**…When a woman gets married; one of the expectations by society is that she should get pregnant as soon as possible. If she delays in getting pregnant, stories start circulating especially from her in-laws...they start saying that maybe she is sterile or she used to play a lot with men before getting married…"* (LF, p1) *"During my upbringing I was told to wait for someone to marry me before having sex…but the **peer pressure** became so much that I fell in the trap of trying what the other were doing…"* (LN, p1)	• Shame and embarrassment • Fear • Excitement • Peer pressure	**Conforming to societal expectations**

*"**Men and women play different roles** in society…some roles are just for men while some are just for women…you can't have men and women playing same roles…such a situation will lead to women not respecting their husband…there is harmony in homes because men and women know what is expected of them…"* (LI, p3) *"…the wife should…be grateful and support her husband by being submissive and **complying** with whatever her husband says…a good wife does not ask a husband for explanations…even though it is for my own good as well as that of my unborn baby I couldn't have an HIV test even if nurses told me to do so…"* (MI, p7) *"I am just praying that I will find a good sympathetic nurse when that time comes…All I am praying and asking for is that they should change how they are currently treating women in labour…**There is nothing I can do, but pray**…"* (LJ, p7) ***I am leaving everything in God's hands**…There is nothing I can do to change events on my own… I don't know who is going to assist me during childbirth…on my own there is nothing I can do but pray…God is in control…God himself knows what is going to happen…"* (LJ, p7)	• Gender defined roles • Compliance • Lack of assertiveness • Leaving childbirth experience and outcome in God's hands	**Clash between traditional and contemporary childbirth practices**
*"I am really in a dilemma when it comes to **choosing where to birth**…I know that although I am guaranteed to be taken care of well during labour and delivery at home; it is risky because the attendants are not skilled…and if a complication arises, anything can happen…On the other hand, although there are trained people working in clinics I am not guaranteed to be taken care of well during delivery…so again anything can happen…You might not have visible complications but be emotionally damaged…"* (LL, p6) *"At the hospital I was advised to eat eggs…at home my aunt forbade me from eating eggs…difficult to know who was correct and **which advice to adhere to**…so I left everything in God's hands…whenever my aunt was not around, I used to eat eggs…"* (MV, p3)	• Choosing where to birth • Choosing the advice to adhere to	**Being in a dilemma**

"She insulted me and angrily…walked away…as I was struggling to turn, she slapped me hard on my face; shouting…she pinched me on the thigh saying that I was stupid…she sneered at me saying that I should have thought of the childbirth pain while I was feeling good with my husband…I was ***abused physically and verbally****…"* (LL, p3) *"…the nurse shouted back at my sister saying that they were busy…my sister…also kept quiet despite having told me that bleeding in pregnancy was very serious…well there was nothing we could do…so there was nothing we could do but wait…****we had no choice*** *in the matter…"* (LI, p3)	• Physical and verbal abuse • Lack of choice	**Loss of dignity**
*"They did not explain anything to me…what these nurses should be doing is telling us all the things regarding pregnancy and childbirth…so that at least when you find out that something…you know the dangers…Not where we don't know anything…****they don't provide us with enough information****…I am sure a lot of people out there are dying due to lack of knowledge…"* (MB, p3) *"…****I was left alone****…I felt that if the nurses could not stay with me they could have asked my aunt to stay with me…I was scared to be alone in the room… and was very anxious about something going wrong while I was alone…something could go wrong while I was alone…"* (LN, p7) *"…****So that I had someone to keep reassuring me*** *that whatever it was that I was experiencing…it was part of the delivery process…****but there was no one****…"* (LN, p7)	• Not provided with enough information • Being left alone • Lack of reassurance	**Feeling insecure**

*"I think my baby died from exhaustion because the labour took very long, I took almost twenty-four hours in labour…I was in labour the whole day and the whole night…I started crying and begging my grandmother to take me to the hospital because the pain was killing me. They kept telling me to just continue pushing because that meant I was about to deliver…**they couldn't notice that something was wrong**…"* (LY, p5) *"After giving birth to the second child the nurses did not observe me. I started bleeding heavily and fell off the bed…they picked me up and put me back on the bed and started pouring water on me…One of the nurses got one roll of cotton wool from my bag and inserted it inside me to stop the bleeding…**that was not safe…it was dangerous**…"* (MK, p3) *"…there was a lady who came from some village or compound…we were admitted in the labour ward at the same time, and being attended to by the same midwives…the way they treated her was really bad…the way they handled her was completely different from the way they handled me. There was a lot of shouting around her bed…that she was dirty…she did not have this and that…she needed to do this and that…things that they did not do to me…**they were not impartial**…"* (LD, p4)	• Unable to notice deviations from normal processes • Unsafe practices • Lack of impartiality	**Inadequate service provision**
*"My grandmother stayed with me the whole time I was in labour. **That made me feel safe** and it encouraged me to be strong…whenever I felt that the pain was a bit too much for me, I would tell her and she would examine me. She kept encouraging me that I was progressing well, and that I was able to give birth…this was different from the way I was treated at the hospital…"* (ME, p1) *"For me I feel that the pain of labour is the pride for any woman. **It is a big achievement** for me…Actually after giving birth and having undergone the pain I am now looking forward to having another child…now I am ready for another delivery"* (LD,p4)	• Feeling safe • Sense of achievement	**Being there for the woman**

4.3.1 Conforming to societal expectations

"Conforming to societal expectations" was the first theme outlining how participants interpreted the childbirth experience. The theme was constituted by four sub-themes: "Shame and embarrassment", "Fear", "Excitement" and "Peer pressure". It was defined and expressed in the context of hiding or revealing facts about one's pregnancy and childbirth from people. The individual reaction of each participant was dependent on whether; she was married or unmarried at the time of getting pregnant. Hiding or revealing childbirth was described by participants as a long established pattern of behaviour for birthing women in Zambia that has been passed down through generations as a societal norm. Participants explained that one of the societal norms that Zambian women were expected to conform to was not to get pregnant and experience childbirth before marriage. This is how Mrs LD put it:

> *"We grow up knowing that a single girl or woman is not supposed to get pregnant and thus consequently give birth. If she does, she brings shame and embarrassment to her family…Society expects childbirth to be for married women only…"* **(LD, p1)**

The expectation of society stipulating that an unmarried was not supposed to get pregnant changed when a woman got married. Immediately a woman got married she was expected to get pregnant and experience childbirth. If a woman did not get pregnant and give birth within the first year of marriage, community members, particularly the in-laws started questioning her sexual integrity prior to getting married. It was therefore, not surprising to get different reflections depending on whether a participant gave birth before or after getting married. One way in which this theme was expressed was through the sub-theme: "Shame and embarrassment".

4.3.1.1 Shame and embarrassment

This sub-theme, which informed the theme: "Conforming to societal expectations" explicated the phenomenon by reflecting the experience of awkwardness and humiliation that women went through if childbirth occurred outside marriage. The experience was lived in secrecy and silence, entailing the difficulties that each individual woman who got pregnant before being married went through, as she tried to conform to her societal norms relating to one's sexuality. All the participants who got pregnant before being married narrated being preoccupied with feelings of shame and embarrassment before their pregnancies became evident. Participants talked about the expected reactions of shock from people after seeing and hearing news of their pregnancies. This is how 20 year old Mrs LN expressed her reflections of the experience of getting pregnant before marriage:

> *"Being a single mother…for a young girl is embarrassing and people laugh at you…I remember I too used to laugh at my friends who were getting pregnant…I kept on thinking who I could tell my dilemma…my husband (boyfriend then) and I were members of church…so it was going to be a shock for our Pastor to have to hear that I was pregnant before getting married…I got worried and started asking myself what could be happening…I was really in a problem…"* **(LN, p1)**

Ms LV who was in grade 11 when she fell pregnant also narrated having similar feelings. Unlike Mrs LN who got married before her pregnancy was noticeable, Ms LV still expressed feelings of shame and embarrassment during the interview because the man who had impregnated her did not marry her.

> ***"****When I discovered that I was pregnant…it was embarrassing on my part…I could not imagine the embarrassment and surprise when my friends heard that I was*

pregnant…I never got courage to tell anybody that I was pregnant…I am still living in shame because I have an illegitimate child…everyone knows about it…anyway the father to my child has promised to marry me when he finishes his studies…" **(LV, p1)**

The two participants narrated spending most of their first few months of pregnancy, psychologically battling within as to how they were going to avoid people noticing that they were pregnant. They isolated themselves and for a long time did not admit to anybody who asked whether they were pregnant. For Mrs LN who was staying with her aunt in an informal sector, where almost everyone knew everyone; the pressure of being asked whether she was pregnant from neighbours was tremendous. She said:

"…when asked by neighbours why I was isolating myself and looking withdrawn…I would lie to them (neighbours) that I was just not feeling okay…What they (people around) did not know was that I was always deep in thoughts thinking what was going to happen to me now that I was pregnant…I would go in a mirror to check how I was looking, worried that people would notice that I was pregnant…" **(LN, p1)**

The experience of "Shame and embarrassment" was expressed a bit differently by Miss LV who got pregnant when she was in grade 11, and living in a low density residential area. In her view the feeling of "Shame and embarrassment" was from her fellow classmates and church mates and not necessarily her neighbours because people hardly knew each other.

"I kept thinking of what I was going to do…I was full of shame…I stopped concentrating in class…my mind was occupied with what I was going to do with this pregnancy…My other dilemma was that I was a dedicated member of the youth group

at church…I never got the courage to tell anybody that I was pregnant…so I continued doing things as if nothing was wrong…I never bothered about my neighbours because they hardly knew whether I was married or not…" **(LV, p1)**

The experience of "Shame and embarrassment" for a single girl who got pregnant did not only affect the individual girl, it affected her whole family for generations to come. Mrs LN explained that in order to avoid bringing stigma to her family, she was secretive about the conception of her child:

"It is even worse if the child from a single mother gets pregnant or impregnates somebody; people just say 'what do you expect from a child of a parent who is not married?'…Nobody looks highly at anyone with a child outside wedlock…such pregnancies are kept as secrets…like the way it is with me…apart from my family members, everybody else thinks that I got married first then got pregnant… **(LN, p9)**

For Miss LV, her situation was different because she had to stop school, and the father of her child did not marry her. Therefore, neighbours later came to know that she had a child before marriage and thus, the possibility of her being stigmatised became likely. In a low voice, she said that she was worried about her child's future.

"…I am worried for my child…I hope he will not be stigmatised when he gets older…that he was born from a single mother…he did not choose to be born, it is I who made the mistake, not him…" **(LV, p8)**

Feelings of shame, humiliation and embarrassment were also expressed by married participants who failed to adequately prepare items that were required during institutional births. Most of the participants reported that marriage was expected to give dignity and financial stability to a woman because she had a husband who was considered to be a provider for the family. Therefore, married women who failed to buy the required items expressed shame and embarrassment because the failure revealed that they were not well taken care of by their husbands. Twenty-six year old Mrs MI expressed her experience this way:

> *"In a marriage, the husband is the breadwinner. He has to ensure that he looks for work and get money to be able to assist him take care of his wife and children. He ensures that the wife has the money to run a home effectively as well as raise the children well…therefore, it is embarrassing if a wife fails to buy the required items for birthing in a health facility…it reveals that she is suffering in her marriage…"* **(MI, p7)**

Mrs LP was a 25 year old participant who went to a health institution to give birth. She was escorted by her husband. Despite having attended antenatal care and thus, aware of the items she was supposed to purchase before going into labour, she was unable to buy the items. She stated that her husband, whose duty was to give her money to buy the items, kept promising to give her money. However, he failed to give her the money because his salary was low. The mentioned items that were required by healthcare workers to assist women in labour were: gloves, sodium hypochloride, cord clamps, maternity pads, syringes, apparatus for intravenous infusions and baby layette. Women were asked to purchase these items antenatally, in order to supplement stock in health institutions. When Mrs LP and her husband arrived at the health facility, the midwives were very upset with both of them for not

having the items. The healthcare workers shouted and scolded both of them. After the scolding, the husband was sent home to go and look for money to buy the required items. During the time Mrs LP's husband was sent to look for money, none of the health staff attended to her. She was referred to as "*Ms No gloves"*. In reference to the feelings of embarrassment, shame and humiliation, part of Mrs LP's reflections of the last childbirth experience was:

> *"They did not bother to take care of my wellbeing at all…their concentration went into shouting at me. They later told me to get on the bed which was very high for me…they did not bother to assist me get onto that high bed of theirs. In the meantime I had been bleeding antenatally. They told me that they were not going to care for me because I had not brought the required materials for birthing in a hospital…to be very frank I have never been scolded like that in my life…it was horrible…it was a very humiliating experience…I was embarrassed and ashamed…now everybody knew that I was not well married…"* **(LP, p1)**

Later, Mrs LP gave birth with assistance from the midwives, who reluctantly borrowed gloves from another woman. After Mrs LP's baby was born, the midwives left him uncovered for a long time. The infant later developed convulsions and died. When I inquired from Mrs LP why she decided to have a child when she knew she could not financially afford; her response was that she was married, and thus, she was expected by society to have children:

> *"I am married and so people expected me to have children irrespective of the fact that I was poor…I was so embarrassed the whole time, but well what could I do? That is what is expected of me by the society."* **(LP, p1)**

Apart from shame and embarrassment, participants also expressed fear of what was going to happen to them for failing to conform to societal expectations. Some of the participants were fearful of healthcare providers who were going to assist them during childbirth.

4.3.1.2 Fear

The sub-theme: "Fear" entailed a feeling of dread of how people, particularly the unmarried participants' guardians were going to react to the news of their pregnancy. Some participants were fearful of what was going to happen to their future now that they were pregnant and not married. While others were fearful of being mistreated by healthcare providers during childbirth, which is a period they felt to be most vulnerable to abuse. For the participants, fear implied that there was potential physical and emotional danger to themselves and/or their unborn babies. This is how Mrs LN expressed herself:

> *"I could not eat or concentrate on anything anymore because of fear for my aunt…My mind just kept on thinking of how my aunt was going to react if she heard that I was pregnant. I thought she was going to kill me…I even thought of leaving town and going to … where I had a grandmother…"* **(LN, p1)**

Twenty-nine year old Mrs MK mentioned that she was fearful of being discovered to be pregnant by her mother. At the time of the interview, Mrs MK was married with three children conceived outside wedlock. She gave birth to twins in 2005 and dropped out of school. Hence, when she got pregnant the second time, part of her reflections of the childbirth was fear of being killed her mother. She emotionally said:

> *"A certain lady found me crying…For days I kept on going in the bush with a hoe in order to get the roots that could assist me abort…I was scared that my mother was*

going to kill me if she learnt that I was pregnant again…It is true, I was convinced she was going to kill me…even when I told two of my elder sisters that I was pregnant; they confirmed that somebody was indeed going to be killed…My mother is a very tough woman and I was really scared…" **(MK, p2)**

Some participants stated that their childbirth experiences were characterised by rumours of misconduct and mistreatment of birthing women by healthcare providers. The rumours influenced them to become fearful of healthcare providers. Twenty-three year old Mrs LF explained that during the time of her pregnancy and childbirth, there was a rumour about midwives draining blood from newborn infants for satanic rituals. She heard this rumour when she was expecting her first child. After hearing the rumour, the excitement of realising that she was pregnant was replaced by fear of her unborn child being a victim:

"After some time the excitement I had after finding out that I was pregnant was replaced by worry and fear of something going wrong with my baby or myself…there was a rumour going around that nurses at the hospital were draining blood from babies. I was scared of what was going to happen to me, as this was my first child and I did not know whether I was going to notice when they take blood from my baby or I would only find my baby dead…" **(LF, p1)**

When asked why she decided to go and deliver at a health facility amidst such a rumour; she replied that there was a government policy forbidding women from delivering from home. Therefore, in order to be in conformity with the government policy, she had to birth in a health facility despite being fearful of losing her baby as a result of healthcare providers'

misconduct. She also stated that despite the rumour, she could not delay getting pregnant shortly after getting married, as delaying in getting pregnant after marriage would have been contrary to what was expected of her by the society:

> *"When one gets married she is expected to start having children…the situation in Zambia is that we are not allowed to deliver from home…so even if there was such a rumour and yes I was scared, I had to go and deliver from a health facility…well I needed to conform with government policy as well as society…I could not delay getting pregnant…these things govern our lives…"* **(LF, p1)**

When participants were asked to highlight the reasons why they feared healthcare providers; most of them could not give reasons. Twenty year old Mrs LN reported that she was so afraid of healthcare professionals that she could not talk when the admitting midwife asked her why she had come to the health facility, shortly after onset of labour:

> *"…my pain became more and more…after some time that is when one of them (midwife) asked us what was wrong. My aunt told them that I was in labour; I was too scared to answer them…I could not answer because of fear…there was no real reason for my fear, but the fact that they were health professionals…I had heard bad things about them, such as being unkind to mothers…I was terrified…"* **(LN, p4)**

Although most of the participants expressed fear of healthcare providers, nevertheless, excitement characterised childbirth experiences of those who were married.

4.3.1.3 Excitement

The sub-theme, "Excitement" defined the exhilaration married participants experienced when they realised that they were pregnant. Participants explained that "Excitement" emanated from knowing that they had fulfilled what was expected of them by society when they got married. They verbally stated that they were excited, and they expressed their excitement through gestures such as smiling, shyly looking down and giggling or waving their hands. Twenty-three year old Mrs LF who was a mother of one child born in 2009, excitedly said:

> *"When I got pregnant with my first child… I was very excited…When a woman gets married; one of the expectations by society is that she should get pregnant as soon as possible. If she delays in getting pregnant, stories start circulating especially from her in-laws…they start saying that maybe she is sterile or she used to play a lot with men before getting married…"* **(LF, p1)**

Some participants reported that when a woman got married she was under pressure from people to get pregnant as soon as possible. This was the experience of 19 year old Mrs MY. She narrated that she got married in 2008. Her expectation as well as that of her husband was to get pregnant shortly after their marriage. She reported that both her husband and she got worried when two years passed without any sign of pregnancy:

> *"I got pregnant with my first child after two years of being married. I do not know what was happening…for me not to get pregnant. When we got married we thought we were going to have a child shortly after. But after months of not getting pregnant, my husband began troubling me saying that it was me who was infertile not him…what were people around us saying?…This situation bothered me day and night…so when I got pregnant two years later, I was over the moon with*

excitement…I proved to society that I was not infertile and did not play with men before I got married…" **(MY, p1)**

Participants who were not married when they got pregnant blamed their failure to conform to their societal expectations to peer pressure.

4.3.1.4 Peer pressure

The sub-theme "Peer pressure" defined the burden that participants experienced from their peers to indulge in activities they knew were against their societal expectations. The experience led to them indulging in activities that led to their getting pregnant before the expected time. Some participants explained that as young ladies they were expected to be clean, smell nice, dress well and possess items such as sanitary towels. In the event that financial resources from one's family failed to provide a girl with such items, participants stated that the pressure from peers who could afford the items, led many girls to get involved in activities that ended in them getting pregnant. Mrs LN, a 20 year old participant stated that her upbringing was characterised by advice from elders not to indulge in sex before marriage:

"During my upbringing I was told to wait for someone to marry me before having sex…however, we were quite a number of dependants. She (aunt) could not manage to give us pocket money for buying essentials like sanitary towels…the peer pressure became so much that I fell in the trap of trying what the others were doing in order to buy lotion and sanitary towels…I could not buy these items because my aunt never used to give me money…It was at this time that I started a relationship with a certain young man that I met at church. At no time did I think that I could get pregnant…" **(LN, p1)**

Another participant who talked about peer pressure was Mrs MK who got pregnant when she was in secondary school. She reported that she had gone against the societal expectation of not getting pregnant before marriage because of pressure from other female pupils. She explained that observing other female pupils having items that she could not afford to buy with the money her parents used to give her, influenced her to indulge in early sexual activities:

> *"The thing is that there was a lot of peer pressure from other girls at school…girls with boyfriends came to school with nice school bags, smelling nice and with money to buy a lot of goodies…On seeing such things from other young girls, I was tempted to do what they were doing…foolishly because I was not used to such behaviour I got pregnant and my future was spoilt..."* **(MK, p6)**

Together the four sub-themes explained and defined the role society played in relation to participants' experience and interpretation of the childbirth phenomenon. Participants explained that there was a basic value system about acceptable and unacceptable behaviours in communities, and it was these social and cultural processes that defined societal norms. Hence, whether a woman experienced childbirth in accordance with the expectations of her society impacted her experience and interpretation of the phenomenon. Participants' accounts also illuminated the issue of tension between traditional and contemporary childbirth practices. This led to the emergence of the second theme: "Clash between traditional and contemporary childbirth practices".

4.3.2 Clash between traditional and contemporary childbirth practices

The second theme: "Clash between traditional and contemporary childbirth practices" defined the tension expressed by participants in relation to the differences that existed between the information on pregnancy and childbirth that healthcare practitioners and older women at home taught pregnant and birthing women. The theme was constituted by four sub-themes, namely: "Gender defined roles", "Compliance", "Lack of assertiveness" and "Leaving childbirth experience and outcome in God's hands". Participants explained that the information on childbirth practices was provided mainly by older women and healthcare providers. They reported that the information was important because it guided pregnant women's practices, actions and conduct throughout pregnancy, labour and delivery, and the postpartum periods. However, the participants' experience was that more often, the information contradicted each other: between that provided by healthcare providers and the one provided by older female relatives:

> *"Traditional childbirth practises differ from modern way in a lot of ways. Many times, these differences pose a lot of challenges to us (birthing women) because we learn about the new ways when we start going for antenatal…I was taken aback to find a young girl who I believed had never had a child teaching us about childbirth at the antenatal clinic…"* **(LH, p4)**

It was intriguing to learn that irrespective of one's educational level or social status, participants' accounts revealed that both traditional and contemporary practices influenced the way they experienced childbirth. Puzzlingly, although participants tried by all means to adhere to the practices, at times they did not clearly comprehend the reasoning behind. When asked for some clarifications on certain practices, most of the participants said that they did

not know because it was not in their sphere to ask their elders for reasons behind the practices. In some instances, participants revealed that not being able to question their elders proved to be a challenge they faced in relation to traditional practices controlled by older women. They expressed that moreover, the secrecy surrounding traditional practices was handed down from one generation of older women to the other, and therefore, it was difficult to challenge them. Participants believed that after some time their turn would come for them to be responsible for grooming younger pregnant women. It was at this time that they too will be privy to all the secrets that surrounded traditional pregnancy and childbirth practices. The practice of older women inculcating traditional pregnancy and childbirth practices to younger women gave significance to the role gender played in relation to women's experiences of childbirth.

4.3.2.1 Gender defined roles

The sub-theme: "Gender defined roles" was defined as the different responsibilities that men and women carried out during their day to day activities. There were different specific roles that men and women played in relation to childbirth. For instance, men were expected to verbalise their feelings and thoughts, and they played roles related to financially supporting their pregnant spouses. Whereas, women were expected to mask their feelings and thoughts, particularly negative ones, and they played nurturing roles. Twenty-seven year old Mrs LI explained that:

> *"Men and women play different roles in society…some roles are just for men while some are just for women…you can't have men and women playing same roles…such a situation will lead to women not respecting their husband…there is harmony in homes because men and women know what is expected of them…this is not what the*

nurses tell us during antenatal…surely how can a woman sit and rest and allow her husband to cook just because she is pregnant?" **(LI, p3)**

Mrs LT an 18 years old participant and mother of one explained that the different roles between men and women were introduced when they were still young. She stated that her sisters and she were taught how to cook, clean and care for their younger siblings, while her brothers were allowed time to study and play. She pointed out that the toys that were bought for them gave an indication of what their future roles entailed. Her brothers were bought cars, and her sisters and she were bought dolls:

"When we were growing up my brothers would be allowed to play and study after school, while my sisters and I were made to sweep the house, clean plates and cook…my brothers played with cars and we played with dolls…basically my parents were preparing us for our future roles because men and women fulfil different roles in society…" **(LT, p8)**

She explained that it was presumed that when boys grew up they would use their education to find jobs that would enable them support their families financially. On the other hand, girls were expected to marry financially stable husbands, give birth and continue rendering nurturing support to their husbands and families. Due to the gender relatedness of the roles, participants narrated that caring and kind husbands needed to hide in order to perform some of the roles that were meant for their wives. This was irrespective of the fact that at times the focus of performing the female role was to assist a very tired pregnant wife. This was the case with Mrs LN's husband when his wife's pregnancy advanced. To avoid being ridiculed by neighbours and relatives, he did the presumed women chores of washing clothes and cooking, secretly. It was only himself and his wife who knew what was going on. Mrs LN, a 20 year

old participant mentioned that washing clothes and cooking were not a man's role, hence, her husband used to do these chores in the privacy of their home. After finishing washing, the wife used to hang the clothes outside, pretending to be the one who had done the washing. Based on this experience, Mrs LN referred to her husband as "very caring":

> *"I have a very caring husband…My husband used to do the washing and cooking inside the house because if he was seen outside washing and cooking, people would start saying that I had given him medicine (traditional) to turn him into a weakling. After washing I used to hang the clothes outside in order to make neighbours think that I was the one who had done the washing…"* **(LN, p8)**

Gender-defined roles related to childbirth were not only concerned with household chores; they transcended to men's involvement in the birthing process and their general headship over childbirth choices. Men had power and authority in the public domain, but not so much over the private domain of the act of birthing. For instance, even though men's decisions about where their spouses were going to deliver were held in high esteem, they were not permitted to be there when the actual birthing process took place. One of the participants who highlighted this aspect of childbirth was 30 year old Mrs MN, who gave birth to her second child at home:

> *"Yes, my husband was at the helm of all decisions that were made regarding my birthing choices, but when it came to the actual act…my husband was instructed by older women who assisted my birth, to go away and come back home only after being advised to do so…ha! (Giggling) He could not argue…he went away quietly like a child! This is different with what nurses advise us…during one of my antenatal care visits one nurse said that we should encourage our husbands to be present when we are giving birth…"* **(MN, p5)**

The attitude of excluding men from the act of birthing was influential even in the experiences of highly educated participants' accounts. Mrs LC mentioned that her husband was not allowed to follow her to the hospital where she went to birth. In the absence of an older female relative, she was escorted by her younger sister. Asked why her husband was only allowed to drive her to the health facility and not to participate actively in assisting her during the birthing period; she replied that it was because of his gender. Another highly educated participant, Mrs LD, stated:

> *"Actually if my husband had been there I would have been nervous. Anyway my husband was told to go back home immediately I was admitted…it was a relief for me that he was not there when I was giving birth. By the time he came back the baby had already been born and I think I liked it that way…"* **(LD, p3)**

Participants mentioned that in contrast, healthcare providers were encouraging women to come with their spouses for delivery services. This information from healthcare providers clashed with the traditional practices of birthing women. Participants stated that it was taboo for a man to be near where a woman was giving birth, even if the birthing woman was his wife. Ironically, participants seemed comfortable with the practice of excluding men from the birthing process. Sixteen year old Mrs MS emphatically said:

> *"…Men are not supposed to see a woman give birth…it is against our tradition and we should adhere to it…you know these modern ways of doing things wants to mix everything…it will just bring confusion in homes…imagine the nurses in some institutions are telling women to be having their husbands on the bedside when they are giving birth…hey this is taboo…a delivery room is taboo for a man unless he works there…even then I do not think it is right for a man to see another man's wife's*

private parts…if your own husband is not allowed to see you give birth, why should another man see you?" **(MS, p8)**

When asked to express her views regarding males who work in the labour being around and assisting women during childbirth, while husbands were not allowed to be with their wives, Mrs MS shook her head and said:

"It is wrong for a man or husband to see a woman give birth…there is no explanation needed for that…the male midwife can be there because that is his job…the job of a husband is not to assist births. Well I don't know about these modern practices but I know that traditionally it is wrong…As women we need to comply with certain practices not just copying everything that White people suggest to us…" **(MS, p8)**

Gender defined roles were accepted by participants and thus, the sub-theme exposed the impact that the care provider's gender had on a birthing woman's experience and interpretation of the childbirth phenomenon. The second sub-theme that informed the theme: "Clash between traditional and contemporary childbirth practices" was "Compliance".

4.3.2.2 Compliance

Compliance was a sub-theme that was defined by participants as the submissive nature of birthing women during and around issues of childbirth. It was reported that birthing women were expected to comply with what older women, spouses and healthcare provider told them to do. This was despite the fact that they were the ones going through the childbirth experience. They mentioned that this was despite not knowing the reasons for either

traditional or contemporary childbirth practices. Participants pointed out that the traditional practice of compliance was in contrast with contemporary childbirth practices, which encouraged women to make decisions regarding pregnancy and childbirth. In participants' views, if a birthing woman opted to make her own decisions on how she wanted to experience birth, she was more likely to be in trouble with her husband, elders or healthcare providers. It was reported that traditionally, such a woman was viewed as not having been brought up properly. With this in mind, some participants stated that following contemporary practices often deprived a wife from getting financial support from her husband or it could end up in a woman getting divorced. Thus, a wife needed to comply with everything that her husband told her to do. He had the last say in everything. Twenty-six year old Mrs MI said:

> *"…the wife should therefore be grateful and support her husband by being submissive and agreeing to whatever her husband says…a good wife does not ask a husband for explanations…even though it is for my own good as well as that of my unborn baby…I could not have an HIV test even if nurses told me to do so…yes I know the implications of not getting tested…"* **(MI, p7)**

The reasons participants gave for complying with husbands' decisions varied. Some participants explained that a husband's superior role was stipulated by God. Others said it was a cultural norm that needed to be accepted and strengthened. Twenty-four year old Mrs LK, who supported the practice of compliance, stated that a wife could never be equal to her husband because their roles differed:

> *"…a wife and a husband can never be equal; they play different roles that simply complement each other… A wife has to listen to what her husband tells her to do and submit to him. I do not think there is something wrong with that; actually it brings harmony and pride in both parties. I mean how can a wife be proud watching*

television while the husband is cooking, or sweeping the house? So the duty of the wife is to listen to her husband because he is the one looking after her." **(LK, p5)**

Compliance was not only practiced in homes. It was reflected in the way women interacted with their healthcare providers. For example, in relation to childbirth, one programme that was mentioned by participants to have been introduced to maternity health service delivery in Zambia was HIV testing for all pregnant women. In reference to the programme, 22 year old Mrs LR said:

"I knew what the benefits of testing for HIV/AIDS were. But without my husband's permission, there was no way I could get tested…so I duped the nurses that I was going to the toilet when in actual fact I went back home…I told my husband about the test and asked for his permission…well I did not want to risk losing my marriage for a medical test…" **(LR, p2)**

In some of the accounts, participants stated that they had to inform their husbands about whatever transpired during antenatal care at health institutions. Informing their husbands was not only for information; it was also to allow husbands to make decisions for their wives. For example, depending on the husband's decision, some participants postponed, refrained or underwent the HIV test. They said that a properly brought up woman would first obtain permission from her husband before agreeing to practices advised by healthcare providers. If a wife defied her husband's decision, she risked being beaten, divorced or taken back to her parents for counselling on how to be a good wife. Twenty year old Mrs ML said:

"I needed to get permission from my husband before agreeing to have the HIV test…having the test without asking my husband's permission could result in me being beaten or worse still be divorced or taken back to my relatives for counselling…that is a disgrace and no woman wants that…a good wife gets permission from her husband…" **(ML, p5)**

Mrs MO, a 26 year old married participant, pointed out that even when a wife suspected that her sexual encounter with her husband could lead to a sexually transmitted infection (STI), she had no right to deny her husband sex, nor request him to use a condom:

"No, if you are a well groomed wife, you cannot start requesting your husband to use a condom…even in the event that you suspect that he could have been unfaithful and transmit some disease to you…if you get the disease it is not shameful because everyone knows that you are married so such mishaps happen because men are men…" **(MO, p3)**

She explained that the practice of wives being submissive to husbands emanated from the advice brides were given when they got married. Mrs LO, a 22 year old participant, said that her husband had the right to have sex with her whenever he felt like. To facilitate this, brides were advised during marriage counselling to always go to bed naked. If a wife was having her menses, she slept on the floor and not the bed to avoid contaminating her husband. This signalled to her husband that she was menstruating, and hence, not to have sex with her:

"I was told that I was never to go to bed dressed in anything…now that I was married, I was not to deny my husband sex. The only time I was not to sleep in my

husband's bed and not have sex with him was when I was having my periods…a wife cannot deny a husband sex…it is taboo…" **(LO, p4)**

Supremacy of husbands led to some men marrying more than one wife. Mrs ML, a 20 year old participant, in a marriage involving three women, talked about how hurt she was when her husband brought in a second wife, and later, a third one. Despite being hurt, the only thing she could do was cry in private. She explained that older women advised her not to complain lest she lost her marriage and bring shame to her family:

"It hurt me a lot…I would just hide in my bedroom and start crying because I was hurting inside…Older women came and advised me…They said that I could not afford to walk out on my marriage…I also did not have the courage to ask my husband what was happening because I was scared that he would beat me…But since I wanted to keep my marriage, I gave them (the other two wives) plates and pots so that they could be cooking on their own…" **(ML, p5)**

Participants gave accounts of how important compliance to elders and spouses was to them, even when it was at the expense of their wellbeing. They placed a lot of significance on the relationship between marriage and childbirth by explaining that a combination of the two gave a woman dignity and respect. Hence, the participants reported that they could not risk being divorced by challenging practices they felt were oppressive and discriminatory. According to the participants, the advice from older relatives was usually in direct conflict with the advice from healthcare professionals, and therefore, they reported that they did not

know how they could challenge such advice. This expression of helplessness exposed the third sub-theme: "Lack of assertiveness".

4.3.2.3 Lack of assertiveness

The third sub-theme: "Lack of assertiveness" reflected women's inability to stand up for what they thought was right or how they expected to be treated and taken care of by spouses, older women and healthcare providers. Further probing revealed that females' upbringing did not prepare them with skills to challenge information that they did not understand. In the case of this study, it was information on both traditional and contemporary childbirth practices. This led to many of the participants leaving issues of childbirth in other people's hands. In some instances, decisions by older female relatives and friends who were perceived to be experts in childbirth issues rendered women to be vulnerable to manipulation. Twenty year old Mrs LN narrated how she was manipulated by a friend to have her baby's palmar blood vessels cut:

> *"One day an older friend came to visit me. She asked me how the baby was doing. I told her that he was crying a lot especially during the night. She checked his (the baby) palms and said that he had black lines that needed to be cut in order to stop him from crying a lot. I was surprised because to me the black lines she was talking about looked like blood vessels. She argued saying that those were the ones that were making my baby cry a lot especially at night. We called my neighbour who confirmed that, yes indeed those blood vessels needed to be cut. I bought a razor blade and my friend cut my baby's blood vessels."* **(LN, p6)**

Mrs LN stated that despite her secondary education she found it hard to challenge her friend and her neighbour's revelations because they had more children and hence, they were more

experienced in issues of childbirth. Due to her inability to defend her views, Mrs LN's newborn was again exposed to treatment she described as: *"did not make sense"*:

> *"Another neighbour came to see me. When holding the baby she checked my baby's head and said that the anterior fontanelle was too big…it needed to be narrow otherwise my baby's head was going to get bigger and bigger until he died. She said she had some medicine which I needed to apply there in order for it to reduce. I paid for the medicine…"* **(LN, p6)**

Based on the knowledge she obtained from her secondary education, Mrs LN expressed doubt in the authenticity of what her neighbour was saying about her baby's head. However, instead of challenging the neighbour on the basis of her secondary school knowledge, she went and asked for clarification from her grandmother who had never been to school. The grandmother agreed with what the neighbour said, and instruct Mrs LN to start applying the medicine on the baby's head. Mrs LN reported that although she complied with her grandmother's advice, it was against her personal judgement:

> *"I started applying the medicine on my baby's head. The same neighbour also gave me some medicine to be applying on my baby's upper palate because there was a pimple like thing there. I was told that this pimple if left would finish my baby's body till he died. To me all this…did not make sense…but I was not bold enough to argue…"* **(LN, p6)**.

As previously alluded to, women rarely made their own choices. They instead followed whatever they were told by older women and spouses. Older women were said to be held in

high esteem and therefore, their word had legitimacy for younger pregnant women. Lack of assertiveness was also reported in the way women interacted with their care providers. When 30 year old Mrs LE was asked why she did not report the perceived bad attitude by healthcare providers to relevant authorities, she replied:

> *"…there may be places you can go to and complain but I do not know them…I haven't taken time to check where I can report…I have taken such bad attitudes from nurses as a way of life…if you complaint, the other women will not be there to support you…So when you complain you end up being alone and all the others keep quiet…"* **(LE, p5)**

Twenty-seven year old Mrs LJ, a para 4 gravida 5 participant who was eight months pregnant during the time of data collection, said this regarding her approaching delivery:

> *"I am just praying that I will find a good sympathetic nurse when my time to give birth comes…All I am praying and asking for is that they should change how they are currently treating women in labour before I am due…"* **(LJ, p7)**

Participants such as 19 year old Mrs LL attributed her failure to challenge oppressive practices by healthcare providers, to her low socio-economic status, poverty, lack of formal education and lack of information on childbirth issues. In comparing herself to the level of education of the healthcare workers who attended to her, she remarked:

> *"They know that they are dealing with us women who are illiterate and poor…and we allow them to do anything to us without uttering a word…so they toss us in any way*

they feel like…there is nothing that we can do…I cannot challenge nurses because they are more educated than me…" **(LL, p5)**

Although formally educated participants illustrated assertiveness in some aspects of their care, they said that sometimes they went ahead with traditional practices despite knowing that they had no scientific significance on childbirth. For instance, Mrs LC and LD; two participants who were both holders of Master of Science Degrees, mentioned observing certain traditional practices regarding childbirth despite having knowledge that they were not authentic. Mrs LC narrated that she was advised not to cry during labour, no matter how strong her uterine contractions were. She said that her aunt told her that if she screamed or cried, her infant was going to die at birth. She explained that she knew that there was no relationship between a woman crying and the death of the baby, but because the consequence was death, she could not risk her infant's life:

"…I was scared to scream or cry in labour…whenever the pain became too much...it is not the nurses or the doctors who said that I should not scream…my aunt told me that a woman in labour is not supposed to scream or cry, no matter how painful the labour is…otherwise her baby would die immediately after birth…I know it sounds absurd but well you never know…" **(LC, p2)**

Mrs LD, a lecturer, who was living with her husband whom she thought, was not old enough to know cultural issues surrounding childbirth, expressed lack of confidence in herself or her husband's knowledge about pregnancy and childbirth. She revealed that most of the knowledge they had about childbirth was obtained from books. Therefore, although she believed that the information she got from books was reliable, they were not sure whether it

was culturally correct. She explained that when she went into labour, she decided to seek the opinion of an older person, before going to the hospital:

> *"…before going to the hospital…I first consulted this elderly lady who was our neighbour…I told myself that let me consult somebody who is elderly before I go to the hospital…You know I am an African…I didn't want to do something I learnt from books and later find out it was wrong…"* **(LD, p1)**

Mrs LD said that the older person's opinion gave her comfort and peace of mind. Despite the pain of labour, she followed the older woman's advice and walked to the health institution, instead of asking her husband to drive her. She said that information on traditional childbirth practices were repeated by different older people, thus making it difficult to be disregarded. When asked for examples of traditional practices that she was expected to comply with, Mrs LN, a first time mother aged 20, said:

> *"There seemed to be so many dos and don'ts that we used to laugh a lot with my husband whenever we got a chance to be together…You know there are so many beliefs and taboos during pregnancy; so as a young girl I was disillusioned because it was difficult to remember all of them…but whenever I broke one of them there was always somebody to remind me of what I could or could not do."* **(LN, p3)**

Traditional practices on childbirth were introduced to Mrs LN by her aunt when was seven months pregnant. She was advised not to sit in the doorway because, during labour, her baby was going to descend just as far as the pelvic outlet, then get stuck. This would eventually lead to obstructed labour and then death of either the baby or her. Another practice she had to

observe was that if she started going somewhere, and then remembered that she had left something behind, she was not supposed to go back to fetch whatever it was that she had forgotten. If she returned, the baby too would keep receding during labour portraying that he or she had forgotten something in the uterus. Eventually, this was going to lead to prolonged labour and finally an intrauterine death. Similar to Mrs LC's sentiments; Mrs LN expressed concern that because the consequence of not abiding to traditional practices was death, it was difficult for her to challenge their authenticity. She complained that due to the many things she was told to observe, she was scared to do certain things, such as, drinking water during labour, despite feeling thirsty. Her assumption was that drinking water was one of the practices that she was supposed to observe during labour. Since her aunt was not allowed to be present while she was in labour, she was afraid to ask for water from the midwives who were attending to her. Hence, she did not drink water throughout labour. After having a smooth delivery, despite failing to abide by some practices, Mrs LN expressed doubts regarding the authenticity of some traditional practices. However, she said she could not convincingly rule out whether her safe childbirth was due to luck or God's intervention:

> *"The other things that made me start doubting the traditional beliefs was that, during my pregnancy there were a number of times when I used to forget not to sit in the doorway…so if the belief was true, I should have had a prolonged and difficult delivery…but no, I did not have a difficult labour…but (shrugging her shoulders) you never know, maybe I was just lucky or God intervened."* **(LN, p7)**

This theme and sub-themes that elucidated how participants experienced and interpreted the childbirth experience in the presence of conflicting traditional and contemporary practices, highlighted the difficulties that birthing women encountered during childbirth. Participants'

uncertainties on what to observe and what not to observe in relation to the childbirth experience associated the outcome of their births to God's will.

4.3.2.4 Leaving childbirth experience and outcome in God's hands

There were modern day Christian beliefs in participants' accounts of the childbirth experience. The sub-theme "Leaving childbirth experience and outcome in God's hands" entailed a widespread belief and understanding among participants that an individual's destiny was controlled by an external higher and supernatural power. Due to their Christian beliefs, the participants referred to the supernatural force as God. Some participants explained that if a woman survived childbirth or died in childbirth; the positive or negative experience and outcome was ultimately in God's hands. Participants explained that they did not know beforehand who was going to attend to them during childbirth, and neither did healthcare workers know the woman they were going to attend to. Therefore, there was nothing that a woman or the healthcare providers could do beforehand to change the course of the experience. Participants reported that the process and outcome of the childbirth experience was not under the control of the individual woman or care providers, rather, it was under the control of God. Mrs LJ who had her last delivery in 2007, and was pregnant during the time of data collection said:

> *"I am leaving everything in God's hands…There is nothing I can do to change events…I don't know who is going to assist me during childbirth…on my own there is nothing I can do but pray…God is in control… God himself knows what is going to happen…"* **(LJ, p7)**

Since a good birth outcome or experience was not because of what a woman or the care provider did, some participants said that they were fortunate to have survived childbirth. Thirty year old Mrs LE stated:

> *"I feel fortunate because a lot of unfortunate women have not had the opportunity to survive the birth ordeal…they have died, or they have been too hurt…it has nothing to do with doing things right…it is by God's grace…"* **(LE, p4)**

Some participants were explicit, and in their view going through childbirth without complications had nothing to do with healthcare providers' skills or knowledge. They believed that a good childbirth outcome occurred to women who were fortunate and believed in God. In the case where the mother or infant died, that too was the will of God and needed to be accepted. Twenty-one year old Mrs LS who talked about her second delivery that took place in 2008 said:

> *"People should learn to acknowledge the power of God. If I didn't put my childbirth experience in God's hands, the outcome could have been catastrophic even with the best carers in the world attending to me…I feel fortunate to have made it alive and without complications…I wasn't this fortunate the first time…although I did everything that was required of me, my first child died."* **(LS, p8)**

The second theme: "Clash between traditional and contemporary childbirth practices", which was informed by four sub-themes, provided meaning for some of the decisions that participants made in relation to their childbirth practices. Clashes between traditional and contemporary childbirth practices reinforced pertinent and perceived barriers to accessing

modern maternity care. Although the practices were often in conflict with each other, women mixed them up, depending who was around. They reported being disillusioned and thus, interpreted their birth experiences as the will of God. In doing so they became less assertive and complied with whatever they were advised, on the understanding that, that was their role. In complying with both traditional and contemporary childbirth practices, participants reported that they often found themselves in a dilemma.

4.3.3 Being in a dilemma

The third theme: "Being in a dilemma" illuminated participants' predicament in relation to issues on childbirth as well as the birthing process itself. Participants complained that giving birth in health institutions, which was a policy by the MOH in Zambia, predisposed them to negative treatments such as, physical and verbal abuse, discrimination based on socio-economic status, as well as, neglect and poor communication from healthcare providers. On the other hand, birthing at home predisposed them to unskilled care provision because the care providers were not formally trained to assist birthing women. Thus, most of the participants believed that birthing in Zambia was risky; irrespective of whether the birth took place in a health institution or at home. Participants expressed doubt, uncertainties and mistrust in the benefits of care provision within both formalised public health institutions and homebirths. Mrs LL remarked:

> *"I am really in a dilemma when it comes to choosing where to birth because I know that although I am guaranteed to be taken care of well during labour and delivery at home; it is risky because the attendants are not skilled…and if a complication arises, anything can happen…On the other hand, although there are trained people working in clinics I am not guaranteed to be taken care of well during delivery….so again*

anything can happen…You might not have visible complications but be emotionally damaged…" **(LL, p6)**

When Mrs LL was prompted to clarify what she meant, her response was:

"…even if they are not formally trained, the attendants at home treat birthing women with a smile…they welcome you, reassure you and encourage you to be strong…they stay with you and talk to you…not shouting…this is missing in the care we get from nurses…that to me, is being taken care of well." **(LL, p7)**

The two sub-themes that informed the theme: "Being in a dilemma" were: "Choosing where to birth" and "Choosing the advice to adhere to".

4.3.3.1 Choosing where to birth

The sub-theme: "Choosing where to birth" was defined by the participants as the predicament they found themselves in, when deciding whether to birth at home or in a health institution. Although husbands influenced the decisions regarding where their wives birthed, older women had the final say. Participants stated that often, the decision of where a woman was to birth conflicted with the information given by healthcare providers during antenatal care. When study participants were asked to give their own opinion, in line with the principles of interpretive phenomenology, participants who had positive institutional birth experiences said that they would give birth at a health institution next time they became pregnant. Those with negative institutional birth experiences said they would give birth at home. Those with positive homebirth experiences said that they would give birth at home next time they

became pregnant. Those with negative homebirth experiences said they would give birth at a health institution next time they became pregnant. Comparing home with health institutional birth experiences, 23 year old Mrs LX, a participant who had experienced a home delivery in an earlier birth said this about her institutional birth in 2008:

> *"I prefer homebirths in comparison to institutional ones because during a home delivery, a woman is talked to kindly and encouraged throughout the labour process…During my last delivery in a hospital the nurses talked and treated me harshly…they should learn to be like the women who assist in homebirths…they should also be with the labouring women; not leaving them to deliver on their own…At the moment choosing where one is going to give birth is problematic…"* **(LX, p8)**

Twenty-five year-old Mrs LW gave an account with similar sentiments. She said:

> *"There is a difference between giving birth at home and the hospital, in that, the attendants at home try by all means to ensure that no problem arises during the delivery…and they talk to the labouring woman soothingly, so that even if you are in severe pain you feel embarrassed to scream…this is what we desire the nurses to do…because they do not provide empathetic care we struggle to choose where to go and give birth…"* **(LW, p7)**

Mrs LW described the care by homebirth attendants as being *"excellent"*. She mentioned that despite having given birth in health facilities twice before, she did that because there was a government policy that forbade women from giving birth anywhere else. She complained that

had she been given a choice, she would have had her two previous births at home. Similar to other women's birth experiences, she too reported that she was left to birth alone, despite going to the midwives' office and informing them that she felt like she was about to give birth. She narrated giving birth on the floor to a baby who later developed respiratory problems. In her view, the baby became ill because the floor she was born on was cold. Another participant, 30 year old Mrs LE said that she preferred to deliver at home because many healthcare providers in health facilities were not kind:

> *"…it is better to deliver at home because giving birth at home saves one a lot of money and from the inconvenience of carrying around soiled linen, as well as the chance of contracting infections which could have been left on the beds we are provided with…with that kind of attitude, I wonder whether they clean those beds properly after each delivery…I mean the nurses do not even stay with us when we are in labour…generally they are not kind…making it difficult when labour begins…one doesn't really know whether to give birth at home or go to a clinic"* **(LE, p9)**

Mrs LE explained that she was not treated well by healthcare providers because of her low socio-economic status. However, she explained that apart from going through a negative institutional birth experience, she feared giving birth at home in case a complication arose. She reported that the dilemma of not knowing where to birth has left her with the option of not having children any more:

> *"I have decided not to have any more children. I will tell my husband that I cannot risk it any more. This is because I might die if I continue giving birth in hospitals. I want to look after my 3 children now…You may not know but a lot of women are being buried out there. The real cause of these deaths is negligence by nurses during*

childbirth…and although one is given proper care when giving birth at home, it is also risky should a complication arise…" **(LE, p8)**

Nineteen years old Mrs LL who was a mother of two children expressed similar sentiments:

*"With this second bad childbirth experience I have decided to stop having children because I feel that if I continue I may just end up dying and leaving my children…the thing that has made me decide not to have any more children is the attitude of our nurses in the labour wards…*w*hatever…it is hard when it comes to deliver…we don't know where to go because both home and hospital are risky…I may end up dying before my children grow…The way the nurses treated me at the clinic still comes to my mind often, and it scares me…"* **(LL, p5)**

In emphasising this point, Mrs MK, a 29 year old participant angrily said that publications such as the ZDHS (CSO *et al.* 2009), inaccurately reported that factors, such as high illiteracy levels among Zambian women and long distance to health facilities were the main reasons for high homebirths. In her view the most dominant reason why more women in Zambia birth at home and not in health facilities was that healthcare providers had negative attitudes towards their clients. She retaliated that women did not need to be literate to know when somebody was being kind or cruel to them. She argued that whenever a woman became pregnant, she looked forward to having a healthy baby, and not to die, be left deformed nor have her baby die shortly after birth:

"People should not lie about things like distance to the hospitals or illiteracy. The majority of us want to deliver from health institutions, but the same health workers

are the ones pushing us to deliver from home because of their bad attitudes. It is difficult to choose where to go and deliver. If healthcare workers were doing their work properly the difficulty of choosing where to birth would not arise…A lot of women go for good when they go to deliver at the hospital…the next thing we usually hear is that somebody is in the mortuary. If it is not the mother, it is the baby…" **(MK, p7)**

Mrs LH, a 27 year old housewife with no formal education, was one of the participants who said she opted to give birth at home when she became pregnant with her second child. Her choice to give birth at home was based on her previous negative experience by healthcare workers, during the birth of her first child. She excitedly said that her homebirth experience was good. She said her former birth experience influenced her to begin escorting her mother-in-law, who was a trained TBA, whenever she was called to assist in home deliveries. Through escorting and assisting her mother-in-law, she acquired the art of assisting births. Comparing how her mother-in-law helped women during childbirth with how she was assisted by healthcare professionals, Mrs LH said that she could only opt for a health facility birth if she encountered a complication during a homebirth. She proudly said that her experiences with her mother-in-law have helped her conduct three homebirths successfully. The third birth she attended was her own:

"When I went in labour with my second child in 2007, I decided not to go to the hospital because I knew that the nurses at the hospital do not give proper care. Although risky it was better for me to deliver myself at home than seek care from nurses who did not care…I battled to decide where I should deliver my baby…at home or the hospital…I finally settled to give birth at home…I discovered that the care they give at hospitals is not good when I went to give birth to my first child…the

care I got was not nice and that is how I decided never to give birth there (health facility) again…" **(LH, p1)**

In 2009, Mrs ME, a 29 year old housewife with primary education gave birth at home. She said that she refused to be taken to a health facility when she went in labour. This was due to having had two previous *"very bad"* institutional births:

"When I got pregnant the third time…although it was hard to make the decision, I told myself that I would deliver from home. This was because the care I got at the hospital during my previous deliveries was very bad…I did not tell anybody about my decision not to deliver from the hospital. So when I went into labour my grandmother told me to go and have a bath so we could go to the hospital. I refused…I told her that I did not want to deliver from the hospital…" **(ME, p1)**

Thirty-nine of the 50 participants in this study gave birth in health institutions. Nevertheless, in some instances, giving birth in health institutions was not the participants' preferences. The first reason that participants gave for delivering in health facilities was that there was a government policy stating that all births in Zambia should be conducted in health facilities by healthcare professionals. Hence, as women, they had no choice but to follow the government directive. The second reason that some participants gave was that healthcare professionals were more skilled in assisting births in case a complication arose. In their view, an institutional delivery was a safer option compared to a home delivery in case of a complication arising. The third reason was that family members, particularly older women and husbands, were the ones who influenced the decision to take a woman to a health

institution for childbirth care. Mrs LD, a lecturer at one of the Colleges in Zambia, said that her personal view regarding birthing was that:

> *"Well for me, although it is really, really difficult for a lot of women to decide on whether to deliver at home or hospital…for me every woman is supposed to deliver from the hospital because that is where you find experts. The hospital staffs know how to tackle complications that may arise…you know giving birth is a different ball game all together; anything can happen any time without warning…making giving birth at home, risky"* **(LD, p5)**

This sub-theme illuminated the difficulties that birthing women faced when it came to the place where they are expected to birth from. Although, they did not have powers to make the decision of where to birth, the decisions that were made for them influenced the way they experienced the phenomenon. If the chosen place of birth was in agreement with their preference, the birth experience was interpreted as being good, irrespective of the outcome. Birthing women reported that healthcare providers and older female relatives and friends provided them with childbirth information. However, since the information was often in conflict, depending on whether it was from healthcare providers or from female relatives and friends, participants reported having difficulties choosing the advice to follow.

4.3.3.2 Choosing the advice to adhere to

The sub-theme: "Choosing the advice to adhere to" defined the difficulties that participants encountered in trying to synthesise and select information that was provided to them during pregnancy and childbirth. It highlighted the power that individual and groups' advice on childbirth issues had over women. Participants mentioned that they got advice on childbirth

from healthcare providers, relatives, spouses and friends. In this study, advice on practices, beliefs and taboos that were mentioned by participants were diverse because study participants came from different parts of the country. The problem of not knowing which advice to follow was mainly influenced by the contrast between what healthcare providers and what relatives, spouses and friends said. For example, Mrs MC, a 24 year old mother of one, stated that not only did the information she was provided with differ from the information other women from other parts of the country had, the information was also in conflict with the one provided by healthcare providers:

> *"…but madam, cultural norms and practices are what make us who we are, and distinguish us…I say I am Lozi because as a Lozi woman there are some things pertaining to childbirth that I would follow…when I narrate the practices I have been advised to follow to my friend who is Nyanja, she might think I am being ridiculous…so yes I can say I am a Zambian but most importantly I am a Lozi Zambian woman! It gets worse because apart from differences amongst us as women; there are differences in what the nurses advise us to do and not do…Knowing what to do and what not to do is hard because of the contradictions…"* **(MC, p4)**

Women complained that if healthcare providers and relatives gave the same information, following advice would not be a problem. For example, Mrs LN narrated that during the time that she was attending antenatal care, she was found with a low haemoglobin count. The midwife prescribed iron tablets to be taken every day. When she reached home and told her aunt about the iron tablets, her aunt told her not to take them. The aunt brought her a traditional drink and instructed her to drink a cup of it every day:

"…when I was eight months…and after taking my blood and examining me…they (midwife) gave me tablets for blood because they said my blood was not enough. The nurses advised us not to take traditional remedies. When I reached home and showed my aunt the tablets, she advised me not to take the tablets…My aunt brought me some traditional medicine…she said it helped in boosting blood levels…I was confused, I did not know which one to be taking…" **(LN, p3)**

To reconcile the advice from her aunt and the one from health professionals, Mrs LN opted to concurrently drink the medicine she was given by her aunt and the tablets she was given by the midwife. The midwives and the aunt did not know that she was combining the two remedies. By the time Mrs LN was giving birth, her haemoglobin level was normal. She laughed and explained that she was not sure, which of the two helped raise her haemoglobin level. Mrs LA was another participant who found herself in a similar situation. Her grandmother advised her not to eat eggs during pregnancy. The reason for this was that if she ate eggs her baby would be born bald. Her grandmother's advice was in contrast with what midwives advised her. Mrs LA was advised by midwives to eat at least an egg daily as a source of nutrition in pregnancy:

"When I was pregnant I never ate eggs the whole nine months because my grandmother told me that if I did, my baby would be born bald. I was at crossroads because the nurses recommended eggs in my diet…at least one per day…they said eggs were good for my nutrition as well as that of my unborn baby…since the nurses were not at home to monitor my eating I ended up not eating eggs the whole pregnancy because my grandmother was always with me…and for sure my baby was not bald at birth…" **(LA, p5)**

Twenty-three year old Mrs MV gave a similar account. In her case, it was her aunt who forbade her from eating eggs:

> *"At the hospital I was advised to eat eggs…at home my aunt forbade me from eating eggs…difficult to know who was correct and which advice to adhere to…so I left everything in God's hands…whenever my aunt was not around, I used to eat eggs…my baby was not bald at birth…"* **(MV, p3)**

Advice on childbirth that women were given by healthcare providers and relatives was diverse. Nineteen year old Mrs MQ narrated that nurses did not forbid her from having sexual intercourse with her husband. This was contrary to what her aunt advised her:

> *"My aunt advised me that I was not supposed to continue having sex with my husband because my baby was going to be born with a lot of white stuff on the body. However, the nurse advised me that sexual intercourse was not forbidden…it just needed to be done gently…I didn't know which advice to choose…I think my aunt suspected that I was not following her advice…one day she came and told me to pack my things and go to stay with her until after delivery…this was a dilemma for me…"* **(MQ, p2)**

Through the two sub-themes: "Choosing where to birth" and "Choosing the advice to adhere to", the theme: "Being in a dilemma" provided an understanding of women's disillusionment of the birth experience. Participants' birth experiences highlighted the perspective that the power to make choices was held by older women and healthcare providers because they were deemed to have greater knowledge and understanding of the childbirth phenomenon. Thus, birthing women were left with no choice but to follow what they were told. The theme also

provided a reflection of the diversity of issues that influenced women's decisions on childbirth. Most times it was a choice between physical and psychological dimensions of childbirth. Given the limited number of delivery settings in Zambia, participants struggled between choosing whether to birth at home or at a health institution. Not knowing the advice to adhere to, coupled by the obligation to follow cultural norms without asking for clarifications often led to birthing women expressing that they were in a dilemma. Intertwined with other themes was the expression of loss of dignity.

4.3.4 Loss of dignity

This fourth theme: "Loss of dignity" explicated women's expressions of loss of self-respect and self-worth during institutional births. Some participants stated that they were stripped off their dignity by the way they were cared for during childbirth. Participants pointed out that healthcare providers, particularly midwives did not take cognisance of married women's right to get pregnant and give birth, irrespective of whether they could provide for the unborn baby or not. Mrs LL said:

> *"…she sneered at me saying that I should have thought of the childbirth pain while I was feeling good with my husband…I lost my dignity as a married woman…The nurse started cursing that she did not understand why we poor people without well-to-do relatives liked giving birth a lot…"* **(LL, p3)**

The theme was informed by two sub-themes: "Physical and verbal abuse" and "Lack of choice".

4.3.4.1 Physical and verbal abuse

The sub-theme: "Physical and verbal abuse" defined the ill-treatment labouring women received from healthcare providers. It included negative attitudes and harmful interventions

undertaken by healthcare providers, particularly, midwives. The participants stated that they were provided with care characterised by malice on the part of healthcare providers. Hence, most participants expressed childbirth as a very difficult period. Some participants gave accounts of being physically abused. Others complained of experiencing verbal and/or emotional abuse. Although not all 50 participants narrated experiencing abuse from maternity health workers, the participants who did not, gave accounts of personally witnessing other birthing women being abused. Participants who personally experienced abuse gave accounts of being shouted at, being told to keep quiet when they complained of pain, being ignored, being insulted or being beaten whilst in labour. Some quotes illustrating how participants were physically and emotionally abused by healthcare workers were narrated by Mrs LL, a 19 year old married woman, who, in 2011went to one of the health facilities to give birth to her second child:

> *"She insulted me and angrily…walked away…as I was struggling to turn, she slapped me hard on my face; shouting…she pinched me on the thigh saying that I was stupid… …I was abused physically and verbally…"* **(LL, p3)**

Another participant was 30 year old Mrs LE who gave birth to a child with talipes. She narrated being given a bell and instructed to push it when the pain increased. She rang the bell as was advised by the midwives, but to her disappointment no midwife came to assist her. She tried calling but still nobody came to assist her:

> *"The nurse did not come to check on me. I called her, asking her to come because I was in pain and felt like the baby was coming out. She told me to just lie down and keep quiet…I then just started shouting like a mad woman. That is when the nurse came. She was looking angry…I asked her why she has been refusing to come when I*

called her…She got very, very angry and told me that I should have known when I was sleeping with my husband that I would get pregnant…I really felt insulted and humiliated." **(LE, p2)**

Participants narrated that on many occasions when they asked for assistance, healthcare providers either ignored or talked to them harshly. Mrs LN was a 20 year old primipara who was escorted to one of the health facilities at night by her aunt after her labour began. She said the reception she received from the midwives who were in the admission room was not what she had expected:

"When we reached the hospital we found the nurses seated and chatting. They acted like they had not seen us. I had expected at least one of them to get up and get the bag we were carrying. We sat patiently on the bench provided. With time my pain became more and more but no nurse came to assist me. After a long time that was when one of them asked us what was wrong." **(LN, p4)**

Mrs MM, a 28 year old mother of one child gave an account of what happened to her when she took her child back to the health institution shortly after being discharged. The account of the childbirth experience she narrated was for her second birth. Based on her observations, she reported that her baby died due to negligence by healthcare workers. She reported that the baby developed diarrhoea and vomiting immediately when she reached home. Mrs MM was very jovial throughout the conversation. However, when she began talking about her baby's illness, her eyes started to mist. Emotional pain became evident through her facial expressions and her voice became very low:

"…at home my baby began vomiting and having diarrhoea, so we went back to the hospital. The nurses kept on chatting like they had not seen us…I mean they knew me because I had given birth a few hours earlier and they are the ones who discharged me…you know dealing with these nurses one should be ready to have their dignity stripped off…" **(MM, p3)**

Sadly, her daughter died on her lap, while waiting to be attended to. She said that healthcare attendants were seated chatting in their office despite seeing her with a very ill infant. When Mrs MM started crying for help, the healthcare professional's reaction did not please her:

"The nurse told me to keep quiet and instead take my dead baby to another room and wait. Honestly how could the nurse ask me to lift my own dead baby's body...? After a long time of waiting with my dead baby's body in my hands and no nurse coming to assist me I went to ask them [nurses] what was happening…one of them told me that it was not their duty to deal with me anymore because the days my baby spent admitted to hospital were less than three. She explained that a death became a responsibility of the hospital if it occurred after three days from the time of admission…she said my baby's death was now a police case. She told me to either get my dead baby's body and take her home or call my relatives to come and help me, or go to the police…as she had nothing to do with it." **(MM, p3)**

Mrs MM further explained that her main complaint was not only about what the health worker did or said, but it was a combination of what the midwife did and how she went about dealing with the situation. She said the nurse's tone of voice and attitude did not exhibit

sympathy at the death of her baby. In some instances, such negative attitudes were not experienced by only women who gave birth in health institutions. A similar account was given by a participant who had a homebirth in 2006. Miss LY gave birth to a stillbirth after being assisted by her mother-in-law and grandmother. The two older women advised her not to tell anybody about the death of her baby and neither was she allowed to mourn:

> *"I gave birth to a baby boy in 2006 but by the time the baby was born he was already dead…my baby died from exhaustion because the labour took very long. I took almost twenty-four hours in labour. My grandmother and mother-in-law are the ones who assisted me to deliver at home…after burying my baby secretly; they scolded me whenever I cried for my baby."* **(LY, p5)**

Later on, when Miss LY developed vesico-vaginal fistula, unbelievably to Miss LY, her mother-in-law advised her son to divorce her before getting treatment. Miss LY said that she felt abused and lost her dignity through the continuous dripping of urine:

> *"My mother-in-law influenced her son to divorce me. I tried to explain that I did not know what was happening, and that it was not my fault that urine was uncontrollably draining from my private part…they did not want to listen. Finally my husband chased me from his parents' house with approval from the mother saying that he could not live with a woman who was always smelling of urine…So I went back to my grandmother's home disgraced…I was abused and I lost my dignity."* **(LY, p2)**

Miss LY said that her vulnerability to abuse contributed to the hopelessness she felt under the care provided by the two older women. The other sub-theme that contributed to women's

expressions of loss of dignity was their not being availed a chance to make choices regarding their birth experiences.

4.3.4.2 Lack of choice

The second sub-theme: "Lack of choice" defined participants' lack of opportunity to make choices on issues regarding childbirth, or an act of another person making a decision for birthing women. This involved women's lack of choice to seek maternity care when they felt like, whom to seek maternity care from, and when or where maternity care could be sought. The experience was expressed under the influence of how participants interacted with healthcare workers and older female relatives. Compounded with the cultural norm of compliance, participants who at times had the opportunity to ask the people attending to them for clarification did not do so. In her account, Mrs LI, a 27 year old married mother of two, who gave birth to a baby girl at home, narrated how she began bleeding when she was seven months pregnant. After consulting her elder sister, Mrs LI was advised to prepare herself and go to the nearest health centre for assistance. Mrs LI's sister promptly came over and they walked together to the nearest health centre. On arrival at the health centre, Mrs LI was told that her condition was too serious to be managed at a health centre level. She was thus referred to the hospital. To Mrs LI's disappointment, the healthcare professionals at the hospital made her to wait on the queue for a long time without being attended to. This was despite giving them the referral letter from the health centre, stating that her condition was an emergency. After more than an hour of waiting and not being attended to, Mrs LI's sister stopped one health professional and explained to her that her sister's bleeding was getting worse. To Mrs LI's dismay the health professional began shouting at her sister:

> *"…At the hospital I gave a nurse my referral letter from the clinic, which stated that my condition was an emergency. She read it and told us to wait on the queue...we had*

no choice but to wait. My elder sister tried to explain to another nurse that at the clinic we were told that my case was an emergency…The nurse asked my sister if she was deaf or blind not to see that they were busy...we had no choice but to wait until they (the midwives) felt they were ready to attend to me…you know such treatment is so dehumanising and I felt like a nobody…well there was nothing we could do…we just kept quiet…there was nothing we could do but wait…we had no choice in the matter…" **(LI, p3)**

Mrs LI later said that this encounter with the midwives led to her having a homebirth when her pregnancy reached term. "Lack of choice" was also expressed in reference to the place of birth. Some of the participants said that they gave birth in health institutions while others had homebirths because people who were assigned with the responsibility of assisting them during pregnancy and childbirth decided where they birthed. This was done without consulting the birthing woman for her preference or what she had been advised when attending antenatal care. Mrs MV, a 23 year old married lady, who gave birth to her first child in 2008, said that her mother was the one who decided that she goes to deliver at a hospital. The participant emphasised that she had no choice but follow her mother's decision, despite having information that the healthcare providers at the hospital were unkind to birthing women. She pointed out that she could not openly disagree with her mother because she was her parent:

"When I told my mother that I was in labour, she booked a cab without consulting me and took me to the hospital…I did not want to deliver from the hospital because I had information that the nurses there were cruel…I had wanted to deliver from the small

health centre where I had been attending antenatal…well I had no choice in the matter and could not argue because she is my mother…" **(MV, p2)**

In a similar story, Miss LY, a participant who later developed vesico-vaginal fistula narrated how she was forced by her mother-in-law and grandmother, to deliver from home and drink traditional medicines in order to intensify her uterine contractions. This was despite Miss LY's pleas to be taken to the hospital due to continuous and very painful uterine contractions:

"I was made to drink water which had roots soaked in. I drank two big cups…Well. I had no choice but to drink the concoction…the bitter drink was forced on me…After drinking the medicine the pain…oh…it became very severe…I thought I was going to die…" **(LY, p4)**

Miss LY said that her baby was stillborn while she ended up with a vesico-vaginal fistula. After the experience which she referred to as *"horrific"*, the two elderly ladies privately buried the baby and told Miss LY not tell anybody about the baby's death and subsequent burial. She said she obliged to the instruction and lived for five years without telling anybody about the incidence. The first time she talked about it was in 2011 during data collection for this study:

"It is a horrific ordeal I have lived secretly with since 2006…this is the first time I am revealing it to anybody…my grandmother and mother-in-law told me never to reveal what happened to anybody…anyway they have both passed away so I can talk about it…Childbirth made me lose my self-worth and dignity because I was dripping and

smelling urine all the time; not by choice but because my grandmother and mother-in-law refused to listen to my decision of being taken to the hospital… **(LY, p2)**

Another participant, Mrs LN, a 20 year old mother, explained how she was instructed to go and live with her aunt when she was eight months pregnant. She said her aunt told her that leaving her matrimonial home was a traditional practice. Although she explained that she did not see the need of leaving her home, she had to do it:

"I was surprised when my aunt came one day and said I should pack my things because I was going to be living with her until after giving birth…she gave me no choice but do what she told me to do…At my aunt's place I was not allowed to rest like I was doing at my home…This was very difficult for me because now I was feeling very tired and my pregnancy was big and heavy…well I had no choice…" **(LN, p3)**

Antenatally, midwives had told Mrs LN to deliver in a hospital because she was a first time mother with a history of anaemia. However, when she went in labour, her aunt took her to a health centre. The older woman ignored Mrs LN's request to be taken to the hospital as instructed by midwives:

"When I told her that I was having abdominal pains, backache and draining, she asked me whether she could take me to the clinic, I told her to take me to the hospital…While I was lying down I just heard her come and tell me to get in the car so that we go to the clinic. She did not give me a choice and I could not say anything because she is my aunt…" **(LN, p4)**

When Mrs LN was asked how her aunt's decision to take her to a health centre instead of the hospital made her feel, she responded:

> *"…I felt bad that my aunt gave me no choice…but I had no say or control over her decision…I could not overrule her…culture is culture and it has to be followed, no matter how it makes you feel…"* **(LN, p4)**

The theme: "Loss of dignity" through the sub-themes: "Physical and verbal abuse" and "Lack of choice" provided an understanding that there were certain ways in which women expected to be cared for during childbirth. The experience of not having their expectations met, influenced their interpretation of the birth experience as belittling. Despite the acknowledgement that the socio-economic status of most women birthing in Zambia was lower than that of the people who assisted them during childbirth, it was reported that a woman who had experienced childbirth commanded respect from community members. In keeping with the cultural norm of compliance, birthing women often kept quiet irrespective of the knowledge that something wrong was being done to them. Most of the participants stated that although they never verbalised their feelings, they inwardly did not approve being abused and not being given birthing choices. After going through such experiences, participants expressed feeling insecure about the childbirth experience.

4.3.5 Feeling insecure

The fifth theme: "Feeling insecure" defined the apprehension, lack of confidence and anxieties that participants experienced due to not having knowledge of what was going on around them during childbirth. The theme also highlighted birthing women's experiences of

fear and uneasiness with their maternity care providers. In reference to this theme, Mrs MB said:

> *"I felt very insecure throughout my childbirth experience because I didn't know what was going on around me…I didn't know what the nurses and doctors were going to do next…I didn't know whether my baby was well inside or…whatever…it was not a nice feeling…"* **(MB, p3)**

The theme was informed by the following sub-themes: "Not provided with enough information", "Being left alone" and "Lack of reassurance".

4.3.5.1 Not provided with enough information

The sub-theme: "Not provided with enough information" exemplified a lack of awareness and knowledge among participants on the birthing process and how to care for themselves and their newborn babies during antenatal, intrapartum and postpartum periods. Participants reported that even though procedures done by healthcare workers directly affected individual birthing women, not enough information was provided. Accounts by participants were characterised by expressions of not knowing what healthcare professionals who were attending to them were doing. Many times women's accounts pointed to poor communication between maternity healthcare providers and birthing women, or a complete lack of communication. Some participants talked of healthcare providers not communicating to birthing women at all. The problem encompassed inadequate communication skills such as, participants not understanding what healthcare providers were saying, and how the information was relayed. Poor and/or a lack of communication resulted in women saying that they did not have enough information on pregnancy and childbirth. The participants

highlighted that they were not provided with enough information about their pregnancies and childbirth from the time they began attending antenatal care up to the postnatal period. Such experiences contracted birthing women's expectations and hence, resulted in participants' expressions of insecurity and lack of confidence in the healthcare system. Mrs MB said:

> *"They did not explain anything to me…what these nurses should be doing is telling us all the things regarding pregnancy and childbirth…so that at least when you find out that something…you know the dangers…Not where we don't know anything…they don't provide us with enough information…I am sure a lot of people out there are dying due to lack of knowledge…"* **(MB, p3)**

Miss LT, an 18 year old single mother, who delivered in 2009, said that healthcare professionals who attended to her during the antenatal period talked too fast during health education sessions:

> *"I cannot remember what the nurses taught us antenatally in readiness for delivery because they were too fast in their health education talks, and I was afraid to ask them to repeat what they were saying…Not knowing anything made me feel very insecure…"* **(LT, p2)**

Mrs LD, a para 2 lecturer, aged 38 years, who gave birth in 2008, said that she could not remember the things that healthcare professionals talked about during the antenatal care health talk sessions. In her opinion, this was because the sessions were general and not specific to pregnancy and childbirth:

> *"…I cannot remember anything because I expected to be taught things that were specific or associated to pregnancy; not general talk. I expected to hear things like; now that you are pregnant you are not supposed to eat this and that or do A, B, C. I wanted to be told about rest, about exercises, about STIs, about hygiene, clean water and all these other related issues not the monotony that was there. I wanted to hear things that were pertaining to pregnancy and childbirth and what happens after; not the general talk that characterised the health education talks..."* **(LD, p4)**

Participants' explanations of not being provided with pertinent information did not only concern the quality and content of the issues that healthcare workers discussed. Some participants pointed out that healthcare workers, particularly midwives, shouted, scolded, remained mute or/and spoke harshly to women most of the times, They reported that the midwives seemed to act as if they were oblivious of the anxieties of pregnancy and the pain of labour that women were experiencing. For instance, Mrs MB, a 38 years old banker, who had a caesarean section in 2008, due to fulminating pre-eclampsia, said that healthcare workers, who included obstetricians and midwives, did not tell her why she could not be allowed to have a vaginal birth. The healthcare workers did not also explain why she was advised to observe complete bed rest for the whole period that she was waiting to be taken to theatre for caesarean section. Mrs MB narrated that her 2008 birth experience began with her waking up and finding her whole body swollen. She did not think much of this because according to the information she obtained from the antenatal clinic, swelling of the body was normal in pregnancy. Later in the day she decided to call her sister. During the conversation with her sister, she mentioned the body swelling. This is what Mrs MB said about her sister's response:

"My sister told me to urgently discontinue the telephone conversation and rush to the hospital immediately…she said I was not even supposed to drive to the hospital but instead get somebody to drive me or book a taxi…" **(MB, p2)**

Mrs MB was surprised that her elder sister, who apparently was a health person, told her to rush to the hospital. On arrival at the hospital Mrs MB was admitted. Despite the urgency in her sister's voice, regarding the seriousness of her condition, Mrs MB was made to wait the whole day before being taken for caesarean section. She was not given information on what was going on:

"I do not know why I was told not to move…they (obstetricians and midwives) did not explain anything to me. I was surprised at the fuss nurses and doctors were making over me because apart from the body swelling, which I thought was normal in pregnancy; I was feeling well…They said I should just lie down and rest. So to me in a way it didn't make sense…" **(MB, p2)**

After keeping Mrs MB in hospital the whole day, without an explanation of what the problem was, midwives abruptly woke her up at 05.00am and took her to theatre for caesarean section:

"...it is my guess…they never told me anything. I think my condition was getting bad…I just overhead…just overhearing…so anyway I would not lie, I don't know…they just came to my bed and started moving everything…they even cut my rings; so to me it was like ah…what is happening now?...I was not told anything…I panicked because I didn't know what was happening…" **(MB, p3)**

Mrs MB revealed that she later received information about how serious her condition was through several other telephone conversations she had with her elder sister, who had initially advised her to go to the hospital. After a week, Mrs MB was discharged, still without any healthcare worker explaining anything to her:

> "*After seven days I was discharged without any health worker explaining to me how serious my condition was. This has made me lose confidence in the nurses and doctors…"* **(MB, p3)**

Some participants failed to state what health professionals had advised them to prepare in readiness for childbirth. Apart from mentioning the paper outlining the items that all pregnant women were supposed to buy in readiness for childbirth they, participants stated that they did not know why healthcare professionals asked them to buy the items. They explained that the information they had on maternity care in Zambia was that all services, starting from antenatal to postnatal were free. Therefore, when midwives asked birthing women to buy items, such as gloves, they were of the view that they were stealing the items. Mrs LU, a 20 year old para 2 remarked:

> *"We are asked to buy gloves, maternity pads, bucket, a razor blade, jik, a cord clamp and two pieces of cloth (chitenge)…when I came with five pairs of gloves, I was told that they were not enough…I had to buy another five pairs at K15, 000.00 from the nurses I found in labour ward. I do not know why they did not give me hospital gloves…There is a nurse where I live who sells gloves…Tell me, where do you think the gloves she is selling are coming from? Maternity care in Zambia is free…that is what I know…If maternity care is not free, then nurses are at fault because they did not give us that information."* **(LU, p10)**

Mrs LX, a 23 year old para 2 gave similar sentiments. She emphatically said:

> *"The nurses are the ones who are at fault because they do not give us any information…They didn't tell us that government had failed to buy items used during childbirth…and that was why we were being asked to buy…We were just handed papers and told that we needed to buy the listed items before coming to give birth…no explanation whatsoever…"* **(LX, p4)**

Some participants explained that not being provided with adequate information of what was happening and why certain items were demanded of them led women not to trust healthcare providers. Mrs LF who was a first time mother said:

> *"She (the midwife) showed me the sex of the baby and told me to get up and go to another room leaving my baby behind…When I woke up I found that my baby had not yet been brought to me. I started getting worried…Sometime later another mother woke me up and asked me where I had left my baby. I told her that the nurses had not yet brought him from the room where I had given birth. She told me to go there, warning me that the nurses had a tendency of draining blood from babies for satanic rituals leading to babies dying after birth…"* **(LF, p2)**

In Mrs LF's account, a fellow postnatal mother who was sharing a room with her volunteered to go and talk to the midwives on her behalf after observing that they were taking too long to bring the baby to the mother:

> *"I was still feeling too scared to confront the nurses, so this other woman went to tell them that I had sent her to fetch my baby. They told her that they were still dressing*

the baby. The question I asked myself was; why tell the other woman about dressing my baby…why did they not tell me?" **(LF, p2)**

Mrs LF said she was not satisfied with the explanation of keeping the baby in the treatment room for the purpose of dressing him. Even after going to the room and seeing the midwives dressing her baby, Mrs LF said she believed that some misconduct of some sort was being done to her baby:

"…I gained some courage and went to tell the nurses that I needed to breastfeed my baby…I decided to go in and stand there watching how they were dressing my baby. They finished wrapping the baby in a shawl and gave him to me…Even after being given the baby I was still sceptical, so I kept on checking my baby worried that he might suddenly die, for I could not understand why the nurses had kept my baby for so long in their room." **(LF, p2)**

Not being provided with enough information did not involve antepartum and intrapartum periods only, it also encompassed the postpartum period. Mrs MX, a 22 year old mother of one said that she was not given information on care of herself and her newborn baby:

"The nurses did not teach me anything on care after childbirth…they just gave me a discharge slip and told me to bring back my baby to the clinic for review after one week…Had it not been for my mother, I do not know what I would have done in relation to taking care of myself and my baby postnatally, especially that I was a first time mother…" **(MX, p7)**

In part, due to the pattern of communication between healthcare providers and birthing women, participants stated that they had little or no information upon which to act if they experienced difficulties during pregnancy, childbirth and the puerperium. Participants pointed out that the reason why there was poor communication between them and the healthcare personnel was because most women giving birth in Zambia were not educated, and therefore, they had low socio-economic status:

> *"…these nurses do not communicate nicely with us because they know that we are poor and there is nothing we can do to them…I felt very insecure the whole time I was with nurses…"* **(LL, p2)**

This sub-theme elucidated how women experienced birthing under the influence of being insecure and uncomfortable with care providers. They mentioned that their insecurities were heighted by being left alone for long periods of time, whilst in labour,.

4.3.5.2 Being left alone

The sub-theme: "Being left alone" expounded healthcare providers' practice of physically leaving birthing women alone and unattended for long periods of time. Majority of participants gave accounts of having had been left alone, from their time of admission until delivery. They reported that after being admitted, healthcare workers told their relatives to go home with the reassurance that they would not leave them alone. However, in most instances, this was not the case. Mrs LE who was escorted to the hospital by her husband said:

> *"My husband was harshly told to go home without being given a chance to say bye to me…he was not told to bring a female relative to come and stay with me…instead*

after he left, the nurses left me to labour alone…oh, oh I felt very insecure and afraid…" **(LE, p2)**

Twenty-five year old Mrs LW who gave birth to her second child in 2007 said that when her labour began, she rushed to the hospital leaving the bag that contained the items she had prepared to use during childbirth. Her mother and some friends followed with the bag. After Mrs LW was admitted, her mother asked the midwives if she could be allowed to be on her daughter's bedside. The midwives did not allow her. Instead, they advised her to go home and come back to check on her daughter the following morning:

"My mother tried to ask if she could stay with me as it was at night but the nurses chased her together with the other people who had come with my mother...they left me and went back home because they were rudely chased…immediately my relatives left, the nurses also left and went to their office…I was scared…" **(LW, p1)**

Relatives who escorted labouring women to health facilities seemed to be aware of the practice of leaving birthing women alone and unattended. Suspecting that their niece was going to be left alone, Miss LV's aunties asked a relative who was nursing a patient in the same ward to check on her when they were advised to go back home:

"…in the same ward that I was admitted, there was my uncle's niece who was on the bedside of a relative who had delivered by caesarean section. My aunties told her to be checking on me fearing that something might go wrong because they seemed to know that the nurses were going to leave me alone..." **(LV, p2)**

An issue that was raised in relation to leaving women alone in labour for a long time was that of a *"bell".* Not understanding how the bell operated, participants were asked to explain the modalities of the *"bell"*. Participants explained that it was a metal gadget, which made a loud noise when pushed. Miss MA, a 19 year old mother of two who gave birth in a health institution in 2009, narrated how midwives gave her a bell. Miss MA said she was instructed to ring the bell whenever she needed assistance. Ironically, when she rang the bell, the midwives did not come as they had promised. In the end, although Miss MA had an institutional birth, she was not assisted by a health professional:

> *"…they gave me a bell…it was not necessarily a bell, it was a metal gadget that made a loud noise when you moved it…anyway I kept ringing the bell, but none of the nurses came to help me…It is either they were sleeping because it was at night, or they just ignored me…the noise from the bell was loud…I ended up giving birth alone."* **(MA, p5)**

Mrs LU was a 20 year old para 2 participant, who was escorted by her mother to a health facility for delivery care. After being admitted, Mrs LU's mother who expressed desire to stay by her daughter's bedside was told by the admitting midwife to go back home and return the following morning. Mrs LU explained that she suspected that the healthcare workers were not going to be with her. Immediately her mother left, the midwives also left and went to their office:

> *"Inwardly, I knew and even my mother knew that the nurses were going to leave me alone immediately my mother left…I was so afraid to be alone…and indeed the nurses left me alone…"* **(LU, p3)**

Mrs LU was told to ring the bell when she felt the need to have the midwives' attention. She followed the instructions and rang the bell when she felt that delivery was imminent. To her disappointment, the midwives never came to her aid. In the end Mrs LU delivered without assistance. Mrs LU said that the treatment of being left alone was not what she expected from health personnel. She momentarily forgot that she was chatting with me and started shouting that:

> *"…people's expectation when they go to a health facility to deliver is to ensure that they get professional childbirth assistance, and part of that professional assistance is being with a labouring woman and observing her; not leaving her alone…at times one feels like punching these nurses…"* **(LU, p10)**

After some time she calmed down, smiled, and then laughed, apologising to me for losing her temper. Mrs LU and Mrs MA were not the only participants who narrated feeling insecure due to the treatment that they were provided with. In another interview, and amid shrugging of shoulders and shaking of the head, signifying her displeasure, Mrs LN, who was 20 years old and a first time mother said that she felt scared when nurses left her alone:

> *"I got scared when the nurses left me alone in the room…eh!…I was very anxious about something going wrong because the nurses left me alone…what was I going to do if anything went wrong and I was alone?"* **(LN, p7)**

Apart from being afraid and insecure after being left alone for long periods of time, participants explained that they were deprived of being reassured during birthing.

4.3.5.3 Lack of reassurance

The third sub-theme: "Lack of reassurance" elucidated a desire in women to be encouraged and comforted during the birthing process. In the absence of such encouragement women expressed being apprehensive and anxious throughout childbirth. Thirty-one participants mentioned that they would have loved to have a female relative on their bedside the whole time that they were in labour. This was for the purpose of being reassured. The participants explained that such encouragement would have influenced them to be strong and thus, withstand the pain of labour. They pointed out that going through the pain of labour without hearing encouraging and reassuring statements from anybody made the process very long and painful. Twenty year old Mrs LN stated:

> *"I wanted my aunt to be on my bedside whilst I was in labour…surely, since the nurses knew that they were not going to stay with me, they could have asked my aunt to stay with me so that I had someone to reassure me that, whatever it was that I was experiencing, it was part of the delivery process…labouring alone made the whole process very long and unbearable…"* **(LN, p7)**

Miss LT, a single, 18 year-old primipara who gave birth in 2009 said:

> *"Being my first time in labour, my desire was to have my mother on the bedside so that she could let me know what was happening…the nurses told my mother to go back home…I got scared…I didn't know what was happening the whole time…nobody encouraged me to be strong…this made my labour unbearable…it was like eternity for me…"* **(LT, p3)**

The theme: "Feeling insecure", which was informed by the sub-themes: "Not provided with enough information", "Being left alone" and "Lack of reassurance" was expressed to have a negative impact of participants' future reproductive choices, such as who and where to birth. It exposed participants' desire to birth in an environment that gave them peace of mind and safety. In their view, information and encouragement were ways in which birthing women could feel secure with providers who attended to them. In the absence of this they referred to the care they were provided with as being inadequate.

4.3.6 Inadequate service provision

The sixth theme: "Inadequate service provision" was conceptualised by three sub-themes: "Unable to notice deviation from normal processes", "Unsafe practices" and "Discrimination based on socio-economic status". The theme defined women's interpretation of the childbirth experience in the context of provision of maternity care that did not meet expected standards. Experiencing such type of care led to birthing women having uncertainties with the way maternity care providers' provided care:

> *"We are provided with inadequate services…that is why at times we take the risk of giving birth at home…The services given during a homebirth are also inadequate at times because the people who assist are not trained."* **(MS, p5)**

4.3.6.1 Unable to notice deviation from normal processes

The sub-theme: "Unable to notice deviation from normal processes" elucidated the failure by maternity care providers to correctly interpret what was happening to women during childbirth. Mrs MK, a 29 year old mother of three, who gave birth to twins in 2005, said she developed a postpartum haemorrhage (PPH) shortly after giving birth. She stated that her first

twin was delivered at 05.45 hours while the second was delivered at 19.00 hours. She said that she was surprised to observe that healthcare providers did not seem concerned about the almost 14 hours that passed between the babies' births:

> *"Around 05.45 hours one of the babies started coming out with the bottom. By this time all my energy had gone…after some time the first twin was delivered…The second one was a problem to come out…he kept on changing positions. After some time he stopped moving and the labour pains stopped. I slept from 05.45 hours in the morning after the first twin was born up to 16.00 hours in the late afternoon…I was surprised…to me, this was strange but the nurses did not seem to notice that this was not right…they did nothing to assist hastening the birth of the second baby…The labour pains resumed at 16.00 hours and the baby was finally born at around 19.00 hours. After that I started bleeding heavily…"* **(MK, p3)**

She complained that the nurses did not consider that she had given birth to twins, and that the length of time between the births was abnormally long. She narrated falling off the bed and bleeding profusely per vaginum, shortly after being transferred to the postnatal ward:

> *"After giving birth to the second twin the nurses did not observe me…In the postnatal ward I started bleeding heavily and fell off the bed. That's when the nurses came running…they picked me up and put me back on the bed and started pouring water on me…I was surprised when one of the nurses got a big piece of cotton wool from my bag and inserted it inside me to stop the bleeding…I thought that was a strange action…"* **(MK, p3)**

Mrs MK's mother expressed concern about the way healthcare workers were managing her daughter's condition, but she was told to keep quiet:

> *"My mother asked if inserting cotton in my private part was correct and adequate to stop the bleeding…the roll of cotton wool was very big. They (midwives) told her to keep quiet and said that…that is why they do not allow relatives on birthing women's bedsides…they said relatives talk too much"* **(MK, p3)**

The inability to notice deviations from normal was not among healthcare providers only, some participants who birthed from home, narrated undergoing similar experiences. Miss LY, a 23 year old accountant who was assisted by her grandmother and mother-in-law during a homebirth stated that although she was very young when she had her first delivery, she noticed that something was wrong:

> *"I was in labour for a long time but for some unknown reasons I was failing to deliver…Although this was my first time to be in labour, I thought this was not normal…My grandmother and mother-in-law didn't seem to notice that the labour was abnormally long…they kept on telling me to push…I delivered the following day to a dead male baby…A month after giving birth I noticed that water was dripping from my private part uncontrollable…after some time I realised that it was urine not water because of the smell…My mother-in-law didn't notice that this too was abnormal…"* **(LY, p1)**

When Miss LY's contractions stopped, her care providers made a drink from a mixture of roots, and advised her to drink a cup full. After drinking the concoction, the contractions

became very strong. She pleaded with her providers to be taken to a nearby health facility. Her pleas were ignored, and the information that she was given by her two attendants was that the pain was due to her imminent birth. However, this proved not to be the case:

> *"I started crying and begging my grandmother to take me to the hospital because the pain was killing me…They kept telling me to just continue pushing because that meant I was about to deliver…To them the labour was normal…But I never gave birth until the following day…"* **(LY, p4)**

A similar homebirth experience was narrated by 29 year old Mrs LG who was a mother of one. Her second birth, which ended with the infant dying, was assisted by a neighbour. She said that her neighbour did not notice that the foetus was in the breech position until the feet became visible:

> *"My neighbour who assisted during the birth of my late second child didn't realise that the baby was not lying normally…I mean starting with the head. She only realised when she saw the baby coming out with the legs. Unfortunately he was big, so after the legs came out, he got stuck. My neighbour tried to pull the baby out but the baby seemed to be totally stuck…The baby descended up to the abdomen and got stuck again. After another long-time of tagging and pulling, the baby descended up to the shoulders then the head got stuck again…Finally, the baby came out, but he was very, very tired…a week later my baby died…"* **(LG, p2)**

Participants narrated that providers of maternity care, be it at home or a health facility, not only failed to notice deviations from normal, they failed to interpret normal progress of

labour; particularly, the second stage of labour. However, some participants postulated that in the case of healthcare providers the misinterpretations were often deliberate. Participants reported that providing birthing women with wrong information was often aimed at misleading labouring women about the imminent second stage of labour because most of the healthcare providers did not want to stay and assist clients. Twenty year old Mrs LU based her interpretation on the experience that she had when giving birth in 2011. She reported suggesting to the midwife that she felt that the second stage of labour was imminent:

> *"After examining me, she said that my labour was not advanced enough for me to start pushing. I told her that I was feeling like the baby was about to come out. She refused saying that she was the one who had examined me and thus knew that I was still far from giving birth. Shortly after she left, I gave birth…"* **(LU, p1)**

Twenty-two year old Mrs LO also gave a similar account. She too gave birth immediately after being told that she was not yet in second stage of labour:

> *"At the clinic I was told after being examined that I was still far from giving birth. The nurse told me to get off the examination couch and go to the waiting ward. I got up from the examination bed but before I could reach the door, the baby started coming out."* **(LO, p1)**

Both Mrs LU and Mrs LO explained that they failed to understand how midwives could not notice imminent births. Miss LV, a 19 year old participant, who gave birth in 2011, narrated hearing midwives telling other women who were in labour that it, was going to take a while

before they gave birth. She said she was surprised to see the women giving birth shortly after being advised to the contrary:

> *"…women were told that their labours were not advanced, so it would take a while before giving birth…surprisingly the women delivered immediately the nurses turned their backs. The question that I was asking myself was: how were the nurses failing to notice that women were about to give birth?"* **(LV, p6)**

The perceived bad attitude by healthcare was interpreted by participants as being deliberate and negligent. They believed that given the fact that midwives were trained, there was no way that they could mistake a woman who was about to give birth and one whose childbirth was not imminent. Twenty-one year old Mrs LS who gave birth to her second child in 2008 said:

> *"These people are trained to look after birthing women every day, so they knew that I was about to give birth…there is no way they can fail to notice labour that is abnormal…their telling me that my labour was not advanced was deliberate…I know they are well trained so what they did to me was deliberate… they do not look at other women as people like them."* **(LS, p8)**

Apart from stating that most maternity care providers were often unable to notice deviations from normal, participants expressed that they experienced birthing under circumstances that exposed them to unsafe practices.

4.3.6.2 Unsafe practices

The sub-theme: "Unsafe practices" illuminated procedures and practices, which put the lives of birthing mothers and their infants at risk of injury or death. These practices were mostly carried out by healthcare providers. Taking into account that healthcare workers were trained, participants associated the unsafe practices to negligence. Some of the practices mentioned included midwives leaving the responsibility of assisting births to labouring women's relatives, while they went to sit in the offices. Participants reported that some midwives were cruel because they knew that the relatives had no clinical birthing skills and knowledge, and that was why government was encouraging women to give birth in health institutions. Mrs MP said:

> *"…the reason why the nurses asked my sister to remain on the bedside with me was deliberate…*they *left the responsibility of caring for me to my sister who knew nothing about assisting in childbirth while they were sleeping…you know the nurses literally went to sleep leaving me with my inexperienced sister…since my sister was not trained to assist women in labour, she did not know what to do when my baby began coming out with legs…she did not know what to do! She tried knocking on their office and shouting to them to come and assist, but none of them came out of the office to assist…it was very dangerous for both my baby and I."* **(MP, p9)**

With tears in her eyes, Mrs MP narrated that her baby died three weeks after birth. She described the birth experience as *"horrible"* and related the death of her baby to the unsafe, but common practice of leaving women under the care of attendants who were unskilled:

> *"It was not right…it was horrible…actually it was an unsafe practice by nurses to leave me with an inexperienced person to monitor and assist me in labour…my baby*

died because of their cruel, uncaring and unsafe practices…they usually leave birthing women and go to sleep in their office…" **(MP, p10)**

Mrs LN said that midwives left cotton wool in her birth canal after suturing the tear she sustained while birthing. She explained that she did not know when to remove the cotton wool because she was a first time mother. Later she was discharged. Three days postpartum, Mrs LN began experiencing severe abdominal pains. Her aunt tried to give her Paracetamol for the pain, but it did not relieve the pain. Noticing this, the aunt decided to take Mrs LN back to the health centre. While the aunt was bathing Mrs LN, in preparation to taking her back to the health facility, a big piece of smelly rotten cotton wool fell out. Mrs LN said she had to be put on two weeks antibiotic treatment to prevent complications from arising:

"The midwives who helped me during labour were careless. They left cotton wool in my private part without telling me when to remove it…it got rotten and almost led to complications arising…Had it not been for my aunt I would have died…I was a first time mother who didn't know what was happening…" **(LN, p5)**

Participants reported that unsafe practices were not directed at mothers only. Newborns were also affected. Mrs MG, a 24 year old mother of three, who gave birth in 2009, narrated how her third child almost died after bleeding from the cord stump. The midwives who attended to Mrs MG used a bandage to tie the umbilical cord stump:

"The nurse used a piece of bandage to tie my baby's umbilical cord stump. I told her that a bandage could not be tight enough to stop the bleeding…and certainly the cord stump was still bleeding. She (the midwife) answered me that it was not her fault that

I did not have a cord clamp. I tried begging her to use a hospital cord clamp which I was going to replace when my relatives came or better still I could buy one from her. She still refused. Thus my baby was left to bleed slowly until my mother arrived." **(MG, p1)**

Mrs MF, a 20 year old mother, narrated an almost identical ordeal:

"…I found the napkin in which my baby was wrapped soaked in blood…the bleeding was coming from the umbilical cord stump. I got up to wake the nurses up from the room they were sleeping; asking them to come and see my baby who was bleeding. They answered me from inside their office demanding to know what I wanted from them at that time of night, for they wanted to sleep…very late at night that was when one of them came to check on my daughter…she removed the bandage and replaced it with a proper cord clamp…my baby could easily have died…" **(MF, p5)**

Another participant, 30 year old Mrs LE, mother of three who gave birth in 2011, narrated that she gave birth to a daughter with talipes foetalis. The midwives who assisted her during delivery did not examine the baby. After a few hours, Mrs LE was discharged together with her baby. Since both were not examined the baby's deformity went unnoticed:

"After my baby was born, the nurse did not bother to examine her; instead she just wrapped her and gave her to me. I was thinking the nurse who was going to discharge me would examine the baby. She too just brought me the discharge papers and told me to go home…I mean, I am not a nurse, but how do you let a patient go home

without checking whether everything is okay…how careless can one be? I saw the deformity but was scared to tell them…" **(LE, p4)**

During the data collection period, Mrs LE's daughter's legs were still in a Plaster-of-Paris (POP). Mrs LE complained that orthopaedics doctors who were treating her daughter told her that had the abnormality been diagnosed immediately after birth, correction would have been easy and healing would have already occurred. During the time of data collection Mrs LE still exhibited anger towards healthcare workers who assisted her during the birth:

"My daughter stayed with the deformity for two full days just because one midwife did not practice her job properly…honestly at times the practices of some of our nurses is unsafe and one can easily die…suppose the abnormality had something to do with the chest…wouldn't my daughter have died? I am not even sure whether my daughter's feet will ever be normal…I am still very annoyed with those nurses…" **(LE, p5)**

Inability to notice deviations from normal processes and unsafe practices were encompassed with discrimination of birthing women based on their socio-economic statuses.

4.3.6.3 Discrimination based on socio-economic status

"Discrimination based on socio-economic status" was a sub-theme that defined the discriminatory treatment that some individuals received from care providers. Participants highlighted that healthcare workers did not provide the same kind of care to birthing women. Women with high social status were said to be cared for well, compared to those of low social status. Twenty-four year-old Mrs MR who gave birth in 2009 said:

"…there was no fairness in the way women were treated in labour. During the birth of my second child, the women with high social status were provided with whatever they wanted…us from the low class were left to struggle throughout the process…even a kid could see that the nurses' care provision lacked impartiality" **(MR, p3)**

Economic and educational influences on birthing mothers were inherent in this theme. According to the participants, these factors influenced the way women were cared during institutional births. Mrs LD, a 38 year-old participant, with a Master's Degree, pointed out that healthcare workers treated her well because they knew she was educated. In her view, her level of education made midwives go out of their way to please her:

"When it came to delivery, the midwives could not be rough to me because they knew I was working, educated and had a bit of knowledge…they were sort of scared to treat me badly…(smiling and shaking her head) it is because they knew I was educated…that was why they treated me well…" **(LD, p3)**

Such were childbirth experiences and opinions of other participants with similar attributes. Mrs MB was a 38 year old banker married to a well-known White man:

"…they were just being nice to me because of my husband…because he knew these doctors, and I knew them too…they frequent our restaurant…I don't know if this is what they always do to the other patients...But with me they were there for me because of my husband and my socio-economic status…other women were not treated as well as I was…" **(MB, p1)**

Mrs LB was a 31 year old teacher and mother of two sons. Her account was on the birth of her second child in 2011. She gave birth in a hospital and this was her reflection of the experience:

> *"…the doctors and the nurses were very helpful and they were very caring too… but…although a lot of women complain that doctors and nurses are rude, I did not see that because to me they were good and friendly…they even gave me a back massage…it is because they knew that I was working…"* **(LB, p1)**

Mrs LC was a 31 year old healthcare worker, who gave birth to her first child in 2010. Antenatally, she was informed that her baby was in the occipito-posterior position (OPP). Suspecting that the medical personnel at the institution where she was attending antenatal care were not skilled, she went to give birth at a mission health facility located in a different town. Despite the labour being long and difficult, this was her reflection:

> *"On the care I cannot complain…Yes I can say that the nurses took care of me well because they knew that I was a medical person and educated…what I can say is that, the nurses' negative attitudes towards me were not very noticeable…none of them shouted at me or talked to me harshly…"* **(LC, p3)**

In her account, Mrs LC revealed that the care she received before healthcare workers knew she was a medical person was different from the way they cared for her, after gaining information that she was a University lecturer:

> *"Before they knew who I was, some midwives tried to raise their voices when attending to me…but I could see that there was non-verbal communication from*

midwives who knew who I was…and before long, my care completely changed…I was taken care of with respect…" **(LC, p3)**

Accounts from participants with high socio-economic status differed from those who were housewives, with very little or no formal education. Mrs LL attributed the lack of impartiality in caring for labouring women, to women's low socio-economic status, illiteracy and poverty:

"When well-to-do women go to the same public health institutions to deliver; they are treated well and talked to with respect…It is us the poor and uneducated who are treated badly…the nurses are more educated than most of us…" **(LL, p5)**

Some participants said that their preference for homebirths was influenced by the discriminatory care provision by health workers. Nineteen years old Miss LV, who was one of the few participants who received privileged care, reported being unhappy with the way other birthing women were treated. She attributed her receiving privileged care to being a friend to a daughter of one of the midwives on duty:

"The other clients were really shouted at…although the nurses who were caring for all of us were the same, they answered all the questions I asked them but when the other women asked them, they either shouted at them for asking or they did not answer their questions at all…such lack of impartiality in care is bad…we are all human beings…" **(LV, p10)**

In 2008 when 38 year old Mrs LD went to a health facility to give birth to her second child, she found another woman in labour. The woman was not so 'well-to-do'. She explained that the midwives attending to her as well as the other woman kept on shouting at her counterpart:

> *"…there was a lady who came from some village or compound…we were admitted in the labour ward at the same time, and being attended to by the same midwives…the way they treated her was really bad…the way they handled her was completely different from the way they handled me. There was a lot of shouting around her bed…that she was dirty…she did not have this and that…she needed to do this and that…things that they did not do to me. They said insulting things to her…like, why getting pregnant when she knew she could not afford to buy items for the coming baby and herself…I am sure there were a lot of things that she did not understand and what she presented to the midwife was the best she could…but instead of helping her, the midwives were just shouting at her…"* **(LD, p4)**

The theme elaborated the bias, abuse and lack of safety, that birthing women faced during childbirth, irrespective of whether the birth took place at home or a health institution, through the three sub-themes. Participants pointed out that one would have expected better provision of care from healthcare providers. Nevertheless, there were some providers who were described as being there for birthing women.

4.3.7 Being there for the woman

The seventh and last theme: "Being there for the woman" defined the sympathetic care and kindness that some maternity care providers showed their clients. The theme did not only

elucidate the physical presence of a provider, but it encompassed the feeling of being recognised and accorded respect. Consequently, the feeling of being cared for well and recognised, gave birthing women courage and confidence to experience birth in a positive manner. Mrs MB said:

> *"For me, I can't complain…the nurses and doctors were there for me…none of them shouted or scolded me…they smiled and asked how I was whenever they got in my room…it gave courage that they knew what they were doing…I wouldn't mind giving birth here if I happen to get pregnant…"* **(MB, p4)**

The theme was constituted by two sub-themes: "Feeling safe" and "Sense of achievement".

4.3.7.1 Feeling safe

"Feeling safe" was a sub-theme that explicated the feeling of being at ease and at peace with the birthing experience. Participants mentioned that they felt safe and at peace when they were assisted by care providers who were empathetic and kind. They pointed out that because of the way care providers talked to birthing women and their relatives, the way they went about providing care, as well as the tone of their voices when interacting with clients, made women feel at ease and safe with the birth experience. Mrs LD said:

> *"…the midwives we found welcomed me…they pleasantly told me to sit on the bench because they were still attending to another client…I felt safe and this made me relax despite the anxiety of labour…"* **(LD, p3)**

Mrs LD associated her being provided with good treatment to the fact that health professionals knew that she was educated. However, other participants such as Mrs MM, a 28 year old mother of two with only grade two level of education, said that the midwives who attended to her treated her well. She reported that due to the good care that she received she had a good institutional birth experience, which put her mind at peace:

> *"She (midwife) then gave me a bed and observed me until I delivered. After I delivered she wiped my baby and kept her warm before starting to attend to me. After attending to me and cleaning me up, she told me to dress up and rest…she was very good…Throughout my birthing process I knew I was in safe hands and inevitably my mind was at peace…I had a good birth experience…"* **(MM, p1)**

Mrs MM, who was expecting her third child at the time that she was being interviewed, said that she would go to the same health institution where she had her previous birth, because of the good and safe care that she was provided with during the birth of her second child. When asked to elaborate what she meant by "*good and safe care*"? She said that the providers, who cared for her during the previous delivery, talked kindly, and kept smiling throughout their interaction with her. Mrs LF, a 23 year old mother of one, with only grade seven level of education said that she too had a good, peaceful and positive childbirth experience during her institutional birth:

> *"She kindly gave me a bell saying that any time I felt the pain increasing, I should just push it and it would ring; then she would come to check on me. She was very kind not only to me but to the other women as well. I could hear her talking to other patients and their relatives in the admission room. I heard her explain to my husband to go back home and come back later as I was going to take a while before delivering,*

because this was my first pregnancy…her tone of voice, the way she carried herself made me feel safe…" **(LF, p1)**

Twenty-nine year old Mrs MK said that she felt safe when another midwife took over her care after she experienced a postpartum haemorrhage. She narrated:

"After some time, a midwife from another ward passed through and noticed my mother struggling to stop me from falling off the bed…The midwife quickly assessed me. After being told about the cotton wool that the other midwife inserted in my birth canal, following the bleeding that occurred after the birth of my second twin, the midwife pulled the cotton wool out. She then emptied my bladder, started an intravenous infusion and gave me an injection. After these measures, the bleeding subsided…The midwife did not leave until I got discharged…I felt safe the whole time she was around…" **(MK, p5)**

Comparing the care she received from healthcare professionals during her two previous deliveries in a health facility, to the care she received at home when birthing her third child, 29 year old Mrs ME said there was a difference in the provision of care. Her grandmother who assisted in her homebirth kept encouraging her to be strong, and telling her that she had the ability to give birth. She laughingly said that her grandmother's encouraging words gave her strength. During the whole experience, her grandmother never left her alone. In her opinion, this type of treatment was the complete opposite of her previous institutional births:

"My grandmother stayed with me the whole time I was in labour. That made me feel safe and it encouraged me to be strong…whenever I felt that the pain was a bit too

much for me, I would tell her and she would examine me. She kept encouraging me that I was progressing well, and that I was able to give birth…this was different from the way I was treated at the hospital…" **(ME, p1)**

The other thing that Mrs ME liked about her homebirth experience was the element of privacy. Apart from her grandmother, nobody was allowed in the room where she was birthing. Twenty-seven year old Mrs LH said she was impressed by her mother-in-law's attitude when she found her giving birth on her own. Her mother-in-law calmly encouraged her to carry on until the completion of the birth. Mrs LH said that had the birth been at a health institution, healthcare providers would have scolded her and most likely either her baby or she, would have died:

"Throughout the whole process, my mother-in-law never raised her voice at me…she was gentle all the way through…had it been at a hospital either I or my baby would have died because nurses would have concentrated on scolding me instead of assisting…It was psychologically comforting to be in safe hands…" **(LH, p1)**

In some instances the feeling of being safe came from the knowledge that one had done everything she needed to do in preparation for birth. One of the things that Mrs LD talked about before going to the hospital for childbirth care was, consulting an older neighbour:

"…before going to the hospital…I first consulted this elderly lady who was our neighbour…I told myself that let me consult somebody who is elderly before I go to the hospital…You know I am an African so there is a part of me that always says that the old people know a lot of things and there are these cultural things that we are told

to do or not to do when we are pregnant or in labour. This gave me comfort mentally…" **(LD, p3)**

Experiencing childbirth in this manner led to participants' interpretation that the experience brought them a sense of achievement".

4.3.7.2 Sense of achievement

The sub-theme: "Sense of achievement" elucidated how proud and fulfilled women were of themselves for having gone through childbirth. Participants did not associate the sense of achievement to the outcome of the experience. Rather they attributed it to the whole birthing experience. Providers of care were mentioned to have played a major role in the achievement. Thirty-eight year old Mrs LD said:

"For me I feel that the pain of labour is the pride for any woman. It is a big achievement for me…Actually after giving birth and having undergone the pain I am now looking forward to having another child…now I am ready for another delivery…the midwife, who I will remember for the rest of my life played a major role in what I felt…" **(LD, p4)**

Mrs LD gave an account of an institutional birth that in her opinion gave her peace of mind and fulfilment. This was despite the pain and not being given any remedy for the pain. Thirty-one year old Mrs LB who had an institutional birth in 2011 excitedly said:

"I am feeling fulfilled that I managed to have my second child in peace. The experience reinforced my dignified status of being married and being a mother. With

the help from the nurse, I came out of childbirth a much stronger woman because of the achievement I attained…" **(LB, p5)**

Mrs MB who delivered by caesarean section said that:

"Going through childbirth was a great achievement for me…I mean I do not have bad memories about my childbirth. The doctors and nurses were very caring although I don't know much of what they were doing because they didn't explain anything to me…their overall interaction with me was marvellous…so yes I am a fulfilled mother…" **(MB, p4)**

The theme "Being there for the woman" defined the good care participants were provided with during childbirth. This was in contrast to the experiences of participants who felt they were treated unfairly. The theme encompassed both physical and psychological safety and being at ease with self and care providers. Included in this theme were the attitudes and practices that participants viewed as being kind and safe. Participants reported that it were attributes such as these, which influenced their birth experiences. Birthing in a pleasant environment and being attended by care providers that a woman felt safe and comfortable with, instilled in participants, a sense of achievement from the childbirth experience.

4.4 Summary

This chapter presented findings of the analysis of data from individual interviews with participants who experienced birthing in Zambia between 2005 and 2011. It provided participants' interpretation of how they experienced and gave meaning to the childbirth phenomenon. The themes and sub-themes depicted the social, economic, environmental,

religious and cultural context of childbirth through the eyes of women birthing in Zambia. Thereby, conveying knowledge that led to a better understanding of the phenomenon. For participants who felt that they were taken care of well, the experience was empowering and gave them peace of mind. For those who felt they were not taken care of well, the phenomenon was experienced with despair and despondency. They emphatically said that they wanted something to be done, so that healthcare providers changed their negative attitudes towards birthing women. Without a sense of both physical and mental safety, participants felt insecure and felt afraid to give birth again. They stated that they were struggling to come to terms with the effects of bad childbirth experiences. The next chapter presents a discussion of the findings in relation to the wider literature on childbirth.

CHAPTER 5: DISCUSSION

5.1 Introduction

This chapter discusses the findings of this interpretive phenomenological study, which was focused on providing an understanding of the childbirth experience, through the lens of 50 women who birthed in Zambia between 2005 and 2011. The study addressed the question: "How do birthing women in Zambia experience and give meaning to the childbirth phenomenon?" In line with the principles of interpretive phenomenology, letting participants' voices to emerge and to be reflected in the data analysis was central to this study. Hence, the themes and sub-themes that emerged form the basis for discussion in this chapter.

5.2 Conforming to societal expectations

This theme moved beyond the physiological understanding of childbirth by contextualising the phenomenon as a social, as well as a biological process. It defined women's birthing experiences within a social and cultural context of norms and customs surrounding the phenomenon. For instance, it highlighted the importance that women attached to the relationship between marriage and childbirth. This was without considering the implications of childbirth on whether a married person was a teenager or not. The lens of looking at childbirth, where more emphasis was placed on one's marital status than on the individual woman's age neglected the physiological impact of pregnancy and childbirth on adolescent girls. The theme supported the ZDHS report, which states that childbirth in Zambia starts very early (CSO *et al.* 2014). Thus, irrespective of the fact that most participants in this study were married, they were not yet physically mature when they had their first births. Therefore, they were at risk of complications such as obstructed labour. One participant (Miss LY) who was 18 years when she experienced birthing for the first time narrated having a vesico-

vaginal fistula after childbirth. This was due to a prolonged second stage of labour. Each one of the participants who were single at the time of conception contemplated having an abortion due to fear of being ridiculed and criticised for engaging in sexual activities before marriage. In a previous qualitative study by Dahlbäck, Maimbolwa, Kasonka, Bergström and Ransjö-Arvidson (2007), the reasons that were given by participants for performing unsafe abortions were fear of facing personal shame and social stigma following premarital pregnancies, such as parental disapproval, abandonment by partner, and expulsion from school. Similar to this study's participants, a blend of traditional (taking roots) and modern methods (drinking un-prescribed medicines) were sought to abort.

Understanding the reasoning behind the unintended pregnancies was an important finding of this study, as it had the potential to inform interventions towards improving the reproductive health of Zambian women, particularly, adolescents. Non-provision of comprehensive adolescent reproductive health services and the stigma attached to premarital pregnancies are likely to continue, consequently compelling adolescent girls to go into marriages that they are not ready for. According to Eden (2006), adolescents face higher reproductive risks than older women, and babies born to teenage mothers are more likely to suffer health, social and emotional problems than children born to older mothers. Mortality and morbidity rates are higher among infants and their teenage mothers because they are less likely to get antenatal care early (Eden, 2006). The interpretive phenomenological paradigm that was used in this study elucidated that childbirth for an unmarried teenage girl was experienced with shame, embarrassment and fear. In contrast, if the teenager was married, the phenomenon was experienced with excitement and pride. According to a UNICEF (2007) report, more than half of the mothers in sub-Saharan Africa give birth before the age of 20 compared with one third for Latin America and the Caribbean. This consolidates the finding of this study in the

sense that when maternity care stakeholders understand how young women experience childbirth, programmes on how to empower them could be put in place. When the young girls are empowered, influences such as, peer pressure could be managed because girls would learn to take responsibility for their actions.

In addition to what is highlighted in other literature about adolescent mothers, the results from this study elaborated that while biological and socio-economic factors contributed significantly to early sexual activity and related consequences; enculturation played an important role in shaping the attitudes of participants towards key aspects of reproductive health. It led to stereotyping, which in turn affected the planning, management and implementation of their reproductive health. As highlighted in the findings, participants in this study interpreted the experience of childbirth from the perspective of whether it occurred within the confines of marriage or not. Not only were adolescent mothers in the majority, none of them perceived early childbearing within the prospect of it having an impact on their childbirth experience. For example, in as much as it is acknowledged that the care that one of the participants (Miss LY) was characterised by inadequate service provision from the mother-in-law and grandmother who helped her birth, Miss LY's younger age and non-attendance of antenatal care also had an impact on how and why she experienced childbirth the way she did. Miss LY's interpretation of the experience was that culturally, she had conformed to societal expectations because despite the pregnancy being unplanned, it occurred under the confines of marriage. An important interpretation that was not highlighted in Miss LY's account was that had she attended antenatal care, healthcare providers could have been availed an opportunity to suspect that her foetus could be too big for a vaginal delivery. Hence, she could have been advised to birth in a health institution where caesarean section facilities were available. Miss LY's account, as well as accounts from other

adolescent mothers gave an indication of the importance of marriage and childbirth in a Zambian married woman's life. This was irrespective of the significance of the medical, physiological, economical, and psychological impacts of early childbearing. Teenage pregnancy and childbirth, irrespective of the individual's marital status was an important issue for several reasons, such as the ones that were highlighted through the four sub-themes: "Shame and embarrassment", "Fear", "Excitement" and "Peer pressure". Through the theme: "Conforming to societal expectations" the sub-themes elaborated what went on behind the scenes before a woman finally experienced childbirth. The four sub-themes highlighted issues related to how quickly and easily a woman accessed maternity health care, depending on whether she was married or not. Consequently, late accessing of maternity care created uncertainties among women and hindered timely provision of information and maternity services. Adolescents in Uganda reported that mistreatment that they and their friends experienced during facility-based childbirth influenced them to deliver at home in future births (Atuyambe, Mirembe, Johansson, Kirumira and Faxelid 2005). This posed a risk to the women and their infants.

5.2.1 Shame and embarrassment

The sub-theme: "shame and embarrassment" defined the complexities and challenges that unmarried pregnant adolescents faced regarding their reproductive health. These were exacerbated by the low social status of young women within communities. It described the vulnerability of an adolescent female in relation to childbirth and brought forth voices that had been silent for a long time. Participants who were unmarried when they got pregnant experienced intense emotions as soon as they realised that they had conceived. In reference to Heidegger's concept of 'Thrownness' (Thomson, 2011), the young women were thrown into

a world of understanding that stipulated that their premarital pregnancies were not an accepted social expectation. Their emotions started out as denial that they were pregnant, confusion about what was going to happen to them, fear of their guardians' reactions, shame and embarrassment for having gone against societal expectations, and humiliation for not being obedient adolescents. They tried to figure out how they would tell their parents or guardians, as well as the men who were responsible for their pregnancies. Naturally, early in pregnancy, they became overwhelmed with decisions that needed to be made and faced. In the case of this study, the commonly mentioned decision was whether to terminate or keep the pregnancy. These were big questions that many of the teenage participants were not mature enough to face. In some instances, the intense upheaval interfered with the young girls' education. Ironically, the teenage participants mentioned going through the process alone. According to CSO *et al.* (2009), childbirth and early marriage are the leading reasons why teenage girls especially in the rural areas of Zambia drop out of school and in the case of this study, they ended up in early marriages. Some of the participants were so overwhelmed that they contemplated suicide and/or running away to places where they were not known, rather than face their parents/guardians or deal with the life-changing decisions. Through hiding and pretending to people around that they were not pregnant, the young women lost the opportunity of starting antenatal care early.

Antenatal care provides women with the opportunity to detect and treat anomalies of pregnancy, and to deliver preventive health services such as, immunization against tetanus, prophylactic treatment of malaria and worms, and HIV testing and counselling leading to prevention of mother to child transmission (PMTCT) of HIV (Villar and Bergsjo, 2003). To fully benefit from these interventions, it is important that women book early. Several studies (Rockers, Wilson, Mbaruku and Kruk, 2009; Mpembeni, Killewo, Leshabari, Massawe, Jahn,

Mushi and Mwakipa, 2007; Abou-Zahr and Wardlaw, 2003) have reported that women who book early, and attend frequently, are more likely to deliver from a health facility compared to those who initiate antenatal care late. Although antenatal care might not have the potential to predict and avert obstetric emergencies, it exposed women to health education on risk factors. The studies suggest that women who knew about risk factors were more likely to utilise health facilities for delivery than those without knowledge. The revised FANC model of the WHO (Villar and Bergsjo, 2003) recommends at least four antenatal care visits for uncomplicated pregnancies, with the first visit starting before 16 weeks of gestation. A comparative analysis of the use of maternal health services in sub-Saharan Africa showed that adolescent mothers initiated antenatal care attendance much later than 16 weeks, and had poor maternal health care than adult mothers (Magadi, Agwanda and Obare, 2007). Adolescent pregnant women have been reported to most likely either not attend antenatal care or initiate attendance late and infrequently, due to lack of knowledge, lack of power to take decisions, lack of money, and cultural factors (Bearinger, Sieving, Ferguson and Sharma, 2007; Magadi *et al.* 2007; van Eijk *et al.* 2006; WHO, 2006a; Treffers, Olukoya, Ferguson and Liljestrand, 2001). In the case of this study, although all the 50 participants reportedly attended antenatal care, none booked before 16 weeks gestation. Information from other studies provided relevant information as to why teenage mothers face a lot of challenges relating to childbirth. However, the sub-theme of 'shame and embarrassment' in this study elucidated how the teenage mothers experienced childbirth the way they did.

5.2.2 Fear

Fear was reported more frequently by adolescent and unmarried women at the time of getting pregnant. Participants who were unmarried at the time of getting pregnant stated that they

were not only embarrassed and ashamed of what they had done. They were also fearful to share the information of their pregnancies and childbirth with anyone. Intertwined in their statements were revelations that being pregnant before marriage rendered them to be vulnerable to ridicule, and at times harm from their guardians. However, none of the participants who got pregnant before getting married reported getting physically harmed by a guardian. Apart from being ridiculed, some participants were reprimanded. During the period when participants were pregnant, fear was a real experience, and hence they opted to hide their pregnancies for as long as they could. As time passed, the pregnancies grew and could no longer be hidden and thus, close family members came to know about them. Participants narrated that the information of their pregnancies was restricted to close family members only. The practice of hiding a pregnancy and childbirth outside marriage pointed to a culture of secrecy and silence. Participants explained that the practice was aimed at protecting the woman and her unborn child from the stigma of having an illegitimate child and being labelled illegitimate, respectively. The resultant outcome of keeping the pregnancy a secret was that the young woman lived with guilt and thus, had an impact on her future experience and interpretation of childbirth. Interpretive phenomenology theorises that past experiences and preconceptions of a phenomenon have an impact on the interpretation of current experiences. One participant (Mrs LN) revealed during the interview that none of her friends knew that her baby was conceived before marriage. As a result of complying with the advice of keeping her pregnancy a secret while waiting to be married, Mrs LN began attending antenatal care after she was five months pregnant. She reported living with the guilt of having failed to conform to societal norms throughout her pregnancy. Despite her secondary education, she failed to interact freely with healthcare providers. On admission during labour, her aunt had to talk on her behalf. Mrs LN mentioned that she opened up to me during the interview because I had reassured her of confidentiality. Exploring the participants' accounts

revealed that secrecy of having an illegitimate child was rooted in cultural norms surrounding pregnancy and childbirth.

Many of the participants who were unmarried when they got pregnant also expressed fear of a break up with the fathers of their babies. According to the National Campaign to Prevent Teen Pregnancy (2013) report, eight out of ten teen fathers do not marry the mothers of their babies. In contrast with the accounts from this study's participants, immediately older family members knew that their young girl was pregnant, they arranged a meeting with the man's family and a marriage between the pregnant girl and her boyfriend was quickly arranged. This ensured that by the time the pregnancy became visible to the public, the young man and woman would have been married, thereby, legitimising the birth to society.

Participants described the structural and cognitive barriers they needed to overcome in order to access maternity care. The barriers that participants faced included logistical and financial concerns, unsupportive policies, gaps in services, as well as inadequate community and family awareness and knowledge about maternal and newborn health issues. For many, the barriers were insurmountable and led to their interpretation that the childbirth experience was difficult, and hence instilled fear in them. For example some participants gave accounts of walking to health institutions at night. In the case of 24 year old Miss MC who walked to a health institution at night with her grandmother, she found the institution closed and so she had to walk back home. Very few participants described the childbirth experience as easy. Given the negative influences of fear and anxiety on the progress of labour (Sellers, 2007), it was not surprising to note that most study participants described childbirth as being a very painful, long and difficult experience. This information could assist healthcare providers in

the provision of care. For example, women who are not socio-economically sound could benefit more from the experience by being accepted and being talked to empathetically, rather than being given medication for pain relief.

There was also an expression of fear for maternity healthcare providers and health institutions in general. Most accounts illustrated how participants understood and mistrusted both healthcare providers and formalised healthcare systems, leading to their strong belief that giving birth at home was better than birthing in a health facility. Apart from one participant (Miss LY) who later developed a vesico-vaginal fistula, all the participants who developed complications or those whose infants died, neither put the blame or criticised the care they received during a homebirth, nor the women who assisted the birth. In contrast there was an expressed fear of dying by participants, had their births taken place in health facilities. Trust and kindness were expressed as qualities participants found in TBAs and women who assisted in homebirths. Participants mentioned gaining confidence in care providers who were patient, kind, sympathetic and exhibited an understanding of the labour pain. They prioritised social norms such as, privacy for the birthing woman over health institutional practices of ensuring that births were hygienic and clean. The fear of maternity healthcare providers and health institutions expressed by participants in this study was also echoed in a study from Tibet, by Adams, Miller, Chertow, Craig, Samen and Varner (2005). Thus, in reference to Heidegger's concept of 'fallenness', it was more important for some participants to follow societal norms and birth at home, than to seek care even when there was presence of a potential life-threatening problem. For instance, some participants did not undergo HIV testing because their husbands, who had more decision making powers traditionally, did not authorise them. Although some participants were able to articulate the risks of being HIV positive and pregnant, they said that it was better to die while one was married than get

divorced and then later die. This kind of thinking undermined the goals of programmes such as the PMTCT in Zambia. However, for the participants, their 'fallenness' prevented them to appreciate the benefits of antenatal HIV testing. The elements of shame, embarrassment and fear that surrounded childbirth experiences of unmarried participants were in contrast to married women's experiences. This contrast in the experiences between married and unmarried participants, exhibited stigma and discrimination of birthing women based on marital status. In addition, this phenomenological study exposed the influence of the concepts of 'thrownness', 'fallenness' and 'enculturation' on the childbirth experience. This contrast was highlighted in married participants' expression of 'excitement'.

5.2.3 Excitement

During the interviews participants who were married were more at ease when talking about their childbirth experiences compared to their counterparts who were unmarried. The expressed excitement, alluded to the impression that the more one prepared for pregnancy and childbirth, the less overwhelming the effects would be. In this study, since married participants had nothing to be ashamed of, they started attending antenatal care and planning for childbirth earlier than their unmarried colleagues. Birth preparedness and complication readiness, which is the process of planning for normal birth and anticipating the actions needed in case of an emergency, is essential because women and newborns need timely access to skilled care (Kaso and Addisse, 2014). Too often, however, women in this study's access to maternity care were impeded by delays in seeking, reaching and receiving care.

Although childbirth has been described as a joyous (Whitty-Rogers, 2006) and empowering event (Lundgren, 2005), the sub-theme: "Excitement" in this study highlighted the insights of

married birthing women for having conformed to societal expectations, and not only having gone through the experience unscathed. It explained why and how birth experiences of married women through the concepts of 'fallenness' and 'enculturation' differed with unmarried women's experiences despite having similar birth outcomes. In contrast, in trying to emphasise their feelings of shame and embarrassment, participants who had premarital pregnancies mentioned the issue of "Peer pressure" being influential in their getting pregnant against societal expectations. Peer pressure has been mentioned in previous studies by Osulah (2013); Mothiba and Maputle (2012); and Katayamoyo (2010).

5.2.3 Peer pressure

Peer pressure was identified by participants who had premarital pregnancies and childbirths as having had a major influence that led to them going against the societal expectation, of not engaging in premarital sex. They stated that due to the pressure to make friends and fit in with their peers, they ended up indulging in activities that were contrary to what they were advised by parents and guardians. They emphasised that they did not fully understand the consequences of premarital sex at the time, and thus expressed surprise when they discovered that they were pregnant. Their indulging in premarital sex was a way in which they could be accepted and hence, participate in the sharing of experiences that other teenagers were having. One of the consequences of peer pressure that study participants pointed out was experiencing childbirth before the stipulated time, and dropping out of school. Mothiba and Maputle (2012) in their study asked whether school dropout was a consequence of teenage pregnancy only. Their findings were that poverty, cultural practices and peer pressure were among the factors predisposing girls to dropout from school. In the case of this study, peer pressure was expressed to be an influence that exposed young ladies' vulnerability to

unplanned pregnancies and consequently, childbirth. Their 'thrownness' in a society where adults made all decisions and younger ones complied with the decisions without questioning, opened them to manipulation because they were not socialised into a society that encouraged young women to be assertive, and to critically think of the consequences of their actions. This information from this study fit into the gap left by information from other studies from sub-Saharan Africa.

5.3 Clash between traditional and contemporary childbirth practices

This second theme, which highlighted participants' revelations that there was often a clash or tension between traditional and contemporary childbirth practices in Zambia exposed birthing women's deep-seated knowledge of their traditions. Four sub-themes: "Gender defined roles", "Compliance", "Lack of assertiveness", and "Leaving childbirth experience and outcome in God's hand" illustrated the role that the concept of "fallenness" played in the lives of women birthing in Zambia. The policy of encouraging women to birth in health institutions was good. However, it was undermined by the lack of a clear government policy on the role cultural norms played in relation to women's decisions around birthing. The theme highlighted the need for supportive policies based on the understanding of people's cultural orientation to childbirth issues. Shifting of births from homes to health institutions not only led to changes in women's attitudes towards where and how they birthed. It also affected attitudes of healthcare providers, as traditional and cultural-based knowledge of childbirth were superseded by scientific knowledge. For example, participants mentioned that during an institutional birth, they were advised to adopt the dorsal lithotomy position. Although giving birth on a bed was perceived by some participants as being modern and prestigious, according to Maimbolwa *et al.* (2003), the practice restricted birthing women from adopting other birthing positions, such as the squatting or all-fours, commonly used

during homebirths. Study results by Soong and Barnes (2005) on birthing positions, state that the all-fours and squatting positions were easier, more comfortable, and quicker for the woman to birth, than the dorsal lithotomy position. The dorsal lithotomy position placed the birth canal at an angle that made the baby move upwards, thus, forcing the mother to push the baby against gravity through an increasingly narrowed space (Sax and Rosenbaum, 2006). Study participants' complaints of the position were in agreement with information that has for a long time stated that the dorsal lithotomy position was the favoured position in health institutional births because it was easier for the attendant to access the birth canal and perineum, and thus made his or her work easier (Soong and Barnes, 2005). A number of studies (Janevic *et al.* 2014; McMahon*et al.* 2014; El-Nemer *et al.* 2006) have reported that some women resented that health workers forced them to give birth in undesirable or humiliating positions, such as the dorsal lithotomy, which rendered them passive.

Traditionally, childbirth was a phenomenon that women experienced secretly and privately (Maimbolwa *et al.* 2003). Hence, if a woman publicly complained about the phenomenon, she was perceived not to have been raised properly. Consequently she brought embarrassment to her family. To ensure privacy and secrecy during birthing, women were instructed to be silent during the actual process, irrespective of the intensity of the labour pains. Some participants reported that most female Zambian maternity care providers were also aware of the practice. However, from the contemporary practices' perspective, the traditional practice of keeping quiet during labour was in contrast with the GNC (2001) guidelines, which state that birthing women should be provided with adequate and appropriate pain relief during childbirth. Therefore, some healthcare providers gave birthing women pain relief irrespective of whether they complained of pain or not. However, although appreciated by some participants, others were unhappy with this practice because it deprived

them of the "pride of a woman", which traditionally entailed going through the experience of labour in silence, and without getting pain relief. Accordingly, Heidegger's concept of 'Enculturation' affected the way birthing women interpreted the care they were provided with.

Another contemporary practice mentioned by participants was lack of privacy during childbirth. In their studies, Kwaleyela *et al.* (2009) and Maimbolwa *et al.* (2003) pointed out that birthing in privacy was a cultural norm that characterises birthing in Zambia. Through the traditional practice of privacy and secrecy, what happened during childbirth was known only to those who were in attendance as well as the birthing woman. In contrast, privacy was not usually observed during institutional births, as women were subjected to birthing in a room that was divided only by curtains (Kwaleyela *et al.* 2009). Findings from studies from other developing countries, also mention that women reported feeling stripped of their dignity during childbirth because they were subjected to exposing their bodies to numerous healthcare workers (Hatamieh *et al.* 2013; El-Nemer *et al.* 2006).

Such experiences contrasted those from participants who had homebirths. They pointed out that they were assisted either by one or two women, and nobody else, including husbands was allowed near where the birth was taking place. Participants emphasised that although husbands were involved in making certain decisions that pertained to childbirth, such as, undergoing an HIV test; when it came to the actual birthing process, they were told to leave the house where a birth was taking place. Participants stated that birthing in private, and particularly in the absence of husbands, contributed to their satisfaction with the birthing experience. Kwaleyela *et al.* (2009 and Maimbolwa *et al.* (2003) mention that

recommendations to renovate public health institutions' labour wards, as well as, involving men in the birth process, have been suggested to the MoH. However, given the situation that Zambia is a low income country, which is dependent heavily on financial assistance from high income countries; accommodating women's preference of birthing in private labour rooms has not been high on the political agenda.

In a study by Kyomuhendo (2003) in Uganda, one of the findings was that although death of a woman in childbirth was a sad event, traditionally, it was viewed as being normal. Therefore, encouraging women to seek delivery services from health institutions on the basis of reducing MMR, might not be fully understood, unless the information was accompanied by explanations of the role that skilled attendance played in reducing MMR. Similar to studies from Zambia, when a labouring woman has prolonged labour, traditionally, it is believed that the woman has been unfaithful to her husband (Maimbolwa *et al.* 2003). The woman is asked to first confess her infidelity before any remedy can be offered (Maimbolwa *et al.* 2003). Thus, in the event that the woman does not confess, she is left without assistance. This therefore, has in some instances led to women dying from avoidable complications. In contrast with contemporary childbirth practices, such a death would be interpreted to be as a result of the woman's infidelity, and not due to a complication, which could have been rectified had the birth been assisted by a skilled attendant.

Participants voiced misgivings regarding men (midwives and obstetricians) attending to birthing women. They explained that during institutional births, they were expected to embrace care from attendants who at times were male. According to a study by Maimbolwa *et al.* (2003), it was taboo for a man to attend a delivery. In Zambia, involvement of men,

particularly spouses in the actual birthing process is an issue that is being carefully considered by stakeholders because it contrasts the practice of gender defined roles. For some time exclusion of men has not been of concern in Zambia's reproductive service provision. As recent as the 1980s and early 1990s, almost all reproductive health programmes in Zambia were exclusively focused on women. It was only during the mid-1990s that researchers and stakeholders started talking about the important role that men could play as supportive partners in achieving good reproductive health for women. According to Moore, Singh, Ram, Remez and Audam (2009), good reproductive health is the right of all people: men and women alike. Together they share the responsibility of making decisions about reproductive matters. Moore *et al.* (2009) further reported that neither women nor men are likely to enjoy good reproductive health, until they begin to discuss sexual matters and make reproductive health decisions together. This contemporary view of involving men in the assistance of women during the actual birthing process was not well received by participants in this study. It was interpreted as being their enculturation to the society they were born into. Therefore, subjecting women to practices that were viewed to be foreign negatively impacted most institutional birthing experiences.

5.3.1 Gender defined roles

In agreement with Bwakali's (2001) statement, this sub-theme illustrated that traditional African culture had clearly stipulated and defined roles of men and women. Participants articulated the roles that men in Zambia played in relation to childbirth. The accounts revealed that although men were excluded from the actual process of childbirth, they had powers related to decision-making around pregnancy and childbirth. The belief that contraception, pregnancy, childbirth and prevention of STIs were exclusively women's

concerns, reinforced men's lack of involvement in safeguarding their own reproductive health and that of their partners. Myths and misconceptions mentioned by participants perpetuated the power structure and weakened women empowerment. As mentioned by Heidegger (1962/1927), human beings have a deep-seated inner knowing that provides the primordial basis through which they are able to engage with, and make meaning of their world. Accordingly, human beings awake to find themselves thrown into the world and any involvement in any phenomenon was part of a conscious experience and knowing (Heidegger (1962/1927). In the case of the participants in this study, they awoke to find themselves in a society that had separate roles for men and women. Bwakali (2001, p83) states: "as boys herded their livestock, girls would fetch firewood and water. As boys hunted, older girls would perfect their cooking prowess. Then marriage would come along and young men would grow into husbands that fit the society's description of a husband. The same applied to young women. Thus would their lives be lived; in this age-old pattern; more according to the norms of the society, and less according to individual aspirations."

Girls grew up knowing that they had to be resilient and submissive in order to appeal to a man as a wife (Hutson, 2007). According to Bwakali (2001), women were taught to be obedient, submissive and dutiful to their husbands from a very young age. Hence, when healthcare providers introduced women to the contemporary practice of looking at childbirth as an experience that should be shared by both men and women, they found it hard to accept. Some participants pointed out that the practice of mixing responsibilities of men and women would dilute the significant differences between males and females. They went on to say that such a practice would lead to women not respecting their husbands and eventually lead to high numbers of divorce. The did not interpret the practice as empowering women.

5.3.2 Compliance

The sub-theme: "Compliance" in this study was reinforced by ignorance of alternatives and fear of the unknown. Even though participants acknowledged that at times what healthcare professionals and older women did to them during childbirth amounted to discrimination and oppression, they stated that they complied. One study participant (Mrs LK) pointed out that the practice of compliance was often reinforced by older women when a young woman was being prepared for marriage. The older women who were held in high esteem by communities spent weeks and at times months, depending on which part of Zambia the girl came from, with the bride, teaching and demonstrating to her how to be compliant to her husband. It was during this period that a young woman was initiated to her traditional female role of being a wife. According to the women's accounts, compliance was a sign of respect for the man, who was considered the head of the family. As one participant (Mrs LO) put it: *"that is the kind of thing we learn when we get married…the husband…he has the last say in everything".* In other words, childbearing was a woman's safety net for sustaining her marriage. According to Gaba (1997), if a wife could not have as many children as the husband wanted, her husband was at liberty to marry a second wife for the sake of carrying on the family lines. Ironically, despite that husbands were the ones who were tasked to bring financial resources to the family, study participants stated that they had to supplement their household food security by engaging in informal chores, such as street vending.

Many cultures especially in sub-Saharan Africa, have maintained a traditional patriarchal system in which men are the primary decision makers in family and social relationships. Although the results compliance was generally not to the advantage of women, they remained acquiesce to keep their place within the community, and eventually earn the respect due to a

mother. Women's upbringing of being compliant to men was extended to their care providers. They surrendered their bodies to healthcare providers even though they were not happy with the way they were treated during childbirth.

5.3.3 Lack of assertiveness

The sub-theme: "Lack of assertiveness" was a reflection of how participants were socialised to society. Heidegger (1962/1927) referred to this as 'enculturation'. Assertiveness is not something that is inherited; it is a skill that is learnt. Participants narrated that they tried their best to please their husbands and healthcare providers to avoid rejection and being reprimanded. This in relation to childbirth was often times at the expense of sacrificing their personal needs. For example, some participants mentioned the need to obtain permission from their spouses in order to be tested for HIV during pregnancy. This was despite being able to clearly articulate the consequences of not testing and having knowledge of the PMTCT programme. Lack of assertiveness was more pronounced among participants who lacked basic education and financial resources. According to Meer (1992), African cultures' value systems perceived women as inferior to men and therefore, women failed to stand up and express themselves even in matters said to be in their realm, such as childbirth. One participant (Mrs MI) narrated how she used to cry in secret when her husband married two more wives. Despite not being in agreement with polygamy, she continued having children, who she referred to as "*my husband's children"*. Participants, especially the ones from poor backgrounds acknowledged that childbearing worsened their socio-economic problems. However, since it was one avenue by which they sustained their marriages and raised their social status, there was nothing they could do. Participants saw their families as a source of emotional strength, although their role as mothers and homemakers did not give them

economic power. Anunobi (2003), states that without economic empowerment women have no power to make important decisions pertaining to their reproductive health. Without formal education, girls failed to gain high paying jobs when they grew up. Thus, they ended up depending on their husbands for financial assistance. According to Hutson (2007), even when conventional wisdom tried to give women more of a voice and more of a handle in society, traditional viewpoints remained overpowering and overbearing. This exposed the effect of enculturation on the childbirth experience. Quite often participants expressed disillusionment at what was going on around them during childbirth because they were not part to the decisions that were made. Instead they followed what they were told by relatives and healthcare workers. It was thus, not surprising when some participants pointed out the role God played in the childbirth experiences.

5.3.4 Leaving childbirth experience and outcome in God's hands

This sub-theme provided an understanding of the religious structures and beliefs that participants had about childbirth. This sub-theme is seldom mentioned by studies on childbirth mainly because of methodological limitations. Heidegger (1962/1927) asserts that humans are embedded in their world to such an extent that subjective experiences are inextricable linked with social, cultural and political contexts. Through the study participants' perspective, the sub-theme offered an explanation of childbirth experiences that at times did not go according to expectation. Their faith in a supernatural power, which in the case of this study, participants referred to as God, seemed to be woven into the fabric of their everyday life. Hence, when faced with a situation that they had no logical explanation for, such as the childbirth phenomenon, they connected their interpretations to religious and traditional beliefs. In such instances, some interventions that clearly offered important benefits to

birthing women, such as choosing who and where to birth, were not acknowledged by the participants. They did not seem to know the underlying causes or understand the reasons why some complications, such as foetal distress developed during labour, nor did they understand the physiological processes of childbirth. They instead put everything in God's hands. This way of interpreting the childbirth experience could be attributed to the effect that the declaration of Zambia as a Christian nation in 1991 (Muwowo and Buitendag, 2010) has on Zambian people in general. Although participants could not give tangible proof of how God intervened in their birth experiences, they talked about him as having mystical powers, thus having tangible evidence was not essential. Participants stated that knowledge about God was there before they came into physical existence. This interpretation was in agreement with Greatrex-White's (2004) assertion that human beings have a deep-seated inner knowing that precedes their conscious knowing.

The sub-themes: "Gender defined roles", "Compliance", "Lack of assertiveness", and "Leaving childbirth experience and outcome in God's hands" explicated the complexities of the beliefs, practices and challenges that birthing women in Zambia face in trying to harmonise traditional and contemporary childbirth practices. Through the women's 'fallenness', 'thrownness' and 'enculturation', the sub-themes provided an effective way of understanding the larger social and cultural context of childbirth and childbirth related practices, beliefs and traditions in Zambia. The challenges and complexities, compounded with the lack of decision-making authority and low social status of women within communities led to a situation, which some study participants described as: "Being in a dilemma".

5.4 Being in a dilemma

The theme: "Being in a dilemma" exemplified the difficulties women faced when choosing where to birth and whose advice to adhere to in relation to birthing. When comparing the two birthing places (home or institution) available to women in Zambia, most of the participants based their decisions primarily on previous experiences and perceptions of safety. For women who felt that they were not cared for well during both an institutional and a homebirth, they stated that they were in a dilemma because they did not know where to go and birth in future. In their view safety was not guaranteed in either setting. For some participants physical safety was more important while others thought psychological safety was equally important. The parallel between physical and psychological safety was in agreement with the recommendation by Larkin *et al.* (2010) that measuring the quality of maternity services must encompass recognition of psychological and emotional well-being, alongside physical safety. Bailham and Joseph (2003) in a review of literature on post-traumatic stress disorder (PTSD) following a traumatic childbirth experience also emphasised the importance of integrating psychological and emotional care, alongside physical aspects in the provision of maternity care. To create an environment that takes into consideration physical and psychological dimensions of childbirth, attention must be paid to the different aspects of the experience. This could be done by working and valuing the complexities of the childbirth encounter and providing both physical and psychological support. The focus of understanding the trend of having homebirths rather than institutional ones by many women in Zambia has been more on the physical aspects such as, distance to health institutions. This seems to confirm the interpretation that while healthcare professionals tend to focus more on the outcome of birth, and in this case, a live mother and infant, women focused more on the birth experience. Larkin *et al.* (2009), explain that childbirth experience is a complex, multidimensional and subjective phenomenon, relating to both the outcome and the process of childbirth. Thus, to

understand the childbirth phenomenon, the effects of both the outcome and the process need to be understood. The accounts of participants in this study had a lot of emphasis on how birth attendants treated women and not much on the outcome of the labour. Apart from a few, who had complicated homebirths, the rest said that it was better to deliver and die dignified at home than give birth in a hospital and live with their dignity, stripped. In a study by Kwaleyela *et al.* (2009), practices such as instructing women to undress during admission influenced women to shun institutional births. Apart from the caring attitudes that attendants in homebirths were associated with, the squatting positions adopted during birth were some of the factors that influenced participants' choice of homebirths compared to institutional ones. Participants talked of institutional births as being long and painful, in comparison to homebirths.

5.4.1 Choosing where to birth

This sub-theme brought to light an interpretation of the childbirth experience that is not being conceptualised with the same biomedical constructs used in medical thought. It was a sub-theme that brought out the human aspect of childbirth that embodied and illuminated the complex context of childbirth. Many of the participants said that the people behind the decision for a woman to birth either at home or in a health institution, were spouses or older female relatives. Thus, one could assert that if spouses and older female relatives were made aware of the importance of women having institutional births with skilled attendance, more women would not be having homebirths. Care of birthing women by TBAs and relatives in homes, especially in rural areas of Zambia is well documented (MoH, 2011). For the last 20 years, ZDHS reports (UNZA *et al.*1993; CSO *et al.* 1997; CSO *et al.* 2003; CSO *et al.* 2009) have been revealing that more women were having homebirths, compared to institutional

ones. This trend has however slightly changed. The ZDHS 2013 – 2014 report states that 67% of births in Zambia take place in a health facility, while 31% take place at home (CSO *et al.* 2014). According to (MoH, 2011) the increase in institutional births could be attributed to the involvement of male in maternity care.

The sub-theme also highlighted the impact that people who attend to birthing women have on the experience. If a birth was attended by a kind and caring person, the experience was described as being bearable. The extent to which an attendant affected a woman's childbirth experience went as far as describing him or her as skilled even if a complication, which physiologically could have been avoided, arose. Through a trustful relationship, women managed to handle unexpected outcomes and gained control over such situations. Non-availability of funds to buy the required items for the baby and the mother to use during labour and childbirth in a health facility, and concerns about the poor state and lack of basic social and healthcare needs such as privacy, had an impact on participants' preferences for birthing. A study by Ganle, Parker, Fitzpatrick and Otupiri (2014) also reported that there were often inadequate supplies, including medication, gloves and blood in Ghana's health institutions. These items are critical for the execution of standard care. The practice of birthing women bringing their own supplies could cause healthcare workers to first attend to women who bring their own supplies. Such a practice could therefore influence birthing women to interpret that there is no fairness in the provision of care during institutional births. The findings from a study by Bohren *et al.* (2015), were that asking birthing women to bring their own items influenced them to think that healthcare workers were withholding supplies from them for malicious reasons. With such an interpretation, women opted to give birth at home.

5.4.2 Choosing the advice to adhere to

This sub-theme elucidated birthing women's disillusionment when advice from older women and healthcare workers were in conflict with each other. Older women were seen as having the greatest influence on childbirth matters in the community and thus, their advice and guidance was sought due to their standing in society. For instance, a participant mentioned that healthcare providers did not trust that women take Fansidar, the drug that is given to all pregnant women due to the prevalence of malaria in Zambia. Therefore, in order to avoid a situation where the drug was thrown away, women attending antenatal services were usually asked to take the tablets in the presence of the attending midwife. Some participants talked of pushing the tablets under their tongues, pretending to be swallowing the tablets and later spitting it out after leaving the examination room. The reason for not wanting to take the medication was based on the information commonly provided by older female relatives that the drug precipitates abortions. Although, healthcare providers advised birthing women that the information was not correct, some participants' revelation that some women pretended to be taking the malaria medication when in the presence of healthcare providers highlighted their level of mistrust for institutional care.

Trust in institutional care is very essential. It should be instilled in women through healthcare providers' interpersonal skills with women. The Skilled Care Initiative in their technical report states that interpersonal skills by care providers are equally as important as their clinical skills (Family Care International, 2006). The report which provides an overview of the activities implemented by Family Care International was intended to strengthen maternity care providers' interpersonal communication and counselling skills. It has a special focus on ensuring caring and compassionate treatment of clients. After the launch of the Skilled Care Initiative in 2000, the project conducted extensive baseline research in health facilities and

communities of Burkina Faso, Kenya and Tanzania. All the three countries are in the sub-Saharan African region. The aim of the research was to identify gaps in the quality and availability of maternity care and barriers that limited women's use of services during pregnancy, delivery, and the postnatal periods. The report states that in all the three countries, community members raised concerns about the interpersonal communication skills of maternity care providers and the way that pregnant women were treated (Family Care International, 2006). In the case of this study, participants mentioned that trust was a quality they embraced regarding their older female relatives who they believed were experienced enough in matters of childbirth because of the way they related and cared for birthing women.

5.5 Loss of dignity

This fourth theme embodied participants' belief that childbirth was the pride of a woman. In participants' opinions, experiencing childbirth brought a woman dignity, and elevated her status because it was not easy to achieve and remain unscathed. Thus, during childbirth, women expected to be treated with respect and not being talked to in a disrespectful manner, such as being shouted at. According to some participants, women who birthed in health institution were not accorded the respect they deserved during childbirth. For instance, most participants reported being asked by healthcare providers who at times were younger or male, to undress before being admitted for childbirth care. Participants did not approve of this practice. They expressed that it stripped them of their dignity. Nevertheless, due to their enculturation into a society that embraced the norm of compliance, participants did what they were asked to do without verbalising their inner feelings. Participants' attitude of agreeing to do practices they did not approve in silence, supported literature on oppression, which illustrates that a common response to abuse is passivity (D' Oliveira, Diniz and Schraiber, 2002). Similarly, in a study by Kabakian, Campbell, ShediacRizkallah and Ghorayeb (2000)

on childbirth, the findings showed that women very rarely questioned the usefulness of many routinely applied procedures, even those they knew were unnecessary. An example of one such practice in this study was undressing before admission. When probed, women reported that many aspects of the technical care provided by healthcare workers were intimidating and that they experienced discomfort. Participants reported that they were passive because of their low social class. The interpretation of this theme in this study contributed to an understanding of women's preferences, practices, beliefs and traditions related to childbirth. Information from two detailed reviews that concern disrespect and abuse that women face during childbirth (Bohren *et al.* 2015; Bowser and Hill, 2010), suggest that disrespect and abuse may sometimes act as more powerful deterrents to skilled birth care utilisation than other more commonly recognised deterrents such as, geographic and financial obstacles. The majority of the studies in the reviews were undertaken in low and middle income countries. Lack of respectful and non-abusive care at birth may encompass many points along a continuum that spans dignified, patient-centred care, non-dignified care and overtly abusive maternal care (Bohren *et al.* 2015). Examples of disrespect and abuse in the two studies included subtle humiliation of women, discrimination against certain sub-groups of women, overt humiliation, abandonment of care, and physical and verbal abuse during childbirth (Bowser and Hill, 2010). Bohren *et al.* (2015) identified seven categories of disrespect: 'physical and verbal abuse', 'non-consented clinical care', 'non-confidential care', 'non-dignified care', 'discrimination based on specific patient attributes', 'abandonment of care', and 'detention in facilities'.

While Bowser and Hill (2010) acknowledge that there are many reports on disrespect and abuse in facility-based childbirth, there are very few examples of impact studies to guide evidence-based policy and future programming. This compelling gap in evidence is the

purpose of this phenomenological study that was done in a low income country in sub-Saharan Africa. Understanding 'Dasein' and the concepts of 'thrownness', fallenness and 'enculturation', gave a clearer picture of how women experience childbirth. The participants were more vocal about patient-provider communication and valued the good interaction with the care providers in homebirths. The extent of passivity and feelings of discontent with healthcare providers varied according to participants' social class and the amount of psychosocial support they received throughout the childbirth process. Bohren *et al.* (2015) categorised this type of care as discrimination based on socio-economic statuses. After a review of 65 studies, they concluded that across the world, women who were of lower socio-economic status reported feeling discriminated against, due to their social class or income level. Compounded with their traditional norm of compliance, some women found themselves in situations where they were physically or verbally abused by care providers, and they allowed it.

5.5.1 Physical and verbal abuse

Reasons why abuse existed within a caring profession, such as midwifery, has resulted in many studies (Bohren *et al.* 2015; Bowser and Hill, 2010; Kwaleyela *et al.* 2009; Amooti and Kabakyenga, 2006; Seljeskog *et al.* 2006; Kyomuhendo, 2003) being conducted. MacKeith *et al.* (2003), who did a mixed methods study in Zambia, reported that one fifth of the respondents in their study indicated being shouted at, scolded and treated badly during labour. The chronic effects of under-resourced and strained health systems on provider motivation are frequently described as important contributors to disrespect and abuse in facility-based childbirth. In Nigeria for instance, it is reported that the negative attitudes of

healthcare providers towards birthing women could be attributed in part to being understaffed, overworked and underpaid (Centre for Reproductive Rights, 2008).

In this phenomenological study, the sub-theme: "Physical and verbal abuse" expounded birthing in Zambia in reference to how participants experienced and gave meaning to the phenomenon in the midst of being abused. They described maternity healthcare providers as being: violent, uncaring, unsympathetic, harsh, cruel, and only focused on having their work done, rather than caring or providing emotional support to birthing women. Women reported feeling disgraced by healthcare workers who made inappropriate remarks to them regarding sexual activity and getting pregnant despite knowing that they were poor. With such experiences, some participants did not appreciate the important service healthcare workers, especially midwives, provided. Irrespective of the fact that during childbirth, healthcare providers and a birthing woman worked closely with a common goal of having a complication free birth, the focus for the women encompassed the process. In the absence of harmony between providers and women during childbirth, participants referred to their interaction as: 'they did this'; instead of 'we agreed to do this'. In reference to the childbirth process, a participant (Mrs LD) argued that midwives' views that they were being undermined by birthing women were misplaced. She said that birthing women and other community members appreciated the work that midwives were doing. She indicated that midwives themselves were the ones who were undermining their profession by not acting professionally.

5.5.2 Lack of choice

Literature on childbirth emphasises that where, whom and how women birth should not be prescribed (Cook and Loomis, 2012; Pitchforth, van Teijlingen, Watson, Tucker, Kiger,

Ireland, Farmer, Rennie, Gibb, Thomson and Ryan, 2009; Department of Health, 2004). Instead, women should be accorded the platform to choose. However, in sub-Saharan Africa, prescribing where, whom and how women should birth has been found to be necessary because homebirths are associated with high morbidity and mortality in the region (CSO *et al.* 2014; National Bureau of Statistics, 2006; Government of Malawi, 2000). Unlike in high income countries where women have choices of where to birth and who to assist during childbirth (Department of Health, 2004), women birthing in Zambia are advised birth in health institutions only (MoH, 2011). In most participants' view, being restricted to birth only in health institutions was synonymous to having no choice. The sub-theme reflected the assertion that not providing women with an opportunity to choose to be attended by healthcare providers whom they felt safe with and trusted deprived them of the choice of whom to birth. Therefore, through 'Dasein' and experiencing childbirth, participants in respecting their elders under the umbrella of compliance often birthed at home. According to CSO *et al.* (2009), childbirth in a health institution attended by trained medical personnel is associated with lower rates of maternal mortality compared to a homebirth. Nevertheless, socio-demographic variables of age, educational status and occupation are associated with higher institutional delivery service use (Abeje, Azage and Setegn, 2014; CSO *et al.* 2014). The sub-theme thus elucidated the important role older female relatives, spouses and education played in relation to how women experienced childbirth.

5.6 Feeling insecure

This theme, which highlighted feelings of insecurities and misunderstandings about childbirth, negatively impacted women's childbirth experiences. As one participant (Mrs MB) remarked: *"there is power in information as it makes a person feel secure"*. Hence, in the case of this study, participants reported feeling insecure because they were not provided

with enough information about what to expect during childbirth. Poor interpersonal and communication skills by healthcare workers have been mentioned in a number of studies from sub-Saharan Africa (Kwaleyela *et al.,* 2009; Amooti and Kabakyenga, 2006; Seljeskog *et al.,* 2006; Kyomuhendo, 2003; MacKeith *et al.,* 2003). Chadwick, Cooper and Harries (2014) and Hatamieh, Shaban and Homer (2013) in their studies reported that women were often dissatisfied with explanations from healthcare workers regarding their care. They believed that healthcare workers were more interested in birthing women's compliance than in answering questions or clarifying proposed procedures. However, what could not be expounded by Chadwick *et al.* (2014) and Hatamieh *et al.* (2013) was how the poor interpersonal skills and communication between birthing women and healthcare providers were interpreted. This gap in information was elucidated by participants in this phenomenological study's interpretation that the poor rapport made them feel insecure. Being talked to disrespectfully or rushing through explanations not only made women feel unappreciated, oppressed and discriminated against, it made them feel insecure, thereby impacting negatively on their experience. Participants believed that adequate explanations from healthcare workers were imperative if women were to fully comprehend the situation. According to Miller *et al.* (2003), when communication between care providers and women took place, it was often inadequate. Participants expressed their anxieties during their encounters with healthcare professionals, stating that it was difficult to feel secure because they did not know when they were going to be scolded. Hence, due to such uncertainties, most participants reported holding back information that had potential to guide healthcare workers to provide acceptable maternity care. From the women's perspective, feelings of physical and emotional security were inseparable because conditions that physically and/or emotionally affected the quality of care put them at high risk of being harmed. Through the

sub-themes: “Not provided with enough information”, “Being left alone”, and “Lack of reassurance”, the theme was expounded and became clearer.

5.6.1 Not provided with enough information

Reports from studies from the sub-Saharan region (Human Rights Watch, 2011; Janevic, Sripad, Bradley and Dimitrievska, 2011; Seljeskog *et al*. 2006) state that the information that healthcare workers provided to birthing women, often left them feeling ‘in the dark’. For example, Seljeskog *et al*. (2006) who studied why women in Malawi were attending antenatal care from multiple health institutions during one pregnancy, reported that birthing women viewed an antenatal care card as a ‘ticket’ to having a free institutional birth, in case a complication arose. Due to lack of adequate information from healthcare providers, on the use of the antenatal care card, women did not view it to be a document with vital information that guided maternity care. In midwifery practice, an antenatal care card is a vital document that guides the way maternity healthcare providers take care of a pregnant woman and her unborn child (GNC, 2001). It is not merely a document that entitles a woman to have free maternity care.

Due to poor interpersonal skills, which included poor communication between healthcare professionals and mothers; healthcare professionals were viewed as holding expert status over childbirth. Not having enough information on birthing influenced women’s feelings of insecurity and lack of control over a phenomenon that they personally experienced. In the case of this study, most participants reported getting information on childbirth from relatives and friends. Paradoxically, the information from relatives and friends often conflicted with the one from healthcare providers. Consequently, women reported feeling insecure when

interacting with their healthcare professionals because they did not know whether what they were practicing was correct or not. In discussing their childbirth experiences participants' expressions, body language and tone of voice did not portray ownership of the childbirth experience. They kept on saying things such as: *"I could not tell her (the midwife) the exact time that my labour started, in case I should have come earlier"* (Mrs LL)*, "…she (the midwife) decided that I lay on the back when it came to pushing the baby…not squatting like I was advised by my grandmother"* (Mrs MJ). In studies by Chadwick *et al.* (2014) and McMahon *et al.* (2014) it is reported that some women preferred to deliver in a squatting or kneeling position, rather than the supine position. Apart from women's resentments that have been mentioned in previous studies, results of this phenomenological study highlighted that not providing birthing women with adequate information on the care being provided was not safe for the healthcare provider and birthing women. This was because both kept vital information from each other. In the case of Zambia where healthcare providers attended to women from different parts of the country, and thus, had diverse information from relatives and friends on childbirth, provision of adequate information is vital. It is therefore, imperative that healthcare providers find time and provide women with enough scientifically based information. This type of care provision has the potential to make women feel that they are part of the team, and therefore, find it necessary to open up to health professionals.

5.6.2 Being left alone

From as way back as the 1980s, in a study done in sub-Saharan Africa by Klaus, Kennell, Robertson and Sosa (1986), leaving birthing women alone and unattended for long periods of time has been a common characteristic of institutional births. A mixed methods study done in Zambia by MacKeith *et al.* (2003), mentioned that 171 women who participated in their study reported having been left alone in labour for long periods of time. Being left alone for long

periods of time was commonly experienced by women who delivered in health centres (MacKeith *et al.* 2003). In contrast, this study found that the aspect of labouring women being left alone for long periods of time was commonly experienced by women who birthed at night, irrespective of whether the birth occurred in a hospital or a health centre. According to the study participants, the incidences of being left alone for long periods of time were higher at night. They attributed this to healthcare workers having fewer supervisors at night. In some accounts, participants narrated birthing in the absence of skilled attendance. Some mentioned being attended to by relatives or other women who happened to be nearby when the birth occurred. In a study by MacKeith *et al*. (2003), three births were attended by cleaners, one by another unqualified person, and 19 women delivered alone with no assistance. Such incidences pointed to the fact that having an institutional birth in Zambia did not guarantee presence of skilled attendance at birth. Therefore, one could postulate that in some instances, women would have been better off giving birth at home because in the absence of a complication, they would have been assured a caring caregiver in attendance throughout the labour process.

Healthcare professionals left labouring women alone with a gadget, which was popularly known as a 'bell'. Women were advised to push it whenever they needed assistance because it made noise when pushed. However, the participants reported that healthcare providers never responded to the 'bell'. Leaving women alone for long periods of time put the lives of birthing women and their unborn babies at risk. Some participants gave accounts of how their babies almost fell off the beds, during the birthing process. Some mothers together with their newborns almost died from bleeding after the delivery. There were three accounts where newborns died shortly after birth and the mothers blamed the midwives for the deaths. Incidences such as these intensified women's feelings of insecurity during institutional births.

However, leaving women alone in labour for long periods of time was not always deliberate. Some participants explained that in some instances, they were left alone because healthcare workers, especially midwives, were attending to too many clients at any one given time. Millennium Development Goal number 5, which is one of the eight UN goals that were expected to be achieved by the year 2015, stipulated that 90% of births were to be attended by skilled attendants, in the regions where they were not routinely available, if MMR was to be reduced (WHO, 2006a). World Health Assembly (WHA) states that because of the shortage of qualified staff in Africa, only 42% of deliveries are attended by a midwife or other skilled health personnel (WHA, 2006). The effects of HIV/AIDS and brain-drain to high income countries are some of the factors that have led to shortage of qualified staff in sub-Saharan Africa's health facilities (WHA, 2006). An exodus of trained healthcare workers, as well as a breakdown of infrastructure has disproportionately affected birthing women in Zambia (MoH, 2011). The main reason participants gave for not wanting to be left alone during labour was that they needed someone to reassure them that everything was going to be well.

5.6.3 Lack of reassurance

This sub-theme contributed to the body of knowledge that supports a context specific understanding of how women in countries with high maternal mortality experience and give meaning to the childbirth phenomenon. Historically, women have been attended and supported by other women during labour. However, in hospitals in sub-Saharan Africa and other low income countries, continuous support during labour has become the exception rather than the routine (Hodnett, Gates, Hofmeyr, Sakala and Weston, 2013). The results of

Hodnett *et al.* (2013) on continuous support for women during childbirth are that continuous support during labour has clinically meaningful benefits for women and infants.

One participant (Mrs LD) stated that childbirth was like venturing into the unknown, where a woman did not know whether she or her unborn child were going to come out alive and well. Therefore, women needed reassurance during labour and childbirth than at any time in their pregnancy. Study participants explained that the presence of a female companion who kept reassuring them was a way that offered support and safety. It made the birthing process much easier and bearable, thus humanising the process. Reassurance of a birthing woman by a family member contributed to women's physical and emotional welfare by offering comfort and encouragement.

As reflected in other studies (Hodnett *et al.* 2013; Palinski, Souza, Silveira, Salim and Gualda, 2012), when supported by a family member, women are more likely to report positive birth experiences, thus feeling more satisfied and happy. It allowed a reduction of the feelings of loneliness, anxiety and stress levels caused by the vulnerability of the woman and other factors, such as discomfort during labour, fear in relation to the things to come, unfamiliar environments, and contact with unknown people (Hodnett, Fredericks and Julie, 2010). The presence of acquaintances provided the opportunity for women to express themselves without feeling threatened, whereas, remaining beside unknown people during childbirth awakened negative feelings in some women (de Oliveira, Rodrigues Guedes, Felipe, de Galiza and Monteiro, 2011).

5.7 Inadequate service provision

In some studies from sub-Saharan Africa (Shiffman, 2007; Seljeskog *et al* 2006), inadequate service provision is mentioned as a major factor contributing to high MMR in the region. It discouraged women from seeking institutional births, and hence high numbers of homebirths. Inadequate service provision in the studies included midwives' negative attitudes, poor communication between midwives and pregnant/birthing women, leaving labouring women alone for long periods of time, abuse, segregated maternity care, and lack of appropriate equipment in health facilities (Bohren, 2015; Bowser and Hill, 2010).

In this phenomenological study, the theme "Inadequate service provision' elucidated women's interpretation of how the practice was experienced under circumstances they perceived to be inadequate. They mentioned that it did not only result in mortality nor was it only about the non-availability of resources and absence of services, as most studies from low income countries suggest. Participants in this study gave very succinct and concise accounts of inadequate service provision, which led to an understanding of how women birthing in Zambia experienced childbirth. In agreement with Koblinsky, Chowdhury, Moran and Ronsmans (2012), inadequate service provision contributed to an acute and chronic clinical and psychological morbidity for the estimated 20 million women who survive childbirth. According to Storeng, Baggaley, Ganaba, Ouattara, Akoum and Filippi (2008) it also had a lasting effect on mothers' and infants' physical and psychosocial health and wellbeing on their need to pay for on-going healthcare costs, and ultimately on the ability of their families to escape poverty (WHO, 2005b). Thus, inadequate maternal service provision has an economic effect on communities and countries (Singh, Darroch, Ashford and Vlassoff, 2009). It hampered efforts to tackle intergenerational inequalities in health (Marmot, Allen, Bell,

Bloomer, Goldblatt and the Consortium for the European Review of Social Determinants of Health and the Health Divide, 2012).

5.7.1 Unable to notice deviation from normal processes

Given the high number of homebirths in sub-Saharan Africa, studies from the region have mentioned that when a complication arises during childbirth, the attendants seldom have the skills to tackle it. However, accounts from participants in this phenomenological study highlighted that it was not only homebirth attendants who were unable to notice deviation from normal processes; some healthcare workers too failed to notice deviations. They pointed out that there were some inexperienced or poorly trained healthcare workers who were often responsible for inappropriate levels of care. In most accounts, these were members of staff that were mentioned to be mistreating birthing women in order to hide their inefficiencies. The accounts supported Utz, Siddiqui, Adegoke and van den Broek (2013) and Hussein, Hundley, Bell, Abbey, Asare, Graham and Phil's (2005) statements that although by implication one assumes that the label of health personnel as a midwife or an obstetrician makes them skilled attendants, it was not the case. Participants in this study reported that most healthcare providers were insensitive to birthing women's needs. This made them feel unconfident, anxious, afraid and alone. Some of the participants believed that birthing in a health institution ensured a positive birth outcome for them and their infants compared to a homebirth. However, while they expressed that they received technically sound care, their experiences during birthing in health institutions were marred by feelings of being emotionally unsupported, systematised and mechanical because the care that was provided was focused more on the technical outcomes, rather than on supportive care that incorporated reassuring communication and a comforting touch. Thomson and Downe (2010) in their

phenomenological study used Heidegger's concept of 'Machination' to elucidate technical care during labour.

5.7.2 Unsafe practices

Unsafe practices that put mothers and their newborns at risk were mentioned by many study participants. Most of the unsafe practices were by healthcare professionals. A peculiar practice that was mentioned by a lot of participants was the issue of midwives giving birthing women 'a bell' immediately after admission in labour. Participants were instructed to push the bell when they felt they needed attention from the care provider. However, there was a paucity of information about when exactly the women were supposed to ring the bell. It was therefore, not surprising when many participants mentioned ringing the bell whenever they felt that the pain had intensified. Participants complained that at times they experienced long delays but most often they reported that the healthcare workers were inattentive and ignored their requests for assistance. These experiences of being neglected, ignored, and abandoned by healthcare workers during institutional births have been mentioned in a number of studies from sub-Saharan Africa and other low income countries (McMahon *et al.* 2014; Roost, Jonsson, Liljestrand and Essen, 2009; D'Ambruoso *et al.* 2005) and were reported to be direct barriers to seeking future institutional births.

Each birth experience had an impact on a woman's future reproductive health choices on where and whom to birth. In two previous studies, conducted in Thailand (Liamputtong, Uimyam, Parisunyakul, Baosoung and Sansiriphun, 2005) and Mozambique (Chapman, 2003) healthcare providers and TBAs were utilised interchangeably in order to maximise social and biological support during childbirth. The results from the two studies were that

women expressed feeling safe because any practice that they perceived to be unsafe was quickly corrected by either the healthcare or the TBA present during birthing. Participants in this phenomenological study went on to elaborate that even though TBAs were not formally trained in issues of birthing, they knew when a practice was unsafe to birthing women and their infants.

5.7.3 Discrimination based on socio-economic status

This sub-theme elucidated experiences of going through childbirth with the grief and anguish of being discriminated against and oppressed on the basis of not being known to carers or having low socio-economic status. Women with high socio-economic status and those who were known to healthcare providers were provided with privileged care, while those with low socio-economic status and not known were discriminated against. Some participants reported that their low socio-economic status and not being known to healthcare providers rendered them vulnerable to abuse and poor communication from healthcare providers. This finding was similar to the finding by MacKeith *et al.* (2003), who stated in their study that women who did not have education were scolded and shouted at by healthcare providers. Differential treatment by healthcare providers often pervaded women's experiences of childbirth and influenced their interpretation. It tended to make women feel alienated from their healthcare providers. Lack of impartiality in care during childbirth is referred to as discrimination in two studies by Bohren *et al.* (2015) and Bowser and Hill (2010). Fear of such discrimination was considered a powerful disincentive to giving birth in health institutions in Ghana (Moyer *et al.* 2014), Sierra Leone (Oyerinde, Harding, Amara, Garbrah-Aidoo, Kanu, Oulare, Shoo and Daoh, 2013) and Tanzania (Kowalewski, Jahn and Kimatta, 2000).

Lack of impartiality during childbirth was pointed out to be in conflict with the participants' expectations of having a childbirth experience that was a joyous event, in which care providers were informative, kind, empathetic and treated birthing women equally. Participants complained that when a woman with low socio-economic status tried to point to healthcare providers their impartiality, she made the situation worse. Healthcare providers not only scolded her, they refused to attend to her thereafter. Similar to the results from other sub-Saharan countries (Moyer *et al.* 2014; Oyerinde *et al.* 2013; Kowalewski *et al.* 2000), experiencing discrimination for participants in this phenomenological study was mentioned to have an impact on future reproductive choices. Feelings of neglect and being marginalised are not good, particularly for birthing women. According to Peterson (2010), childbirth experience has an effect on a woman's self-esteem after birth. It can impact her emotional availability to her baby and future reproductive choices. Peterson (2010) states that having birth has the potential either to motivate or break a woman, depending on the support, preparation and acceptance of the woman's feelings before, during and after the birth. Hence, a woman's sense of maintaining psychological wholeness throughout labour and childbirth, whatever the method or kind of birth, is key to a positive sense of self. As was observed during data collection, the eyes of some participants became misty as they recalled their childbirth experiences with harboured pain and dread. Sometimes, participants' voices shook with emotions. On six occasions, interviews had to be stopped for some time to allow the participants gain their composure. Given the impact of labour, psychologically and physically, it naturally follows that the more intact a woman feels, emotionally, the easier it is for her to adapt to the intensity of labour. Heightened amounts of fear and anxiety have the potential to send messages that could lead to physiological reactions, which could complicate labour. The link between experiencing discrimination during childbirth and participants' social status was also identified in an earlier study from Zambia by MacKeith *et al.* (2003).

The lack of prospects of having an impartial childbirth experience from healthcare providers seemed far-fetched for some participants. They exhibited signs of dejection, shrugged their shoulders, and stated that the only chance for them to experience impartial care during childbirth was in having a homebirth.

5.8 Being there for the woman

The theme: "Being there for the woman", which was defined by participants as a feeling of comfort, trust and belief in their maternity care providers, as well as the treatment that was prescribed, expounded their not being afraid of the surroundings and establishing a trusting relationship with their care providers. The theme was mainly supported by interviews from women who had homebirths. Participants expressed the comforting and peaceful nature of birthing in an environment, which was known and comfortable to them. Hence, there were many participants who preferred to seek home deliveries over institutional childbirths. Studies done by Lundgren (2010); John (2009); Bayes, Fenwick and Hauck (2008) and Sjoblom, Nordstrom and Edberg (2006), have demonstrated that women value the midwifery care concept of 'being-with-woman' during childbirth. Although the context in which the studies by Lundgren (2010), John (2009) and Bayes *et al.* (2008) were conducted was different from the context of this study, in the sense that they were conducted in high income countries, the results were similar to those from this study, which was conducted in a low-income country of Zambia. Participants expressed the need for a provider who was there not only physically, but emotionally and mentally. The theme "Being there for the woman" explained experiences that deeply impacted women's interpretations of the childbirth experience. With yearning in their voices, study participants expressed their desire to find healthcare workers who treated birthing women with kindness and empathy and were caring, sympathetic and informative. These are the same attributes mentioned by Hunter (2002) in

her description of 'Being-with-woman'. Hunter (2002, p615), defines 'Being-with-woman' as "the provision of emotional, physical, spiritual, and psychological support by the midwife as desired by the labouring woman." The benefits of 'Being-with-woman' through the provision of sensitive and individualised care have been well documented in maternity literature (Edwards, 2005; Kennedy *et al*, 2004; Hunter, 2002). In this study the theme "Being there for the woman" was expressed through sub-themes that exemplified participants' feelings of safety with their providers leading to a sense of achievement.

5.8.1 Feeling safe

The sub-theme: "Feeling safe" resonated one of the goals of midwifery care, which strives at helping women to realise that labour and childbirth are normal life processes that are safe (GNC, 2001). According to Berg (2005), the knowledge of the ability of one's body could lead to a woman trusting her body and feeling safe with the process of childbirth. This is irrespective of influences such as, low socio-economic status and intimidating cultural practices. Thus, once a woman knows that her body was designed to birth, she could approach childbirth with confidence. The knowledge equips her with relevant skills to address circumstances she encounters during the process (Rizvi, Khan and Shaikh, 2014). This view was expressed by a few study participants who narrated having been well looked after during childbirth. They sounded confident with their future births. In some instances, the sub-theme expressed formally educated participants' confidence in institutional deliveries. This corroborated CSO *et al.* (2009) report, which states that educated women in Zambia have more institutional births than the ones without education. AbouZahr and Wardlaw (2003) states that a woman's overall status in society, including economic and social vulnerability, affects her access to and utilisation of health care services. Safety that study

participants talked about encompassed both physical and psychological aspects. It was caring behaviours such as showing women kindness and respect, giving them privacy, and making them feel comfortable irrespective of their socio-economic status, that made a qualitative difference of their experience of childbirth.

Changing provider–client interactions is often more challenging than modifying clinical practices. According to Family Care International (2006) provider behaviours are often rooted in deeply held attitudes, assumptions and prejudices about the communities they serve. For example, some study participants expressed that healthcare providers' treatment of birthing women was not always good because they knew that they were mainly serving underprivileged communities. Therefore, if more births in Zambia are to occur in health facilities, healthcare providers should provide women with care that makes them feel physically and mentally safe. Women need to trust and feel safe that authority figures, such as midwives, can make right decisions for them. Some participants who gave birth in health facilities expressed their desire to give birth in their homes with people they knew and trusted. Thus, trust was cardinal in the way women related to their care providers during childbirth. In the absence of trust, most women felt that they were better off birthing at home. They prioritised social norms such as gender of the attendant over biological problems.

5.8.2 Sense of achievement

The sub-theme: "Sense of achievement" defined participants' expression of pride that came through experiencing childbirth. It helped women feel recognised and instilled in them faith in their own abilities to birth and be able to cope with childbirth. By being present physically and psychologically for the birthing woman, birth attendants, particularly midwives, assisted in

raising women's confidence levels. For women with low socio-economic status, childbirth was an achievement that raised their status through portraying to the community that they were strong. Although some of the birth experiences were characterised by incidences of mistreatment, in reference to the achievement of birth, there was pride in the women's voices. The sense of achievement was described as an experience that redeemed women from all the difficulties they went through during their everyday lives. When asked to shed more light on what they meant, it was explained that women were not treated equally with men, and thus, childbirth became very important because it was the only phenomenon that placed them at a higher level in comparison to men. To consolidate their recognition of being well groomed women, some participants talked about going through childbirth in silence. Going through childbirth in silence was defined as something that was an achievement to a woman. Hence, women were not allowed to publicly complain about the experience. Mrs LD explained that common statements such as: 'labour pain was the pride of a woman' were meant to encourage women not to complain about the childbirth experience. Women experience labour in a variety of contexts and with differing aspirations (Bailham and Joseph, 2003). However, the experiences have far reaching implications for women's health and that of their babies. In the case of this study, complying with traditional expectations was perceived to be very important to birthing women.

5.9 Summary

This chapter highlighted the importance of the concepts: 'fallenness', 'thrownness' and 'enculturation' on how women experienced childbirth. The 'Dasein' or 'Being-there' of the women as they recounted their birth experiences revealed their being intertwined with their observations, thoughts, feelings and past experiences. In support with Heidegger (1962/1927), their world of experiencing birth was indivisible with their being human.

Therefore, separating themselves from their experiences of birth and their context was impossible. The knowledge provided by this study is unique and original in the sense that it was provided by women who experienced birthing in Zambia. It has highlighted the complexities of the experience that led to a clearer understanding of how birthing women in Zambia experience the childbirth phenomenon. The findings through the themes and subthemes revealed meanings and an understanding of taken-for-granted meanings of the phenomenon. The next chapter is the conclusion to the study.

CHAPTER 6: CONCLUSION

6.1 Introduction

This chapter looks at the whole study and answers the "so what?" question that was at the centre of conducting the study. The study's contribution to the body of knowledge forms the first part of this chapter, followed by implications for practice emanating from the findings. Implications for midwifery research, theory and practice, as well as recommendations on how maternity healthcare practitioners and all stakeholders could utilise this information are provided. This was with a view to improving practice and ultimately providing a platform that could help to stimulate programmes that address the drivers, consequences and effective interventions for achieving and improving maternal health for all women. Limitations of the study are also presented in this chapter.

6.2 Contribution to the body of knowledge

Although there are numerous studies from sub-Saharan Africa and other low income countries on childbirth, the phenomenological framework used in this study captured the essence of the childbirth phenomenon through the lens of women birthing in Zambia. Through the theoretically informed insights of 'Dasein', 'enculturation', 'fallenness' and 'thrownness' the findings illuminated women birthing in Zambia's interpretations of the childbirth experience. The embodied experiences of participants illuminated the complex context of childbirth in Zambia. The themes and sub-themes from the women's interpretations elucidated that childbirth in Zambia was experienced through the confines of one's 'thrownness', 'fallenness' and 'enculturation', which could not be separated from women's 'Dasein' or 'Being-there'. This led to a better understanding of how and why the phenomenon was experienced. This contribution to the body of knowledge points to the need

to have women's voices heard because they are the ones who experience the phenomenon. Uncovering women's experiences and the meaning they attach to the phenomenon could be a beginning step to exploring interventions that are intended to address the reduction of maternal mortality, which is unacceptably high in the sub-Saharan region. Consequently, when a perspective focusing on the interests of women is used, more relevant, sensitive and culturally congruent public health programmes and policies can be developed.

The findings of this study could be a starting point for social transformation for birthing women in Zambia, as it represents the reality of 50 women who participated in the study. The participants gave accounts of experiencing birthing from different parts of the country, hence, it gives perspectives that a number of Zambian women could associate with. From the participants' perspective, physical and psychological dimensions of childbirth were instantaneously important to the phenomenon. They gave insights of what went on in the minds of women in relation to childbirth, and how different factors played a role through their 'fallenness', 'thrownness' and 'enculturation' towards the phenomenon. Findings revealed that most of the participants were multiparous despite their younger age. Some were single and at times still in school when they got pregnant. Hence, the necessity to give adolescent girls more attention and advocacy is essential. Understanding the poor maternal outcomes at a micro level, which is at the level of birthing women, can help inform decisions and influence policy at the larger macro levels of institutions and government. Even though MMR in Zambia has reduced from 591 to 398 per 1, 000 live births, and more women (67%) are reported to birth from health institutions (CSO *et al.* 2014), the ratio of mothers dying is still high. Until that time, when women in Zambia are bestowed full rights, formally educated and treated with respect at all times, maternal mortality will continue. It is this intrinsic level that could be undermining attempts to reduce the high MMR in Zambia.

The findings of this study gave an understanding that highlighted how formal education, religion, and traditional practices and beliefs impact women's experiences of childbirth. The factors had an impact on when a woman began having children, how many children she bore, where and whom she birthed, and how she was treated during childbirth. Participants with less formal education did not conceptualise childbirth with the same biomedical and physiological constructs used by the women with formal education. In their view, God was the one who had an impact on how they experienced childbirth, as well as the outcome. They did not conceptualise that they too played a major role that could influence the phenomenon. For example, by undergoing HIV testing they would know their HIV status and plan where and how to birth beforehand. They embraced cultural practices and beliefs that at times infringed on their reproductive human rights. Women lived through the experience of childbirth in private, behind the closed door of secrecy that encompassed the difficulties involved in trying to conform to societal expectations. Birthing women's resilience and submissiveness to husbands and older women extended to their interaction with healthcare providers. Participants gave accounts that showed that their resilience and submissiveness around issues of childbirth at times, almost led to their death or the death of their infants. Some accounts provided glaring evidence of institutional and domestic discrimination and oppression of women that was both gender and class oriented. This saw participants with high social status receiving privileged care, while those with low social status were neglected. The impact of the discrimination and oppression, as well as a disregard of women's concerns propagated unjust health systems. They intrinsically shaped women's future reproductive choices, such as having homebirths, which in Zambia, predisposed to maternal morbidity and mortality.

6.3 Implications for practice

Attempts to reducing maternal mortality in Zambia and other sub-Saharan countries have mainly targeted macro reforms, such as, training healthcare providers and TBAs in the recognition of emergencies and encouraging institutional births. However, in the absence of inclusion of women's subjective data and preferences, the instituted interventions have not yielded the envisaged results (Darmstadt, 2005), pointing to the need for inclusion of micro reforms, in the sense of individual attitudes and caring behaviours. Designing approaches to combating disparities of maternal mortality between low and high income countries thus requires unravelling and addressing the concerns of women through respect of their interpretation of the childbirth experience. The lack of knowledge on how women experience and give meaning to the phenomenon has contributed to the creation of a picture in which healthcare providers, especially midwives, were viewed as not giving maternity care that puts women's preferences at the centre of the phenomenon. The significance of the meaning of childbirth revealed by this study requires organisational and policy development within the context of an environment that acknowledges diversity. Otherwise, the continued exclusion of women's subjective childbirth experiences and interpretations will continue rendering a distorted and an incomplete depiction of the childbirth phenomenon.

For many of the women with low social status, everybody made decisions for them. This however, was not the case for participants who were formally educated. According to Kabeer (2005), education has cognitive benefits that lead to significant social development. Improved cognitive abilities increased the quality of life for women (Nussbaum, 2011) in the sense that an educated woman was better able to make better decisions related to health, for herself and her family (Kabeer, 2005). Apart from decision making, education raised a woman's social status. The effects of a woman's education in relation to social benefits and a woman's

empowerment have constituted a significant area of research within international studies. Women's education has been noted to lead to significant benefits, such as decreased fertility rates, lower infant and maternal mortality rates, because an educated woman was more involved in the decision-making process of the family (Levine, Lloyd, Greene and Grown, 2008; Kabeer, 2005). One of the study participants who had a Master's Degree narrated that when she was told that her baby was in the occipito-posterior position, she decided to go and birth at a hospital different from the one she was receiving antenatal care. This was in contrast to accounts of women with no formal education who left such decisions to their older female relatives and spouses. Besides the intrinsic value of increasing a woman's confidence; the benefits of having an educated woman extended to economic stability in households. Educated participants did not complain of being asked to buy items needed for institutional birthing. This demonstrated that the socio-demographic characteristic of education, which in most instances raised a woman's socio-economic status, had an impact on a woman's birth experience. Education provided the women with a platform to be assertive. When healthcare providers failed to provide adequate information on birthing, formally educated participants reported using other sources such as magazines, radio and television to search for information. Therefore, the more educated a birthing woman in Zambia is, the higher the chances of her opting for an institutional delivery. Although educated participants' accounts too exhibited elements of 'enculturation' into communities that embraced norms such as 'compliance', their 'Dasein' of the childbirth experience encompassed their experience of undergoing formal education.

Formally educated participants brought forth an argument elucidating how the benefits of having an institutional birth outweighed the risks of birthing at home in Zambia. Only two participants out of 11 participants who had homebirths had been educated to secondary or

college level. But even though Miss MC, a participant with secondary education, and Miss LY, a participant with college education, reported having homebirths, there were reasons why this occurred. Miss MC explained that she had a homebirth because she found the health facility where she was advised to birth from closed. She walked to the health facility with her grandmother at night. The next nearest health facility was very far. She pointed out that to avoid giving birth on the way, her grandmother and she, had no choice but to go back home. Miss LY, in her account explained that she was still young when she gave birth to her first child. She had not yet had her college education. The background to Miss LY's account was that, after the death of both her parents who lived in Lusaka, she went to live with her grandmother in a rural village. Her grandmother failed to pay her school fees, thus she was forced into a marriage to a young man from a nearby village. When she went into labour, her mother-in-law and grandmother decided to conduct the delivery at home because they had conducted home deliveries before. Due to Miss LY's young age, she was not provided with the decision-making power on where and whom to birth.

Insights into how women experience childbirth are needed to provide starting points for the design of workable interventions to reduce high MMR in Zambia. By understanding how women experience and give meaning to the childbirth phenomenon, healthcare providers could be able to assist birthing women appreciate the experience. Better and clear information, as well as having open discussions on childbirth could help women to recognise their strengths. The best route to changing women's way of thinking is through leadership from healthcare providers, particularly midwives. Supporting the education and training of girls and women; promoting women's participation in health, education and economic activities; lobbying for increased funding for basic social services, working to improve the quality of programmes, and demanding that family life education be taught in schools could

be some of the ways in which to address gender inequality in Zambian societies. Furthermore, women whose rights are violated need to be availed access to legal and other resources to address their grievances. Until maternity healthcare workers and stakeholders reach a level when they acknowledge and accept that women in Zambia do not have the required voice regarding childbirth, as well as issues related to the phenomenon, it will be difficult to make workable interventions. It is therefore, incumbent on maternity healthcare workers and all stakeholders to utilise the findings of this study and tailor them in such a way that interventions do not infringe on women's beliefs and practices. This can be strengthened through midwifery research, theory and practice.

6.3.1 Midwifery Research

This study highlighted a variety of issues that need addressing at local, national and regional levels. The interpretive phenomenology framework used for this study provided a foundation to inform future research on childbearing women especially in countries with high MMR. Therefore, research on childbirth should prioritise giving voice to the segment of society (birthing women) that is most affected by the phenomenon. By examining childbirth experiences of women in low income countries, researchers could gain a better understanding of the contextual factors that impact the experience. From this starting point, a spectrum of reproductive health issues, such as, examining the huge disparities in birth outcomes between countries could be explored. Further research with women could enhance a reciprocal relationship between participants and researchers. Study findings showed that women in Zambia did not have the power or influence to set the agenda of addressing maternal mortality. Therefore, as more women become aware of their rights and factors that affect their lives; their voice could be used to empower other women. Interventions on how the findings could be integrated in the current midwifery curriculum could also be instituted.

6.3.2 Midwifery Theory

This study highlighted how the concepts of women's vulnerability, lack of knowledge of their rights, as well as gender and class discrimination and oppression in institutional and domestic contexts impacted the childbirth experiences of women birthing in Zambia. The findings showed that childbirth was not just a physiological phenomenon, but rather, it is also a social event that encompassed a woman's enculturation, thrownness and fallenness into the world. Hence, by understanding women's experiences of the childbirth phenomenon through these interpretive phenomenological concepts, interventions that could help reduce the persistent trends of high maternal mortality can be put in place.

6.3.3 Midwifery Practice

This study provides the beginning of the development of an understanding of how and why women in Zambia interpret the childbirth experience the way they do. The findings can help guide clinical practice because they support the premise that physical and psychological dimensions of childbirth are inseparable, just as human beings cannot be separated from their world and experiences. Hence, maternity care providers, especially midwives, could incorporate findings from this study into their everyday practice. Eliciting adequate information and providing accurate information to birthing women about childbirth should not be a difficult task for a midwife. Grounding the experiences into simple but truthful explanations could abate some of the traditional practices and beliefs that infringe on women's rights to accessing skilled maternity care. Maternity care providers need to be culturally sensitive to women's beliefs and traditions when implementing interventions and programmes. For example, in the western culture, interventions are often targeted at the individual woman as the predominant beneficiary. Such an approach could be less effective in the Zambian context where spouses and older women's inputs on birthing issues are highly

valued. Therefore, community based interventions targeting all community members could be considered instead.

6.4 Areas that require further research

Continued development of this interpretive theory in studies focusing on the childbirth experience could provide new perspectives from which to view the ageless problem of high maternal mortality in most sub-Saharan African countries. Other qualitative studies involving stakeholders such as, birthing women's husbands/partners, older female relatives, and relatives of women who have succumbed to a maternal death could also be beneficial in the understanding of how childbirth is experienced and interpreted.

6.5 Recommendations

In Zambia, much has been done in the social realm to empower women. Nevertheless, many more issues need to be kept in mind, in order to understand why more has not been done. Maternity healthcare stakeholders must re-examine current approaches to improving reproductive health by addressing the issue of improving women's experiences of childbirth. This could start by addressing the contextual factors and community based issues that have been brought to light by this study. To achieve this, the following recommendations are made to policy makers, and midwifery educators and clinicians.

6.5.1 Policy makers

Edgley, Stickley and Masterson (2006) in their article on philosophical tensions between the rights of the individual and the rights of the community, concluded that policy must enshrine

a clear human rights agenda; not only for the benefit of service users, but provide effective guidance and professional protection to those practitioners responsible for care in the community. Borrowing from this insight, it is recommended that policy makers in Zambia should not only concentrate on ensuring that women birthed in health institutions, instead they should also look at how to protect midwives who are willing to assist women in homebirths, thus fulfilling women's birthing preferences. Provision of maternity care that is sensitive to women's cultures and traditions is important in the process in order to enhance the relationship of the woman with her spouse/partner, older female relatives and maternity care providers.

Culturally specific knowledge from this study could be used to guide policy makers in the future development of safe motherhood initiatives. Many of the interventions adopted over the past 20 years of safe motherhood initiative in Zambia have focused on the core strategy of skilled attendants and health centre based childbirth. This strategy is difficult to achieve in Zambia and many other countries in sub-Saharan Africa because of lack of proper infrastructure and human resource, as well as a distorted and an incomplete depiction of the childbirth phenomenon. Inadequate knowledge on how women experience and interpret the childbirth phenomenon has the potential to render certain interventions to be culturally incongruent with most childbirth practices and beliefs. There is also a parallel need to build agency and autonomy in women, which needs to be addressed at an individual and societal level, beginning with simple things, such as assertiveness training through to educational opportunities, so that women develop economic independence.

A childbirth experience, where all key players: the woman, the birth attendant and the woman's family, as well as the social/cultural factors surrounding the women are recognised should be cardinal in care provision. There needs to be an integration of a woman's sense of control over her body, her role during childbirth and the role of the partner and other family members into maternity care, in preparation for childbirth. In order for this to be effected, there is need for this kind of thinking to be inculcated during the training of midwives. Men, older women, policy makers and healthcare providers should know that birthing women have the right to choose, whom, where and how to birth. If women are made aware of their right to choose, they would know that they need to be treated with dignity, and be involved in decision-making regarding issues of childbirth. This information will entail that by the time student midwives qualified, they would know their role in the process of providing maternity care that takes into consideration birthing women's preferences.

6.5.2 Midwifery educators

During the training of midwives, discussions on women's roles on childbirth, their responsibilities, and the limits of their own capacity to birth, must be part of modern maternity care. There is therefore, a need for the midwifery educators to re-evaluate their curriculum and if the issue of the importance of the childbirth experience to birthing women is not addressed, there is need to include it. According to Heidegger (1962/1927), it is our heritage of enculturation into a shared community at a specific historical period that provides the ontological basis, through which we are able to engage with, and make meaning of our lifeworld (Thomson, 2011). In the context of this study, the shared community is the country of Zambia, and the specific historical period is the childbirth process. Listening, supporting, guiding, respecting, and paying attention to women's individual needs and desires is

important in attempting to help women realise their innate potential and gain confidence in their abilities. During the training of midwives and updates for the qualified midwives, there should be emphasis on the provider-woman relationship. Care providers should be aware that birthing women are at the centre of the experience and therefore, their involvement is paramount to attaining an experience that is empowering. This could be achieved through skills-based learning opportunities during training, using women's voices/narratives as part of midwifery education programmes and mentorship. Through such training, midwives can become aware of the need to value the significance of childbirth and the concept of 'being-with-woman'. Consequently, this could assist birthing women to value themselves. Maternity healthcare professionals are advised to take responsibility for their actions and understand that each woman is a unique human being who is entitled to receiving quality maternity care, free from discrimination and oppression. This is enshrined in their human rights. For instance, through numerous rules such as the one that did not allow homebirths, women's subjective experiences are overlooked and hence, serving as a deterrent to seeking institutional births. Since women in Zambia are socialised to the practice where they should be seen and not heard, their displeasure with the policy of birthing in health institutions has continually been exhibited by the high numbers of homebirths in the country. Emphasis on the importance of providing individualised maternity care to women could lead to a number of health personnel grasping the profoundness of the responsibility embedded in the care they provide.

6.5.3 Midwifery clinical practitioners

There needs to be an attitudinal change among healthcare providers towards a more woman-centred care that involves listening, respecting, being empathetic and kind to women. As the

woman's body is central to the experience; introduction of different forms of physical and psychological support during antenatal and intrapartum care could be beneficial. This could be done through good communication with women and their families, avoiding abuse, discussing and understanding women's cultural practices, providing impartial maternal care and empowering women so that they are at the centre of the experience. According to Hotstede, (2001), attention should be paid to each individual birthing woman, in order to help enhance her to develop trust in her own capacity, her feelings of control and her understanding of her limits. Midwifery educators and clinical practitioners should collaborate on research issues to ensure that care provision is evidence based.

Given the intimate care that midwives provide during childbirth, comments made at such a time stay with women for years. Therefore, it is worth reminding midwives of the emotional fragility of women, given the fact that most of the women they cared for are coming from backgrounds that are characterised by gender discrimination and oppression. Midwives could also help empower women by demystifying myths and taboos related to pregnancy and childbirth. These recommendations can be achieved through:

- **6.5.3.1 Increasing services available to women**

Increasing services available to women can be done through counselling sessions during antenatal care, forming of women support groups or providing information from studies such as this one. This could be done during community talks, through free pamphlets translated into indigenous languages and on the internet for those women who can afford. Childbirth should be more realistically portrayed and possible stresses it might cause should be articulated so that women could stop wearing the mask of being able to cope with the phenomenon in silence even when they cannot bear it. Such programmes will empower

women to share their feeling with their healthcare providers, so that by the time they go into labour, they are ready for the experience.

- **6.5.3.2 Increasing publicity**

For the women who have the socio-economic capacity, websites that discuss midwifery issues such as MIDIRS should have wider publicity in places such as public libraries, newspapers and on public transport. This would help women to be aware of their existence, and hence, seek them out. For women without the socio-economic capacity, midwives together with community health workers could disseminate study findings during outreach programmes. Such topics could generate interest among community members and make them open up to their providers, rather than subjecting them to always listening to routine topics. Some community members could relate to the experiences and hence, evaluate themselves.

- **6.5.3.3 Conducting a community education programme**

It would be worth conducting community programmes aimed at debriefing communities on study results such as this, so that the childbirth experience can be demystified. Through such discussions, community members could get to understand the current relationship between healthcare and birthing women. Such an education programme would need wide advertising through newspapers, radios, televisions and women's popular magazines.

6.6 Moving from recommendations to action

All too often study findings lie on the shelf of the student, the supervisor/s and the library. Nothing or little is done to disseminate the findings or push for the recommendations to be acted on. The way in which I intend to move from recommendation to action is through my spheres of influence. The questions I have asked include: Who and what resources are in my

spheres of influence? What actions could I take to ensure that the study findings could be utilised to inform practice and better women's birth experiences and outcomes? The spheres of influence I will utilise are at local, national and international levels. I intend to share the finding of this study with people at multiple levels: policy, practice, education, healthcare delivery, women, and all other community members.

6.6.1 Local spheres of influence

I plan to disseminate the study findings with students of the UNZA, School of Nursing Sciences, lecturers, those working in midwifery practice areas, as well as students and staff in the Schools of Midwifery, countrywide. In collaboration with stakeholders, such as Midwives Association of Zambia Forum, USAID and UNFPA, I intend to run a mentoring training programme for midwives, educators, administrators and students based on the study findings. Through the Outreach programme that the UNZA, School of Nursing Sciences offers, I will disseminate the information to women and other community members.

6.6.2 National spheres of influence

I intend to arrange meetings with the Permanent Secretaries of the following Organisations and government Ministries such as:

- Ministry of Community Development, Mother and Child Health
- Ministry of Gender and Child Development
- Ministry of Health
- General Nursing Council of Zambia
- Women for Change

This level of dissemination is targeted to assist with development of policy for maternal health and gender, respectively. The objective of the dissemination will be to discuss the study findings with the policy makers and present to them the recommendations. This is meant to raise their awareness regarding women birthing in Zambia's interpretation of the childbirth experience. I also intend to attend relevant national conferences and present my study findings.

6.6.3 International spheres of influence

I have already published one article from this study and I intend to submit two more papers to international peer-reviewed midwifery and nursing journals, as well as attend and present my findings at international conferences, especially the ones organised by the: Lugira Africa Midwives Research Network (LAMRN), Southern African Development Community (SADC) and International Confederation of Midwives (ICM).

6.7 Limitations of the study

This is a phenomenological study and therefore, it contains time-specific experiences of women who birthed in public health institutions in Zambia, between 2005 and 2011. However, the fact that this study contains time-specific information does not mean that the findings would be inapplicable and have no meaning in other contexts, particularly in sub-Saharan and other low income countries.

It was impossible to interview every woman who gave birth between 2005 and 2011; therefore, not all eligible women could be recruited. However, in accordance to

phenomenological underpinnings, study participants were recruited using purposive sampling. Participants were recruited after hearing talks elaborating the purpose for conducting the study, hence, the women who did not hear the talks nor had relatives and friends who heard the talks could not participate because the information did not reach them.

This being a qualitative study informed by the interpretive phenomenological theories, it utilised subjective data from study participants' recollections of their childbirth experiences. Thus, the information that was provided by study participants was exposed to numerous interpretations. It is therefore, possible that another researcher or even the same researcher could come up with other themes, depending on what comes to one's consciousness at the time of interpretation. However, consideration of rigour, in-depth analysis and this being the first study of this nature in the country, and most probably the region, what is presented is one way of interpreting birthing women's experiences of childbirth in Zambia. As mentioned in the methodology and methods chapter, the first seven interviews were noted not to be in-depth enough for phenomenology, and therefore, some relevant data that could have assisted in understanding how women birthing in Zambia experience childbirth was not elicited. Nevertheless, the large data set offered a platform for a wide diversity in information.

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APPENDICES

Appendix I

Operational definitions of terms

- ***Child bearing age:*** Women aged between 15 and 49 years.
- ***Childbirth experiences:*** Events that happen to women during childbirth together with their personal reactions, feelings and meanings of these events.
- ***Essence:*** Most important feature of a thing which determines its identity.
- ***Healthcare workers/providers:*** Midwives, obstetricians or clinical officers
- ***Phenomenon:*** An experience. In this instance "childbirth".
- ***Phenomenology:*** The study and analysis of a phenomenon, whose central founder is Edmund Husserl.
- ***Interpretive phenomenology:*** One of the schools of phenomenology that was introduced by Martin Heidegger, emphasising the view that human beings cannot be separated from their environment: "To be human is Being-in-the-world".
- ***Culture:*** Ideas, customs, practices, and art of a particular society.
- ***Tradition:*** Body of beliefs, customs, and practices handed down from generation to generation.

Appendix II

Ethics Clearance

THE UNIVERSITY OF ZAMBIA

BIOMEDICAL RESEARCH ETHICS COMMITTEE

Telephone: 260-1-256067
Telegrams: UNZA, LUSAKA
Telex: UNZALU ZA 44370
Fax: + 260-1-250753
E-mail: unzarec@unza.zm

Ridgeway Campus
P.O. Box 50110
Lusaka, Zambia

Assurance No. FWA00000338
IRB00001131 of IORG0000774

18 February, 2011
Ref.: 005-09-06

Ms Concepta Namukolo Kwaleyela
The University of Nottingham
School of Nursing, Midwifery and Physiotherapy
Queen's Medical Centre
Nottingham NG7 2HA
UK

Dear Ms Kwaleyela,

RE: **REQUEST FOR ETHICAL CLEARANCE: "CHILDBIRTH EXPERIENCES OF WOMEN GIVING BIRTH IN LUSAKA AND MUMBWA DISTRICTS OF ZAMBIA"**

We acknowledge receipt of your letter dated 24 January, 2011.

We take note of the revisions made to the previously approved study i.e. title, and methodology which has changed from being general qualitative to being interpretive phenomenological. The revised study is approved as per your request.

Yours sincerely,

Dr E. Munalula-Nkandu
CHAIRPERSON

APPENDIX III

Participant's Information Sheet

University of Nottingham

School of Nursing, Midwifery and Physiotherapy

Participant's Information Sheet

Study Title: Childbirth experiences of women giving birth in Lusaka and Mumbwa districts of Zambia

Name of Investigator: Ms Concepta Namukolo Kwaleyela

You are being invited to take part in this research study. But before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Take time also to consider whether or not you wish to take part. Please feel free to contact me and ask about anything that is not clear or if you would like more information.

What is the purpose of the study?

The aim of this study is to explore women's experiences of giving birth in Lusaka and Mumbwa districts of Zambia in order to gain access into the depth of personal experiences of childbirth and understand the meaning that women attach to this experience. This information will be used to help health care planners and providers understand this phenomenon better as they strive and plan for interventions that will make this experience of childbirth in Zambia safe. This is in order that the lives and health of women during pregnancy, childbirth and postpartum periods may be improved.

Why have I been asked to take part in the study?

You are being invited to take part in this research because you have personally experienced the phenomenon of giving birth in Zambia. The one who experiences a certain event has the most understanding of the phenomenon. I hope to learn from listening to your experiences to understand your views of the phenomenon of childbirth, so that from a health care provider point of view we can provide a maternity service that is both safe and fulfilling for the women of Zambia.

Do I have to take part?

No. It is entirely up to you whether or not to take part. If you decide to take part, you will be given this information sheet to keep and be asked to sign a consent form. You are also free to change your mind and withdraw at any time without giving a reason. Your decisions not to take part will not in any way affect the standard or type of care you receive.

What will happen if I take part?

If you are interested in taking part in this study, I will invite you to an interview. You and I will choose the date, time and place of the interview to suit our schedules. I cannot determine the length of the interview because you will be narrating your experience to me. I will again explain the project in more detail and answer any question you may have. With your permission I will need to tape record the interview and take some notes during our conversation. Only I Concepta Namukolo Kwaleyela and my two supervisors, Dr Denis Walsh and Dr Sheila Greatrex-White will listen to the tape recording. This is to ensure that I maintain your confidentiality and avoid manipulation of what you will say. None of your personal details will be included in the transcription. The tapes, my diary notes and transcripts will be made anonymous and stored securely in a safe place. Your taking part in the study will be kept confidential. The only person who will know who has taken part in the study is myself Concepta Namukolo Kwaleyela. Participants will be referred to using numbers, for example participant 1.

What are the possible disadvantages and risks of taking part?

Disadvantages or risks related to this study are unlikely. However, it is possible that you may become distressed during the course of the interview as you recall some hurtful memories. If this happens and you want to stop the interview, you can do so at any time. Furthermore, counselling services will be availed to you should you be in need of them.

What are the possible benefits of taking part?

It is not anticipated that you will experience any immediate direct benefit as a result of taking part in this study. However, some people find it therapeutic and helpful to talk about their experiences. It helps them to ventilate and make sense of what could have been vexing them. It is hoped that taking part in this research will be a rewarding experience for you. Moreover, by taking part in this research you will have the opportunity to increase my knowledge as well as that of other health providers regarding the experience of giving birth in Zambia.

What will happen to the results of the study?

The findings of the study will be summarised and then written up in the form of a research study. These findings will be discussed among health care professionals at conferences and meetings so that the information is disseminated widely. In addition a Doctoral I will write a Doctoral thesis from the information you will provide.

What if something goes wrong?

It is extremely unlikely that anything will go wrong as a result of taking part in this study. However, if you feel unhappy about continuing with the interview I will stop the interview immediately. If during the course of the interview you say something about your health that causes concern, with your permission I will let a doctor know that adequate attention and treatment is given to you.

Will my taking part in this study be kept confidential?

Yes. All information, which will be collected during the course of the research, will be kept on a password-protected computer and notes will be securely locked-up. Information about you that leaves the research domain will not bear your name or address, so you cannot be traced or recognised from it.

Who has reviewed the study?

This study has been reviewed and approved by the UNZA biomedical ethics research committee at Ridgeway campus in Lusaka, Zambia. Researchers and my supervisors at the University of Nottingham, UK have also reviewed this study.

Who is organising this research?

I Concepta Namukolo Kwaleyela, who is a lecturer at UNZA, School of Medicine, Department of Nursing Sciences and currently an MPhil/PhD student at the University of Nottingham in UK, am carrying out this study. It is conducted for my Doctoral thesis.

What if I have further questions?

Please feel free to contact me if you require further information before or after the interview. My details are:

Ms Concepta Namukolo Kwaleyela
MPhil/PhD student, University of Nottingham
Mobile number: 0977844789
Home telephone: 021 1 260793
Office telephone: 021 1 262554
Email: c.kwaleyela@unza.zm
ntxck2@nottingham.ac.uk

Thank you for considering taking part in this study.

Yours sincerely

Concepta Namukolo Kwaleyela (Ms)

APPENDIX IV

Participant's Demographic Data Sheet



University of Nottingham
School of Nursing, Midwifery and Physiotherapy

Participant's demographic data sheet

Age: ……

Marital status: ……

Parity: ……

Occupation: ……

Highest educational level: ……

Town of usual residence: ……

APPENDIX V

Participant's Consent Form

University of Nottingham

School of Nursing, Midwifery and Physiotherapy

Study Title: Childbirth experiences of women giving birth in Lusaka and Mumbwa districts of Zambia

Investigator: Concepta Namukolo Kwaleyela:

RN, RM, BSc, MSc, PhD student

Supervisors: Dr Sheila Greatrex-White and Dr Denis Walsh

Participant's Consent Form

Please read this form and sign it or endorse your right thumb print after the investigator has explained the aims and procedures of the study to you and you have made an informed choice (Please tick the boxes as necessary).

1. I voluntarily agree to take part in the study ☐
2. I confirm that I have been given a full explanation by Ms. Concepta Namukolo Kwaleyela and I have read and understand the information sheet that has been given to me (attached). ☐
3. I have been given the opportunity to ask questions and discuss the study with Ms. Concepta Namukolo Kwaleyela. ☐

4. I agree to Ms. Concepta Namukolo Kwaleyela contacting me at the address I gave her. ☐

5. I agree to the use of extracts from my interview being used in published reports and presentations resulting from this research. If data is transferred to others it will be an anonymous. Anonymous data will be kept for 7 years after the results of this study have been published. ☐

6. I understand that I can ask for further instructions or explanations at any time ☐

7. I understand that I am free to withdraw from the study at any time, without having to give a reason for withdrawing. ☐

Name of participant …….....

Participant's signature or right thumb print…….....

Date…….....

I confirm that I have fully explained the purpose of the study and what is involved

to:……..

I confirm that I have given the above mentioned a copy of this form together with the

Information sheet:……...

Name of investigator: ……

Investigator's signature: ……

Date: …….....

Study Volunteer Number…….....

APPENDIX VI

Transcription and initial analysis of interview with Mrs LN

This is an interview with Mrs LN a 20 years old mother of one son. She spoke in English. Venue – Lusaka. Time - 1 hour 20 minutes 30 seconds. Date – 17/06/2011

CNK: Good morning this is 10.53 and I am having a discussion with Mrs LN, 20 years old mother of one. She is married and she is gone up to Grade 12. She gave birth to a baby boy in 2011. So ba LN could you tell me about your childbirth experience?

LN: Before I got pregnant I used to stay with my aunt, the younger sister to my late dad. This was before I got married. My stay with my aunt was not very good because she was not very kind to me. She used to make me do a lot of house work and she liked scolding me for nothing. I think because we were quite a number of dependants she could not manage to give us pocket money for buying essentials like sanitary towels. It was at this time that I started a relationship with a certain young man that I met at church. At no time did I think that I could get pregnant, so I was very surprised when I missed my monthly period for two months. I waited one month, there was no period and the second there was still no period. Uhm...I got worried and started asking myself what could be happening. The neighbours also started asking me what was wrong. I would ask them how I was looking, and they would tell me that I was looking sickly and weak. I would lie to them that I was just not feeling okay, I was having headaches. What they did not know was that I was always deep in thoughts thinking what was going to happen to me now that I was pregnant. I would go in a mirror to check how I was looking, worried that people could see that I was pregnant. I also lost my appetite and I would be nauseated whenever I tried to eat. My aunt started asking me why I was not eating when everybody was eating, but I would always tell her that I would eat later. At times she would leave me food and then find it still not touched. I would tell her that I just forgot to eat and then pretend to eat when in actual fact I was throwing away the food. I was thinking who I could tell my dilemma; I thought of revealing to a friend but I refrained, thinking that she may tell other people. I had nobody to turn to. I even started thinking of aborting, but this scared me because I have heard that girls die from abortions. I was really in a problem. One day I thought of just going to tell my boyfriend that I was pregnant. So one Sabbath after church service I told him that I was pregnant. Strange enough he did not seem annoyed at all, he calmly asked me what I was thinking of now that I was pregnant. I told him I wanted to have an abortion, but he told me that if I had an abortion I should never visit him again nor tell anybody that he was responsible for the pregnancy. He told me that it was okay, he was going to marry me although he had not planned for it so soon. I tried to argue with him but he kept his stand that if I was going to have an abortion he did not want to have anything with me. Despite his reassurance that he would marry me and look after the baby and myself, I still kept on thinking of what I was going to do. I could not eat or concentrate on anything anymore because of fear for my aunt. My mind just kept on thinking of how my aunt was going to react if she heard that I was pregnant. I thought she was going to kill me. I lost a lot of weight because I was neither eating nor sleeping well. I was also embarrassed that people would laugh at me when they heard that I was pregnant, just as I used to laugh at other girls who got pregnant. It was a time of a lot of mixed emotions for me. I even thought of leaving town and going to... where I have a grandmother, but I had no transport money to go there. There was a younger girl in the neighbourhood who had got pregnant and now she had a baby; I told myself that if she could have a baby and so could I. Thus, I resolved to just stay like that without telling anybody until my aunt discovered on her own that I was pregnant. One

Not married

Aunt failing to provide essentials

Worried at realisation she was pregnant

In a dilemma

Boyfriend against abortion

Afraid of aunt's reaction

Embarrassed

Aunt not very kind

Looking for alternatives to get essential

Hiding pregnancy

Afraid people will notice the pregnancy

Nobody to tell her dilemma

Tells boyfriend about pregnancy

Thinking aunt would kill her

Keeping information about pregnancy to herself

day she called me to ask whether I was pregnant; I told her that I was. She was very annoyed and she started shouting at me, but strange enough she did not beat me. She asked me who was responsible and I revealed. My aunt approached my boyfriend's relatives telling them what their relative had done. A day was arranged for them to come and meet with my relatives so that they discuss the case. When the day came, my boyfriend's relatives negotiated that their son just wanted to marry me. My boyfriend was thus charged for both damage and marriage. So when I was four months I got married though he had not yet finished paying the money, and moved to my husband's house. Still more, even though I was now living with my husband, I was not happy with the pregnancy; I still wanted an abortion. My husband kept on asking me what I really wanted because he had already married me as he did not see the reason why I wanted to still abort. We used to argue a lot, but after some time I learnt to accept my pregnancy. I stopped thinking about having an abortion. My husband was very helpful in assisting me do household chores whenever he was off from work. One day when I was five months pregnant, while listening to the radio I heard an item that all pregnant women needed to be going to the antenatal clinic. The radio announcer also said that the best time to start antenatal was at four months. I got worried because I was already five months pregnant going on to six months. When my husband knocked off I told him about the news item, he told me that he knew about it but he thought my aunt had told me that I would start at a later date. I went to one of my neighbours and asked her the day when the clinic attends to those attending antenatal for the first time, and what I needed to carry when going there. She told me that I needed to go with my husband and that the antenatal clinic at the hospital was open on Monday in the morning. On Monday, early in the morning I went to the antenatal clinic alone. My husband could not accompany me because he had to go for work. I was told that the clinic opens at 14.00hours not in the morning. On my way home I kept on debating whether I should go back at 14.00hours or just stay at home because I was feeling tired. I decided to go back at 14.00hours. There were not a lot of clients. The nurse asked how many of us had not come with our husbands. There were three of us who had not come with our husbands, so the midwife told us that instead of telling us to go back without examining us because we did not have husbands with us; she was going to attend to couples first before attending to us. After attending to the couples; taking them to the laboratory to have their blood checked, that is when the midwife came to attend to us. She examined me and gave me a paper where things like gloves, cord clamp, jik, and bucket were written. She said that those were the things that I needed to buy and come with at the time of delivery. She said that it was important that I started buying these things now not when it was too late. She also warned me that if I was thinking of going to deliver from a faraway clinic it was better that I started off on time so that labour could start on the way. I was also advised to always have transport money for a cab handy all the time. The tablets for blood were not enough, so she gave me only thirteen each. She told me that I should come to collect some more when I ran out of the iron tablets. That was the first and last time I learnt anything from the antenatal clinic. Every other time when I went there the nurses were just examining us, giving us iron tablets and Fansidar when it was due. Since I thought antenatal lessons are only taught the first time you go there, I did not bother. When I came home, I told my husband all what I was told and we started preparing the things. One day when I was seven months pregnant I went to visit my aunt; while I was there she asked me whether I knew that I was not supposed to sit on doorways; not ask for salt from neighbours and not walk bare feet. I told her that I did not know any of those things. She told me that sitting on the doorway would delay delivery because the baby would also just stay in the womb without coming out at the time

Acknowledging pregnancy to aunt

Discussion about pregnancy between the two families

Got married against her wish

Boyfriend thinking marriage would stop him worrying

Hears ANC news from the radio

Getting more ANC information from friends

First encounter with contemporary maternity care was at 5months pregnant.

Given information on things needed for delivery

First & last time to learn @ ANC

Aunt introducing cultural aspects of pregnancy and childbirth

Myths & beliefs abt pregnancy & childbirth

of delivery; she said some people can also lock your pregnancy when they give you salt while others would pick the soil where you have stepped with your bare feet and add some medicine that would prevent one from giving birth on time. Since I live in a low density area I told her that people there do not ask things like salt from neighbours, so there was not possibility that somebody would lock my pregnancy because of asking for salt. When I came home I told my husband what my aunt had taught me and he told me he knew about some of the taboos especially the one of not staying in the doorway. This is a habit I was so used to that it was difficult for me to abide by it. Most times I was found sitting in the doorway and my husband would scold me telling me that I needed to take these things seriously. I would argue with him that these were just beliefs which were not real at all; but he would always tell me that adults would not come up with things that were not real; so he insisted that I abided by them. I went back to the antenatal clinic when I was eight months and after taking my blood and examining me they gave me more tablets for blood because they said my blood was not enough. I was very faithful in taking the iron tablets, I never missed a dose. My aunt also brought me some traditional medicine she said helps in boosting blood. I came back from the antenatal clinic on the 9th February and on the 10th I packed all my things and the ones that I had prepared for the baby, put them in a bag and went to my aunt's house. She had told me to go to her place when I was eight months without telling my husband in order to avoid prolonged labour. At my aunt's place I was not allowed to be resting too much like I was doing at my home because my aunt said my baby would delay in coming out as well. So she assigned me some light duties to be doing every day and she used to wake me up very early. This was very difficult for me because by now I was feeling very tired and just wanted to always sleep during the day. The time that I was at my aunt's place awaiting delivery, my husband was not allowed to come and see me. It was very difficult to abide by this, so whenever my aunt was not there my husband would sneak home so that we could talk. He told me that his mother had also told him that he was not supposed to see me. There seemed to be so many dos and don'ts that we used to laugh a lot with my husband whenever we got a chance to be together. My aunt was not even allowed to tell me where she was going because even this would lead to prolonged and difficult labour. Well I continued living with my aunt until one night around 03.00hours while sleeping; the girl I used to share the bed with kicked me on the back and after that backache started. Not only did I start experiencing backache but I started having this urge to pass urine continuously. I kept on going outside to the toilet to pass urine until the young girl I was with asked me what was happening. I did not want to tell her that I was in pain, so I cheated her that I was looking for something outside. As the toilet was situated outside she told me that I should be careful because there were thieves outside. The pain kept on increasing until it was time to get up. I had this desire to stay alone so that nobody could notice that I was in pain. So in the morning I rushed the children to dress up and go to school. I felt like I should tell my aunt but I kept telling myself to wait a bit. In the morning around 07.00 while sweeping the pain was becoming unbearable but I kept on hiding from my aunt. At one time she caught me sitting down and holding my back. When she asked me what the problem was I told her I was trying to pick something, but since I could not bend over my tummy that is why I was kneeling. As time went by I decided to go and tell my aunt that I was in pain, but when I reached the door to her room the pain went, so I turned back. After a long time of pretending to my aunt that everything was fine I decided to tell her. When I told her that I was having abdominal pains, backache and draining, she asked me whether she could take me to the hospital, I told her to wait a bit. She told me that I was playing because I did not know that labour was scary. I went back to the bedroom

Doubting authenticity of cultural beliefs

Finding it difficult to abide by cultural expectations

Mixing traditional & contemporary remedies

Shifts to aunt's home

Not allowed to rest for long periods

Hiding labour

Told by aunt that labour is scary.

not knowing that she had gone to book a cab. While I was lying down I just heard her come and tell me to get in the car so that we go to the hospital. She picked all the things that we had prepared to take with us to the hospital and we left. I told her not to take me to the clinic, but to the hospital because that is what I was told antenatally. When we reached the hospital we found the nurses sitting and chatting. They just acted like they had not seen us at all. I had expected at least one of them to get up and get the bag we were carrying. We sat patiently on the bench provided with my pain become more and more, after some time that is when one of them asked us what was wrong. My aunt told them that I was in labour; I was too scared to talk to them. They said that the delivery room was full; so the nurse told me to go in a smaller room and wait for her there. After some time she came and told me to take off all my clothes. She told me to give her napkins, cord clamp and gloves. I gave her the six pairs of gloves I was told to buy, but she said that they were not enough; so my aunt had to give her K20, 000.00 so that she could sell us some more gloves. By this time the pain was so intense that I could not lie still. After she examined me she said that I was about to deliver but since the other room was full and I was a primigravida I needed to just stay in that small room alone. She said that I was supposed to use the bucket for passing urine, vomiting or whatever. I was surprised and asked if there was no toilet nearby. She told me that the toilets were there but since she could not stay with me to observe whether I am about to deliver or not, I might give birth in the toilet, so the bucket was better. It was very uncomfortable because my bucket was very small and I could not sit on it properly. My aunt asked why she were leaving me alone even after knowing that it was my first time to be in labour. She said that there was nothing she could do, but if I needed help I just needed to shout and since my aunt would be sitting with other women outside they would hear and come to call the nurses. The pain became intense as time passed that I could not lie on the bed. I kept on pacing about the room because the bed felt too hot for me to lie on it. I knocked on the door; and when my aunt came, I told her that I was feeling very hot and could not stand the pain. She advised me to persevere because there was nothing she could do as that was the progress of labour. After some time she left the room. The next time when I called and knocked nobody came; my aunt had gone somewhere. After some time that is when a nurse came and examined me. She then told me to pick my things and follow her to the other room. When we reached the other room I asked her to switch on the fan because I was feeling very hot. She said that she could not switch on the air-cone because the other clients were feeling cold. I asked her to give me a cloth so that I could fan myself with it. She complained that I was sending her too much. She angrily picked my blouse and threw it at me, then left. When I complained to her that the pain was too much, she answered me that, that was a good sign because it meant that I was progressing. I kept on moving around the bed. When I got tired that is when I sat on the bed; I could not lie down. When the nurse came and found me sitting; she started making fun of me saying, 'ha sitting style!' It was now around 09.00hours and other women around me were delivering apart from me. I was becoming very anxious. After sometime I felt like I wanted to open my bowels. When I called out to the nurse, she told me to do it on the bed. How could I open bowels on the bed? So I started screaming but the nurse just ignored me. Afterwards I decided to just open my bowels on the bed since the nurse was refusing to help me. After pushing what I thought was stool I lay on my side as I felt some relief after something came out, and I kept quiet. Hearing that I was no longer screaming, the nurse came and told me to lie on my back and open my legs. She told me that the head had come out and she told me to push so she could deliver the whole body. After she delivered my baby, she wiped him, weighed him and wrapped him up.

Aunt arranged transport to the hospital

Ignored by nurses on duty.

Scared of health professionals

Surprised at some of the practices she was asked to observe.

Aunt told to go home and leave LN

Told by aunt to persevere the labour pain

Requests not honoured

Being ridiculed by nurse

Anxious for taking long to deliver

CNK: Was this during the night?

LN: No it was in the morning. After one nurse delivered me, another one came and asked whether I got torn. She was told that I was torn both inside and outside and so I needed to be sutured. I got very scared. I begged the nurse to just leave me alone because I did not think I could stand the pain of being sutured. Looking at how big the needles were and how thick the thread was I really began shaking. The nurse said that I should be joking to refuse being sutured. She injected me with some local anaesthetic to numb the place but when she started suturing; the inside was not painful but the outside was very, very painful. I tried to compose myself but I could not avoid screaming. When she finished suturing me she kept on pushing some cotton inside me until I stopped bleeding. After this she did not tell me to go and bath; she just told me to just be sitting in cold salty water when I reached home. The nurse then threw all the soiled linen and placenta in the bucket. My aunt asked where she was going to throw the dirty linen and the placenta; the nurse said that they did not have a pit around, so she needed to carry everything home. The nurse then told me to go in the next room and pick my baby after she took her temperature. I asked how I would recognise him; she said I would see the blanket he was wrapped in, as it was the one I had brought. I went on to pick my baby and then went to lie down because I was feeling very tired now. I gave birth around 10.40hours. The nurse called me to go to her office and collect a birth record form. When I reached the office she told me to sit. I told her that I could not sit because of the pain from the suturing. The nurse said that as long as I stood she was not going to write the birth record; so despite the pain I had to sit. The nurses who were there in the morning finally knocked off and then others came on duty at 14.00hours. I was told that before being discharged I needed to pay a K27, 000.00 for the bed I had used. I asked the woman who was next to me how much she had been asked to pay; she told me K7, 000.00. I started wondering why the charges differed; but I was told that it depended on where the client came from; those who live near the hospital pay less for their beds. I sat waiting for my aunt. She finally came with food and then I ate; the hospital did not provide us with any food. When she came I told her that we needed to pay K27, 000.00. She went and paid and then the cab driver who had brought us came to pick us. When we reached home my aunt asked whether I had bathed. I told her no; so she boiled some water and then went to bath me. She concentrated on pressing my abdomen to get rid of any blood clots that could have remained in the womb. She then cooked some more food for me and then left me to sleep. I was told to be sitting in cold salty water three times a day and bathing twice. During the bathing my aunt would compress my abdomen with hot water. On the third day I started having severe abdominal pains. My aunt gave me some Paracetamol but it did not help; she told me that we needed to go back to the hospital because there might be something wrong in my abdomen. Before starting off for the hospital she told me to go and bath. While she was compressing my abdomen some cotton wool soaked in blood came out; it had now turned black. She asked me whether I had inserted it; I told her it was not me. She just said that the nurses might have left it inside me; so after bathing we went to the hospital. The doctor examined me in my private part after being told that I had given birth three days ago and said that everything was fine. I told him what had come out at home when my aunt was compressing me with hot water. He just said 'these nurses I do not know how they work.' I thought he was going to take some action because that cotton would have got rotten inside me and caused me problems. I was disappointed by his reaction; anyway, he gave me some medicine and told me to go home. At home I was not allowed to go near the stove

Aunt told to discard dirty linen at home

Forced to sit despite the pain from suturing

Her aunt was responsible for paying the bills

Not provided food after delivery

Cleaned/ bathed by aunt at home

Experiencing abdominal pains

Paracetol did not relieve the abdominal pain

Cotton that was inserted at delivery came out rotten 3 days postnatally

Reported the incident to hospital

No tangible action taken against the nurses who left cotton wool in her birth canal.

Not allowed to cook postnatally

until the baby's cord dropped because if I cooked anything all the people in the house would suddenly fall ill. So my aunt is the one who was cooking for me every day. The cord fell off after one week then after two weeks there was a ritual of introducing me to the stove; my aunt held me by the hand and made me touch all the utensils that are used in cooking; pots, pans, cooking sticks and so on. After that now I was allowed to cook, and that was the time that my baby was allowed to be taken outside. My husband then came to get me and we went to our home. Immediately we reached home my husband got his Bible and told me that; there was the baby I had wanted to kill, so this was the right time to kill him. I felt very guilty by this act because I was so much in love with my baby. One day a friend came to visit me. She asked me how the baby was; I told her that he was crying a lot especially during the night. She checked his palms and said that he had black lines that needed to be cut in order to stop him from crying a lot. I was surprised because to me the black lines she was talking about looked like blood vessels. She argued saying that those were the ones that were making my baby cry a lot especially at night. We called my neighbour who confirmed that, yes indeed those blood vessels needed to be cut. I bought a razor blade and my friend cut my baby's blood vessels.

Ritual related to starting to cooking

Reminded of her earlier intention to abort her baby

Cries of the baby associated to palm blood vessels

Baby's blood vessels cut by friend

CNK: What; show me the baby's palms where they cut...goodness me!! (She showed me).

LN: Another neighbour came to see me, when holding the baby she checked my baby's head and said that the anterior fontanelle was too big, it needed to be narrowed otherwise my baby's head was going to get bigger and bigger until he died. She said she had some medicine which I needed to apply there in order for it to reduce. I paid for the medicine and got it but did not apply it on my baby; I thought I should ask my aunt first. When my husband came I showed him the medicine and told him what our neighbour had said regarding out baby's head. He also thought it wise that I consulted my aunt first. When I went to my aunt, she told me to take the baby to my grandmother because she did not know anything of that sort. My grandmother said that it was true the anterior fontanelle was extra big. Actually she noticed that the fontanelle was big even before telling her the problem that had brought me to her. I asked her what caused the ailment; she told me that I should have sat on somebody's grave the time I was pregnant. I sat thinking when I could have sat on somebody's grave; and then I remembered that the time I was one month pregnant I attended the burial of a friend of mine so maybe that is when I should have sat on a grave. My grandmother went on to say that there were three types of these kinds of depressions on a newborn baby's head; the one that my son had; the other one appears between the two ears and then the third one starts from the forehead to the nape of the neck. After this confirmation from my grandmother that is when I started applying the medicine on my baby's head. The same neighbour also gave me some medicine to be applying on my baby's upper palate because there was a pimple like thing there. I was told that this pimple if left would finish my baby's body till he died. To me all this was very scary. Despite all the traditional remedies that were done my baby did not stop crying a lot and the fontanelle was still depressed. The fact that my baby never stopped crying despite all the remedies brought doubt in me as to whether these traditional remedies I was given and the cutting of my baby on the palms really work. I just now started bathing him whenever he cried. He used to keep quiet and sleep after bathing. The other things that made me start doubting all about these traditional beliefs was that, although a lot of people used to say that because I liked standing in the doorway and sleeping a lot when I was pregnant I would have a prolonged and difficult

Abnormality on anterior fontanelle noticed by neighbour

Consulting the aunt over abnormal fontanelle

Consulting grandmother

Grandmother insinuates abnormality was due to sitting on a grave antenatally

~~Above~~ Traditional remedy for abnormality on upper palate

Noticed that the traditional remedies did not assist

Doubting authenticity of traditional remedies

labour; I did not have a difficult labour. So for me I think these beliefs do not work; they are there to just superstitions meant to keep a pregnant woman well behaved, because it is not proper for a pregnant woman to be seen walking around to neighbours asking for salt or stuff like that. On the other hand sitting in the doorway is just a bad habit because you make people keep bumping into you when they pass. (She was giggling).

Thinks remedies have a hidden meaning

CNK: So now when you look back at the treatment you got from the nurses what comes to your mind?

LN: Frankly speaking I was very disappointed with the care that I got. Being a first time mother I expected the nurses to show concern, not leaving me alone in a room and telling my aunt that she will hear me shouting if something went wrong. If now my aunt was the one who was going to nurse me, what was the job of the nurse, and how would I know what was wrong and what was not wrong; this was my first experience? I felt that if the nurses could not stay with me they could have asked my aunt to stay with me so that she kept reassuring me that whatever it was that I was experiencing it was part of the delivery process. I was scared to be alone in the room and was very anxious about something going wrong while I was alone. The other thing is that the bag that had all the things they wanted was heavy, and when we arrived they told my aunt to give it to me to carry it inside where they were going to examine me. It was unfair because I was in so much pain. I felt if they did not want my aunt to enter the room where they were going to examine me from, one of them could have carried it for me. You know there are so many beliefs during pregnancy, so as a young girl I was disillusioned because it is difficult to know all the dos and don'ts. For instance the whole time I was in labour I was scared to even drink water in case it was one of those things that delay delivery. I think it was the dehydration and hunger that made me feel very hot. The nurse also left cotton wool in my private part without telling me. Had I not gone to my aunt after delivery and had she not been diligently bathing and compressing my tummy every day with hot water, the cotton would have got rotten inside me and who knows, I would have been drinking Paracetamol for the pain not knowing that I was rotting inside. Every woman who is delivering buys everything for delivery and pays for the bed on discharge; I wonder where the money goes to. I was instructed to buy gloves but it was very difficult to know what type of gloves or what size. I was surprised when I was told that the six pairs of gloves we brought were not enough. Well there are a lot of unanswered questions because these nurses do not have time to stay with us and explain things to us so that we understand. I would really urge the nurses to find time to explain these things to us because we are never in their meetings where they discuss these things. The confusing thing is that we are told that delivery services are free in Zambia but then why do we buy our own things and pay for the bed that we use? These are our bodies so we have feelings and expectations, but when these are not met anybody can react. For me I began murmuring rudely to the nurse whenever she was telling me what to do, which I think is not good because she was much older than me. Despite all these negative feelings I feel for the hospital I still advise my friends that we should just learn to ignore these nurses when they are rude to us. The best is to answer them when we feel they are being too rude instead of keeping quiet. Motherhood is a very good thing. I remember when I came home, and my husband asked me to look at the child that I had wanted to abort. I think whatever the reasons one has, it is not good to abort because it is as good as killing. I feel very proud now because I am a mother. I am just waiting for my son to get big so that I go to College because I completed Grade 12. These children

Disappointed with maternity care

Not knowing what to do

Felt unfairly treated by nurses

Just knowing where the payments go to

Confused because of lack of information

Urging other women to speak up to nurses

Nursing care did not meet client's expectations

Scared to be alone

Anxious about something going wrong

Disillusioned by dos & don'ts of childbirth

Instructions of what/ items to buy unclear

Nurses not explaining things

Despite the negative experience still urges others to benefit from health facilities

look after us when we get old. A woman who has no child is very lonely and the majority of them are not happy even if they are rich.

CNK: Describe the role that your husband played and how it made you feel?

LN: A husband is a very important person in a wife's well-being when she is pregnant. During pregnancy I was craving for things and it was only my husband who could go and buy these things for me; that way I felt really loved and looked forward to having my baby. Pregnancy is a special time for a woman. I am fortunate to have a very supportive husband and one who loves me. It is not advisable to have a child outside wedlock because as a woman you are looked at as a woman who cannot control herself. It was such a relief when my husband came to get me and take us to our home because I was really worried when I discovered that I was pregnant, and my greatest fear was that he was going to refuse the pregnancy. But from the time that I told him that I was pregnant he just decided to marry me. I know I could have avoided getting pregnant by using contraception but it is difficult to get family planning pills when you are not married especially in a small town like this one because you cannot know who you are going to meet the hospital while asking for contraceptives. Thus, the chances of people you meet there telling your guardian that you are on contraceptives are very high. I wish there were places where teenagers can access family planning services apart from the hospitals. I would have opted to buy but both my husband and I did not have sufficient funds because my husband is just a houseboy and I had just finished school. I tried to use natural family planning but it did not work. Anyway, my husband was very supportive throughout my pregnancy and I think it made the whole process very enjoyable. Even when he was told not to be coming to see me while I was waiting to give birth at my aunt's place, he used to sneak in to see how I was getting on. He was there all the way supporting me and even after delivery he used to take the baby when he was crying a lot. This makes me very confident and I count myself lucky. Well I do not know whether it is because I am more educated than him, so he is scared that I might go for someone who is more educated than him. But we sit and discuss a lot of things together. For now things are still a bit difficult for us because he is still paying for impregnating me before marriage. He used to let me only wash small things when I was pregnant while he would wash the heavy things. He used to do this inside the house because if he was seen outside washing, people would start saying that I had given him medicine to make him docile. So after washing I am the one who used to hang the clothes outside making the neighbours think that I was the one who was doing the work. But since pregnancy and childbirth is a domain for women, my aunt played a pivotal role in ensuring that my husband and I did everything correctly. Had my aunt not been there I would have gone to my grandmother. These elderly people have vast knowledge about these things. My mother-in-law was also there telling my husband what to do and we often used to compare notes. Since he did not know what specific things to buy for the baby, he used to give me the money to buy the things. By the time I was nine months I had all the things that were needed ready.

Husband is very important when wife is pregnant

Pregnancy is a special time

Having a child outside marriage is not good.

Worried boyfriend would refuse responsibility of pregnancy

Single girls take contraceptive secretly.

Inadequate service delivery

Supportive husband makes LN feel confident in self.

Husband doing some house chores in secret because they are considered women roles

Childbirth is women's domain

Elders have vast knowledge

CNK: You are saying that you are lucky the man who impregnated you decided to marry you; is there a problem in being a single mother?

LN: Being a single mother especially for a young girl is embarrassing and people laugh at you. I remember I used to laugh at my friends who were getting pregnant. My husband and I were members of

Being a single mother is embarrassing

church so it was going to be a shock for our Pastor to have heard that I was pregnant before getting married. In my upbringing I was always told to wait for someone to marry me before having sex with them; but the peer pressure became so much that I fell in the trap of trying what the other were doing. Although my aunt was very strict on me and I really thought she was going to chase me from her house when she discovered that I was pregnant, I was surprised by her reaction. Getting pregnant outside marriage is not good and in my case I had just completed secondary school so my family was looking to me going to College. I was going to make a big mark in my family because I am the first to have gone so far in education. My family is not rich at all so my getting pregnant was a big blow to them but they were comforted by the fact that the man who was responsible for my pregnancy decided to marry me. Being married gives dignity to a woman. Even at meetings you find that people tend to favour ideas from those who are married. It is even worse if the child from a single mother gets pregnant or impregnates somebody; people just say 'what do you expect from a parent who is not married?' It is such comments that make women want to get married at all costs. Nobody looks highly at anyone with a child outside wedlock, but the way it is with me; apart from my family members everybody else thinks that I got married first then got pregnant. Getting married is a big achievement to me because there are so many girls out there who want to get married but there are no enough men for all the single girls; so when I got married I did indeed feel lucky. My role now is to support my husband in all he does especially as he tries to improve his education and get a better job that will sustain us. A wife follows what the husband tells her to do because that is what the Bible says. At one time I thought that my husband might think that I had trapped him into marrying me by getting pregnant; but that was not the case, it was an accident. We never used to talk about marriage, we were just friends. I had planned to go to College first, start working then that is when I would marry; but anyway fate was not with me.

Getting pregnant before marriage not an accepted norm.

Comforted by getting married Gives a woman dignity

Single mothers are stigmatised as well as their family

Husband provides financial support

CNK: What have you learnt from this pregnancy and childbirth?

LN: I have learnt that while getting pregnant is easy, giving birth is very hard and painful. I would advise all the young girls out there not to play around with men. This is not the way I wanted my life to turn. I needed to have grown a bit more before getting pregnant. The pain was too much to bear; at one time I thought I was going to die; I could not lie down because the bed felt hot; I kept moving up and about but finally my legs could not hold me so I had to lie on the hot bed. My aunt had to pay for me here and there because I did not have enough money. This in itself was a burden although she never complained openly. I think there should be a deliberate policy by government to teach young girls about their sexuality. For now I am not planning to have another child just as yet; that pain still gives me goose pimples and then the sleepless nights afterwards due to the baby crying were horrible. This is not to say that I am not happy that I have a child; no...I am very happy, the problem is that I had my child when I was still too young. For the girls who are already pregnant I would say that abortion should never be an option because life in priceless. Having a child automatically brings responsibility. Like right now I cannot go wherever I want to go or buy whatever I want, like I used to do when I was alone. Even waking up; this baby makes me wake up very early because he cries when he is hungry. It is a job on its own which I think needs proper preparation.

Getting pregnant is easy but childbirth is hard and painful

Experiencing having a childbirth when one is young is a problem

Labour pain too much to bear

Need to teach sexuality to teenages

CNK: What made you decide to come and talk to me?

Volunteered to participate in order to spread disgruntlement with health care

LN:: Well I decided to come and talk to you to let the world know that the care we get from the nurses in the hospitals is not good at all. I am begging that something will be done. If you move around and mix with the ordinary women all you hear about are these stories of how the nurses abused them when they went to deliver. I knew about these stories even before I got pregnant so the time my aunt took me to the hospital I was scared and kept wondering whether it will be me or my child who will die. The main problem is that there is nowhere one can go to complain. I was keeping the experience of my childbirth to myself and you know it was something that was really scaring me, because being married I am expected to give birth again. You know labour is naturally painful so every person hopes to be treated with compassion, but when you are treated roughly it makes the pain even more. Instead of looking forward to giving birth the thoughts of being ill-treated overrides the pleasure of motherhood in most instances. For most of us it is because our extended families all come into play that is why we could stand the ill-treatment. I do not even want to think about what would have happened if I did not have my aunt with me.

Scared she or he child would die

Being married now, she is expected to give birth again

Support from family helps overcome the pain of ill-treatment.

CNK: Is there anything you would want to add?

LN: No there is not; I just hope that our nurses will start treating us like human beings so that we start enjoying our motherhood.

CNK: Thank you Mrs GM.

Comment: Mrs LN was very calm during the interview. She articulated her story clearly without me asking too many questions. She had her baby on the back while talking to me.

APPENDIX VII

Summary of the interview with Mrs LN

Mrs LN was a 20 year old mother of one son, who got pregnant before getting married. Her parents died when she was still you and so she was brought up by her aunt. She was not the only child that the aunt was looking after. Apart from her cousins (her aunt's children), there were other dependants. Due to the number of dependants, Mrs LN's aunt was unable to provide the girls with essentials, such as body lotions and maternity pads. Lack of these essential items led Mrs LN to begin a relationship with a boy she met at church. Despite that there were a number of dependants; Mrs LN did most of the household chores. She felt victimised by the aunt. Mrs LN began being intimate with her boyfriend despite having been advised by her aunt not to indulge in vices that were against societal norms. Her church too did not allow sex outside marriage. Thus, Mrs LN felt she had failed to conform to societal expectations when she got pregnant. Apart from feeling embarrassed that her neighbours were going to laugh at her for getting pregnant before getting married; she was scared that her aunt was going to kill her. Hence she contemplated abortion. She was deterred by stories of women dying due to abortion. But with nobody to assist her she feared that abortion was going to kill her. She struggled with these emotions because there was nobody she could tell. She thought of revealing her situation to her friends. But she feared they would tell others and her situation would be known. She thought of absconding to her grandmother who lived in another town. She could not because she did not have transport money. Her only option was to keep the pregnancy a secret. She tried by all means to hide the pregnancy from people around her by giving false reasons for her change in appearance and behaviour towards people around. Finally, she told her boyfriend about the pregnancy and her desire to abort. Her boyfriend forbade her from aborting and told her he was going to marry her. Mrs LN was not willing to marry the boyfriend because she was more educated than him. As time went

by, she could not hide the pregnancy anymore and her aunt asked her. She was surprised by her aunt's reaction, as she had expected she would kill her when she discovered. Instead the aunt just asked her if she was pregnant, and when Mrs LN acknowledge the aunt asked her to reveal the name of the man who was responsible for the pregnancy. The aunt approached the man's relatives and a meeting between the two families was arranged. The meeting resolved that the teenagers should marry before the pregnancy could be noticed by people who were not family. Initially, Mrs LN could not accept the pregnancy despite being married. She heard about antenatal care from the radio and after asking her husband she began going for antenatal. Her husband never escorted her because he was very busy at work. Mrs LN did not remember much about antenatal apart from the fact that she was told she was anaemic and was given iron tablets. Her aunt forbade her from taking the iron tablets. She gave her a traditional remedy for anaemia. She did not know which advice to follow. At seven months her aunt introduced her to traditional practices and beliefs related to pregnancy and childbirth. Although what she was told did not make sense, she obliged. At eight months she was advised to leave her house and go to live with her aunt. At her aunt's house she could not have adequate rest as advised by midwives. This was unlike at her home where the husband was helping her with some of the chores, although it was taboo. Mrs LN went into labour and her aunt took her to a clinic, instead of a hospital, which she was advised by midwives during antenatal. The midwives at the clinic ignored her. This reception scared her so much that she could not answer the midwives' questions. Her aunt talked on her behalf, and she was finally admitted. Her aunt was told to go back home and Ms LN remained alone until she delivered. She was later discharged and went back to her aunt's house, until after a month. The midwives left a piece of cotton wool in her and did not know when to remove it. Postnatally, the cotton wool caused her abdominal pains. She reported the nurse who assisted her birth. The midwife was not reprimanded. Her aunt assisted her adjust to postnatal.

APPENDIX VIII

Identifying key statements, developing meaning units, sub-themes and themes from the interview with Mrs LN

Key statements, words or paragraphs	Meaning units	Sub-theme	Theme
…Before I got pregnant…This was before I got married… Getting pregnant outside marriage is not good…Being a single mother…for a young girl is embarrassing and people laugh at you…I remember I too used to laugh at my friends who were getting pregnant…I kept on thinking who I could tell my dilemma…my husband and I were members of church…so it was going to be a shock for our Pastor to have to hear that I was pregnant before getting married…I got worried and started asking myself what could be happening…I was really in a problem…The neighbours also started asking me what was wrong. I would ask them how I was looking…I would lie to them that I was just not feeling okay, I was having headaches…I was always deep in thoughts thinking what was going to happen to me now that I was pregnant. I would go in a mirror to check how I was looking, worried that people could notice that I was pregnant…I thought of revealing to a friend but I refrained, thinking that she would tell other people. I had nobody to talk to…I lost a lot of weight because I was neither eating nor sleeping well. It was a time of a lot of mixed emotions for me…It is even worse if the child from a single mother gets pregnant or impregnates somebody; people just say 'what do you expect from a child of a parent who is not married?'…Nobody looks highly at anyone with a child outside wedlock…such pregnancies are kept as secrets…like the way it is with me…apart from my family members, everybody else thinks that I got married first then got pregnant…	Getting pregnant for an unmarried woman was against accepted societal norms/ Hiding emotional turmoil to people around her/ Feeling alone because there was nobody to talk / Mixed emotions/ Keeping pregnancy a secret	Shame and embarrassment	Conforming to societal expectations/ Being in a dilemma
During my upbringing I was told to wait for someone to marry me before having sex…however, we were quite a number of dependants.	Lacking items that other teenagers had/	Peer pressure/ Lack of assertiveness	Conforming to societal

…She could not manage to give us pocket money for buying essentials like sanitary towels…the peer pressure became so much that I fell in the trap of trying what the others were doing in order to buy lotion and sanitary towels…I could not buy these items because my aunt never used to give me money…It was at this time that I started a relationship with a certain young man that I met at church…My boyfriend helped me with money that I could use to buy items such as pads and lotion…I got myself a boyfriend so that he could help me buy lotion and other items. At no time did I think that I could get pregnant...	Starting a relationship with a male church mate/ Pressure from mates/ Going against what she had been advised by guardian and parents		expectations/ Feeling insecure
At times she would leave me food and then find it still not touched. I would tell her that I just forgot to eat and then pretend to eat when in actual fact I was throwing away the food. I even started thinking of aborting, but this scared me because I have heard that girls die from abortions. I could not eat or concentrate on anything anymore because of fear for my aunt. My mind just kept on thinking of how my aunt was going to react if she heard that I was pregnant. I thought she was going to kill me… I even thought of leaving town and going to…where I have a grandmother, but I had no transport money to go there…I resolved to just stay like that without telling anybody…	Hiding pregnancy/ Fear of being victimised/ Fear of dying from abortion/ Fear of being killed by the aunt/ Thinking of relocating/ Resolving to keep the pregnancy a secret/Mixed emotions	Fear/ Lack of choice	Clash between traditional and contemporary childbirth practices/Loss of dignity
…my aunt discovered on her own that I was pregnant…One day she called me to ask whether I was pregnant; I told her that I was. She asked me who was responsible and I revealed…She was very annoyed and she started shouting at me, but strange enough she did not beat me…It is not advisable to have a child outside wedlock because as a woman you are looked at as a woman who cannot control herself… I know I could have avoided getting pregnant by using contraception but it is difficult to get family planning pills when you are not married especially in a small town like this one because you cannot know who you are going to meet the hospital while asking for contraceptives. Thus, the chances of people you meet there telling your guardian that	Scolded by aunt for getting pregnant/ Revealing to aunt who impregnated her/ Looked down upon by society for getting pregnant outside marriage/ Had contraception knowledge / Hard for an unmarried woman	Lack of assertiveness/ Lack of choice	Conforming to societal expectations/ Loss of dignity

you are on contraceptives are very high. I wish there were places where teenagers can access family planning services apart from the hospitals. I would have opted to buy but both my husband and I did not have sufficient funds because my husband is just a houseboy and I had just finished school. I tried to use natural family planning but it did not work.	to get contraceptives from health facility/ Not wanting guardians to know she one is on contraceptives/ Used natural family planning		
…One Sabbath after church service I told my boyfriend that I was pregnant…I was really worried when I discovered that I was pregnant, and my greatest fear was that he was going to refuse the pregnancy…Strange enough he did not seem annoyed at all…I told him I wanted to have an abortion, but he told me that if I had an abortion I should never visit him again nor tell anybody that he was responsible for the pregnancy…I tried to argue with him but he kept his stand that if I was going to have an abortion he did not want to have anything with me. He told me that it was okay, he was going to marry me although he had not planned for it so soon…Despite his reassurance that he would marry me and look after the baby and myself, I still kept on thinking of what I was going to do… But from the time that I told him that I was pregnant he just decided to marry me…It was such a relief when my husband came to get me and take us to our home.	Telling boyfriend about the pregnancy/ Fear of rejection by boyfriend/ Boyfriend against abortion/ Relief that boyfriend decided to marry her/ Despite marriage promise, still not willing to keep pregnancy	Compliance/ Lack of choice/ Lack of assertiveness/ Fear	Conforming to societal expectations
My aunt approached my boyfriend's relatives telling them what their relative had done…A day was arranged for them to come and meet with my relatives so that they discuss the case. When the day came, my boyfriend's relatives negotiated that their son just wanted to marry me. My boyfriend was thus charged for both damage and marriage. So when I was four months I got married…even though I was now living with my husband, I was not happy with the pregnancy; I still wanted an abortion. My husband kept on asking me what I really wanted because he had already married me as he did not see the reason why I wanted to still abort. We used to argue a lot, but after some time I learnt to accept	Family involvement and decisions made by elders/ Elders decided that she marries the boyfriend/ Not happy with pregnancy/ Accepting pregnancy	Compliance/ Lack of choice/ Gender defined roles	Conforming to societal expectations

my pregnancy….			
…When I was five months pregnant, while listening to the radio, I heard an item that all pregnant women needed to be going to the antenatal clinic…I got worried because I was already five months pregnant going on to six months. When my husband knocked off I told him about the news item, he told me that he knew about it but he thought my aunt had told me that I would start at a later date…My husband could not accompany me because he had to go for work…The nurse asked how many of us had not come with our husbands… After attending to the couples…that is when the midwife came to attend to us. She examined me and gave me a paper where things like gloves, cord clamp, sodium hypochloride (jik), and bucket were written. She said that those were the things that I needed to buy and come with at the time of delivery. That was the first and last time I learnt anything from the antenatal clinic…Every other time when I went there the nurses were just examining us, giving us iron tablets and Fansidar when it was due. Since I thought antenatal lessons are only taught the first time you go there, I did not bother…I was not feeling too confident with the information I had…There were a lot more things I needed to know about pregnancy and childbirth…I felt insecure…When I came home, I told my husband all what I was told…	Not having prior knowledge about antenatal care/ Husband thought that the aunt had told her about antenatal attendance/ First interaction with midwives/ Given information on what to prepare for labour/ Feeling the information was inadequate/ No health education in subsequent antenatal visits/ Reporting everything to the husband	Not provided with enough information/ Gender defined roles/	Feeling insecure
One day when I was seven months pregnant I went to visit my aunt; while I was there she asked me whether I knew that I was not supposed to sit on doorways; not ask for salt from neighbours and not walk bare feet. I told her that I did not know any of those things. She told me that sitting on the doorway would delay delivery because the baby would also just stay in the womb without coming out at the time of delivery; she said some people can also lock your pregnancy when they give you salt while others would pick the soil where you have stepped with your bare feet and add some medicine that would prevent one from giving	Introduction of cultural beliefs and practices by the aunt/ Husband reinforcing practices/ Having doubts on the authenticity of cultural practices and beliefs but doing as was told/ Reprimanded for	Compliance/ Lack of assertiveness/ Lack of choice/ Gender defined roles	Conforming to societal expectations

birth on time…When I came home I told my husband what my aunt had taught me and he told me he knew about some of the taboos especially the one of not staying in the doorway. This is a habit I was so used to that it was difficult for me to abide by it. Most times I was found sitting in the doorway and my husband would scold me telling me that I needed to take these things seriously. I would argue with him that these were just beliefs which were not real at all; but he would always tell me that adults would not come up with things that were not real; so he insisted that I abided by them.	trying to dismiss and break cultural beliefs and practices		
…when I was eight months… and after taking my blood and examining me…they gave me tablets for blood because they said my blood was not enough. The nurses advised us not to take traditional remedies. When I reached home and showed my aunt the tablets, she advised me not to take the tablets…My aunt brought me some traditional medicine…she said it helped in boosting blood levels…I was confused, I did not know which one to be taking…I began mixing both remedies.	Found to be anaemic and given iron tablets by midwives/ Advised not to take traditional remedies/ Given traditional remedies by aunt/ Told not to take the iron tablets/ Not sure of what to do/ Mixing remedies	Choosing the advice to adhere to/ Compliance/ Lack of assertiveness	Clash between traditional and contemporary childbirth practices/ Conforming to societal expectations
I have a very caring husband… He used to let me only wash small things when I was pregnant while he would wash the heavy things…My husband used to do the washing and cooking inside the house because if he was seen outside washing and cooking, people would start saying that I had given him medicine to turn him into a weakling…After washing I am the one who used to hang the clothes outside in order to make neighbours think that I was the one who had done the washing…I am fortunate to have a very supportive husband and one who loves me…Anyway, my husband was very supportive throughout my pregnancy and I think it made the whole process very enjoyable. Even when he was told not to be coming to see me while I	Feeling fortunate to have a husband who assisted in house chores meant for women/ Hiding assistance by husband from other community members/ Feeling confident/ Complying to husband	Gender defined roles/ Feeling safe/ Compliance	Being there for the woman

was waiting to give birth at my aunt's place, he used to sneak in to see how I was getting on. He was there all the way supporting me, and even after delivery he used to take the baby when he was crying a lot. This makes me very confident and I count myself lucky…A wife follows what the husband tells her to do because that is what the Bible says.			
There seemed to be so many dos and don'ts that we used to laugh a lot with my husband whenever we got a chance to be together…You know there are so many beliefs and taboos during pregnancy; so as a young girl I was disillusioned because it was difficult to remember all of them…but whenever I broke one of them there was always somebody to remind me of what I could or could not do…The other things that made me start doubting the traditional beliefs was that, during my pregnancy there were a number of times when I used to forget not to sit in the doorway…so if the belief was true, I should have had a prolonged and difficult delivery…but no, I did not have a difficult labour…Despite all the traditional remedies that were done my baby did not stop crying a lot and the fontanelle was still depressed. The fact that my baby never stopped crying despite all the remedies brought doubt in me as to whether these traditional remedies I was given and the cutting of my baby on the palms really work…but you never know, maybe I was just lucky or God intervened.	Feeling that there are too many beliefs and taboos to follow/ Failing to remember all practices/ Disillusioned/ Doubting authenticity of traditional practices and beliefs/Feels she might just have been lucky and God intervened	Choosing the advice to adhere to/ Compliance/ Lack of assertiveness/ Leaving childbirth experience and outcome in God's hands	Clash between traditional and contemporary childbirth practices/ Feeling insecure
I was surprised when my aunt came one day and said I should pack my things because I was going to be living with her until after giving birth…she gave me no choice but do what she told me to do…At my aunt's place I was not allowed to rest like I was doing at my home…This was very difficult for me because now I was feeling very tired and my pregnancy was big and heavy…well I had no choice…When I told her that I was having abdominal pains, backache and draining, she asked me whether she could take me to the clinic, I	Made to go and live with aunt as pregnancy neared term/ Assigned household chores/ Not allowed to rest a lot/ Preferred place of delivery ignored/ Unhappy but	Compliance/Lack of choice	Conforming to societal expectations

told her to take me to the hospital…While I was lying down I just heard her come and tell me to get in the car so that we go to the clinic. She did not give me a choice and I could not say anything because she is my aunt…I felt bad that my aunt gave me no choice…but I had no say or control over her decision…I could not overrule her…culture is culture and it has to be followed, no matter how it makes you feel…	complying with aunt's preference/ Place of delivery chosen by the aunt		
When we reached the hospital we found the nurses seated and chatting. They acted like they had not seen us. I had expected at least one of them to get up and get the bag we were carrying. We sat patiently on the bench provided. With time my pain became more and more but no nurse came to assist me…after some time that is when one of them asked us what was wrong. My aunt told them that I was in labour; I was too scared to answer them…I could not answer because of fear…there was no real reason for my fear, but the fact that they were health professionals…I had heard bad things about them, such as being unkind to mothers…I was terrified…After some time she came and told me to take off all my clothes…I had no choice but to do it…	Ignored by midwives/ Unmet expectation from midwives' reception/ Failing to verbalise how she was feeling/ Scared of midwives/Told to undress without an explanation/	Fear/ Lack of choice/ Unmet expectation	Inadequate service provision
I got scared when the nurses left me alone in the room…eh!…I was very anxious about something going wrong because the nurses left me alone…what was I going to do if anything went wrong and I was alone?... My aunt asked why she were being asked to leave me alone even after knowing that it was my first time to be in labour…I wanted my aunt to be on my bedside whilst I was in labour…surely, since the nurses knew that they were not going to stay with me, they could have asked my aunt to stay with me so that I had someone to reassure me that, whatever it was that I was experiencing, it was part of the delivery process…labouring alone made the whole process very long and unbearable…I gave her the six pairs of gloves I was told to buy, but she said that they were not enough; so my aunt had to give her K20, 000.00 so that she could sell us some more gloves…She said that I was	Left alone/ Scared of something going wrong while alone/ Aunt told to go back home/ Wished aunt was there to reassure her/ Labour was long and unbearable/ Left with cotton wool after delivery/ Not told when to remove the cotton wool/ Told the gloves she brought	Fear/ Unsafe practices/ Lack of reassurance/ Being left alone/ Not provided with enough information	Inadequate service provision/ Feeling insecure

supposed to use the bucket for passing urine, vomiting or whatever. I was surprised and asked if there was no toilet nearby. She told me that the toilets were there but since she could not stay with me to observe whether I am about to deliver or not, I might give birth in the toilet, so the bucket was better. It was very uncomfortable because my bucket was very small and I could not sit on it properly… She complained that I was sending her too much. She angrily picked my blouse and threw it at me, then left…she started making fun of me saying, 'ha sitting style!'…The midwives who helped me during labour were careless. They left cotton wool in my private part without telling me when to remove it…it got rotten and almost led to complications arising…Had it not been for my aunt I would have died…I was a first time mother who didn't know what was happening…The nurse called me to go to her office and collect a birth record form. When I reached the office she told me to sit. I told her that I could not sit because of the pain from the suturing. The nurse said that as long as I stood she was not going to write the birth record; so despite the pain I had to sit…I was told that before being discharged I needed to pay a K27, 000.00 for the bed I had used. I asked the woman who was next to me how much she had been asked to pay; she told me K7, 000.00. I started wondering why the charges differed…the hospital did not provide us with any food	were not enough/ /Made to buy more gloves/ Primipara, was not conversant with birthing/ Told to use a bucket as a toilet/ Midwives termed as being careless/ Made fun of/ Aunt paid fees for her		
…the girl I used to share the bed with kicked me on the back and after that backache started. Not only did I start experiencing backache but I started having this urge to pass urine continuously…I did not want to tell her that I was in pain, so I cheated her that I was looking for something outside…The pain kept on increasing until it was time to get up. I had this desire to stay alone so that nobody could notice that I was in pain…I felt like I should tell my aunt but I kept telling myself to wait a bit…I kept on hiding from my aunt. At one time she caught me sitting down and holding my back. When she asked me what the problem was I told her I was trying to pick something	Associates onset of labour with being kicked on the back/ Hiding from aunt that she was in labour	Not provided with enough information/ Lack of assertiveness	Feeling insecure

One day an older friend came to visit me. She asked me how the baby was doing. I told her that he was crying a lot especially during the night. She checked his palms and said that he had black lines that needed to be cut in order to stop him from crying a lot. I was surprised because to me the black lines she was talking about looked like blood vessels. She argued saying that those were the ones that were making my baby cry a lot especially at night. We called my neighbour who confirmed that, yes indeed those blood vessels needed to be cut. I bought a razor blade and my friend cut my baby's blood vessels…Another neighbour came to see me. When holding the baby she checked my baby's head and said that the anterior fontanelle was too big…it needed to be narrow otherwise my baby's head was going to get bigger and bigger until he died. She said she had some medicine which I needed to apply there in order for it to reduce. I paid for the medicine…I started applying the medicine on my baby's head. The same neighbour also gave me some medicine to be applying on my baby's upper palate because there was a pimple like thing there. I was told that this pimple if left would finish my baby's body till he died. To me all this…did not make sense…but I was not bold enough to argue… He also thought it wise that I consulted my aunt first. When I went to my aunt, she told me to take the baby to my grandmother because she did not know anything of that sort. My grandmother said that it was true the anterior fontanelle was extra big. Actually she noticed that the fontanelle was big even before telling her the problem that had brought me to her. After this confirmation from my grandmother that is when I started applying the medicine on my baby's head.	Told baby's crying was due to blood vessels/ She knew they were blood vessels but went ahead to have them cut/ Asking aunt then grandmother about the abnormalities spotted by neighbours/ Although not in agreement she felt comfortable when the grandmother agreed with neighbours	Lack of assertiveness/ Feeling safe/ Unsafe practices/ Choosing the advice to adhere to/ Unable to notice deviation from normal process/ Compliance	Being in a dilemma/ Clash between traditional and contemporary childbirth practices/ Inadequate service provision/ Conforming to societal expectations
When we reached home my aunt asked whether I had bathed. I told her no; so she boiled some water and then went to bath me. She concentrated on pressing my abdomen to get rid of any blood clots that could have remained in the womb. She then cooked some more food	Being taken care of by aunt/ Given time to rest/ Excused from house chores	Gender defined roles/ Feeling safe	Being there for the woman

for me and then left me to sleep…During the bathing my aunt would compress my abdomen with hot water…my aunt is the one who was cooking for me every day			
On the third day I started having severe abdominal pains. My aunt gave me some Paracetamol but it did not help; she told me that we needed to go back to the hospital because there might be something wrong in my abdomen. Before starting off for the hospital she told me to go and bath. While she was compressing my abdomen some cotton wool soaked in blood came out; it had now turned black. She asked me whether I had inserted it; I told her it was not me. She just said that the nurses might have left it inside me; so after bathing we went to the hospital…The doctor examined me…I told him what had come out at home when my aunt was compressing me with hot water. He just said 'these nurses I do not know how they work.' I thought he was going to take some action because that cotton would have got rotten inside me and caused me problems. I was disappointed by his reaction; anyway, he gave me some medicine and told me to go home.	Experiencing abdominal pains after discharge/ Discovered septic cotton wool/ Going back to the hospital/ Senior healthcare workers not seen to be hard on erring junior workers/ Erring midwives not reprimanded/ Disappointed	Not provided with enough information/ Unable to notice deviation from normal process/ Unsafe practices	Inadequate service provision
If now my aunt was the one who was going to nurse me, what was the job of the nurse, and how would I know what was wrong and what was not wrong; this was my first experience?...I felt that if the nurses could not stay with me they could have asked my aunt to stay with me so that she kept reassuring me that whatever it was that I was experiencing it was part of the delivery process. I was scared to be alone in the room and was very anxious about something going wrong while I was alone. The other thing is that the bag that had all the things they wanted was heavy, and when we arrived they told my aunt to give it to me to carry it inside where they were going to examine me. It was unfair because I was in so much pain. I felt if they did not want my aunt to enter the room where they were going to examine me from, one of them could have carried it for me.	Not happy with how birthing care was provided/ Midwives leaving their work to her aunt/ Feeling unfairly treated	Lack of reassurance/ Being left alone/ Unsafe practices	Inadequate service provision

Every woman who is delivering buys everything for delivery and pays for the bed on discharge; I wonder where the money goes to. I was instructed to buy gloves but it was very difficult to know what type of gloves or what size. I was surprised when I was told that the six pairs of gloves we brought were not enough. Well there are a lot of unanswered questions because these nurses do not have time to stay with us and explain things to us so that we understand. I would really urge the nurses to find time to explain these things to us because we are never in their meetings where they discuss these things. The confusing thing is that we are told that delivery services are free in Zambia but then why do we buy our own things and pay for the bed that we use?...These are our bodies so we have feelings and expectations, but when these are not met anybody can react.	Not having knowledge as to why she had to buy certain items and not provided by the hospital/ Midwives not explaining issues on birthing/ Contrast between policy statements and midwifery practice	Not given information of what had been done/ Mistrust in healthcare workers	Inadequate service provision/ Feeling insecure
A husband is a very important person in a wife's well-being when she is pregnant. During pregnancy I was craving for things and it was only my husband who could go and buy these things for me; that way I felt really loved and looked forward to having my baby.	Importance of a husband in relation to pregnancy and childbirth	Feeling cared for and appreciated	Being there for the woman
But since pregnancy and childbirth is a domain for women…Had my aunt not been there I would have gone to my grandmother. These elderly people have vast knowledge about these things. My mother-in-law was also there telling my husband what to do and we often used to compare notes.	Specific roles between men and women/ Trust in people who are older	Gender defined roles	Clash between traditional and contemporary childbirth practices
Being married and having children give dignity to a woman. Even at meetings you find that people tend to favour ideas from those who are married and have children. It is even worse if the child from a single mother gets pregnant or impregnates somebody; people just say 'what do you expect from a parent who is not married?' It is such comments that make women want to get married at all costs. Nobody looks highly at anyone with a child outside wedlock, but the way it is with me; apart	Importance of marriage in relation to childbirth	Sense of achievement	Conforming to societal expectations

from my family members everybody else thinks that I got married first then got pregnant. Getting married is a big achievement…being married I am expected to give birth again.			
…the problem is that I had my child when I was still too young…My aunt had to pay for me here and there because I did not have enough money. This in itself was a burden although she never complained openly. I think there should be a deliberate policy by government to teach young girls about their sexuality.	Getting pregnant at a young age/ Teenagers not informed of their sexuality	Not provided with enough information	Feeling insecure
The main problem is that there is nowhere one can go to complain. I was keeping the experience of my childbirth to myself and you know it was something that was really scaring me…You know labour is naturally painful so every person hopes to be treated with compassion, but when you are treated roughly it makes the pain even more. Instead of looking forward to giving birth the thoughts of being ill-treated overrides the pleasure of motherhood in most instances. For most of us it is because our extended families all come into play that is why we could stand the ill-treatment. I do not even want to think about what would have happened if I did not have my aunt with me…I just hope that our nurses will start treating us like human beings so that we start enjoying our motherhood… The pain was too much to bear; at one time I thought I was going to die; I could not lie down because the bed felt hot; I kept moving up and about but finally my legs could not hold me so I had to lie on the hot bed… I am begging that something will be done. Talking to you has brought a lot of relief. If you move around and mix with the ordinary women all you hear about are these stories of how the nurses abused them when they went to deliver. I knew about these stories even before I got pregnant so the time my aunt took me to the hospital I was scared and kept wondering whether it will be me or my child who will die.	No place to lodge complaints/ Keeping childbirth experience secretive/ labour is painful/ Thinking she was going to die/ Expecting to be cared for with compassion/ To be treated humanely birth when one is married/ Talking about the birth experience is therapeutic	Lack of choice/ Not provided with enough information/ Feeling safe	Inadequate service provision/ Being there for the woman