

# EXPERIENCES OF CHILDBIRTH IN NATAL INDIAN WOMEN

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## Abstract

*Through fifteen in-depth case studies of primipara, Natal Indian women's experiences of childbirth have been described. Common problems were identified, including lack of a family support person throughout labour, lithotomy position for delivery, episiotomies and their sequelae, breast-feeding difficulties and lack of professional support in the early puerperium at home. Preparation for common medical interventions in labour, breast-feeding and parenting appeared inadequate. Pertinent sociocultural aspects have been identified. These include continuing family support and culturally prescribed behaviour pertaining most importantly to the early puerperium and affecting the maternal-neonatal dyad. In the early adaptation to motherhood informants continued their role as daughter or daughter-in-law and would only actively continue their role as wife later or at the end of the puerperium. These traditional patterns of behaviour persist despite marked changes in educational level, language spoken and employment status. In the light of this research and founded on scientific evidence, a number of recommendations are made and areas for further research are identified.*

## Uittreksel

*Deur middel van vyftien intensiewe gevalle-studies van primipara, word die ondervindings van Indiër vroue in Natal, tydens hul kindergeboorte, beskryf. Algemene probleme is geïdentifiseer insluitende die gebrek aan ondersteuning deur 'n lid van die familie gedurende die kindergeboorte, episiotomies, en hul verloop, probleme met borsvoeding en gebrek aan professionele bystand gedurende die vroeë puerperium. Voorbereiding omtrent algemene mediese ingrepe wat gedurende die geboorte-proses gebruik kan word, en met betrekking tot borsvoeding en ouerskap, blyk onvoldoende te wees. Pertinente sosio-kulturele faktore is geïdentifiseer en behels volgehoue gesinsondersteuning en kultureel voorskrywende gedrag gedurende die vroeë puerperium, wat die moeder en baba as 'n paar kan beïnvloed. Informante moes hul rol as dogter of skoondogter volhou tydens die aanvanklike aanpassing by moederskap en sou eers later of aan die einde van die puerperium aktief hul rol as getroude vrou hervat. Hierdie tradisionele gedragspatrone word volgehoue ten spyte van beduidende veranderinge in die graad van opvoeding, gebruikstaal en werkstatus. In die lig van hierdie navorsing en ander wetenskaplike bewyse word verskeie aanbevelings gedoen en areas vir verdere navorsing geïdentifiseer.*

Kuper (1960 and 1962) in their studies on Natal Indians some thirty years ago. Childbirth has moved from home deliveries within a familiar sociocultural setting mainly by traditional Indian midwives (Kark and Chesler, 1962) to be placed within a medical frame of reference as hospitals and clinics have become the accepted place of birth. One hundred and forty traditional midwives were listed thirty-seven years ago in Durban (Woods, 1954) as compared with one such midwife in 1987, in which year no home deliveries were recorded (City Medical Officer of Health, 1987). These midwives also gave a home help service and were able to communicate to their clients in their home language, usually not English, and were thus able to meet family customs during the process of childbirth (Kark and Chesler, 1962).

Since 1949 when the first Indian midwife, Miss Savanthalay Pillay (now Moodley), was registered there has been a marked increase in the number of registered Indian midwives, 1232 in 1987 (S.A. Nursing Council, 1988). As a result of past government policy, it has been mainly these midwives who attend Indian women in childbirth at Provincial and House of Delegate institutions which cater for a predominance of Indian clients. The majority of Indian births in Durban take place at the provincial hospital from which the initial sample was selected for this study and a relatively large proportion of the remaining births at the private hospital from which the second sample was selected (Hospital and Nursing Year Book, 1989).

This study focuses on primiparous Indian women's experiences of childbirth. The research incorporates normal birth within the sociocultural framework of this dynamic community. Both of these are very much the brief of the registered midwife (Myles, 1985: 12 to 13) and the findings should thus be of significance to the practice of midwifery within the Natal Indian community.

The objectives of this research are to:

1. Describe how primiparous Indian women in Natal experience childbirth.
2. Examine the sociocultural framework within which these experiences are grounded.
3. Identify common problems which these women encounter in hospital and at home and the implications of these problems.

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## INTRODUCTION

Since the first Indians arrived in Natal, 131 years ago (Kuper, 1960), they have undergone marked social change. The vast majority are now urbanised (Moodley, 1989) and the South African Indian population has increased to 895 000, 80,32% living in Natal (Epidemiological Comments, 1987). Over half of the Indians in Natal live in Durban and form the largest component of the city's population (City

Medical Officer of Health, 1987). Traditional family structures are disappearing (Buijs, 1986). Education for Indian women has advanced, more women are employed in the market place and an increasing number are using English as their home language (Brijlal, 1989 and Ramphal, 1989).

There have been changing patterns of childbirth in the Natal Indians since these were documented by Kark and Chesler (1962) and

For purposes of this study childbirth is the period from the diagnosis of pregnancy until the early puerperium.

## LITERATURE REVIEW

This review incorporates some sociocultural aspects of the Natal Indian community with regard to childbirth and neonatal care. The vast body of international literature dealing with women's experiences of childbirth will be incorporated in a later article.

Despite changes in the traditional joint family structure and the use of Western medical facilities, traditional family support (Buijs, 1986) and traditional health beliefs (Watts, 1980) are still part of the social fabric of the Indian community. Watts ascertained that eighty percent of the households interviewed protected their children through religious rites and/or amulets. After childbirth forty percent of postpartum women drank traditional Indian medicine for strengthening and thirty percent bathed in special substances.

As the majority of the Indian community in Natal are Hindu (Brijlal, 1989) the focus of the rest of this short review will be on selected sociocultural traditions in this group. Health is viewed as being in 'harmony' with oneself, one's family, one's community, God and the 'cosmos' (Kuper, 1960: 242). The way of achieving 'harmony' is through rituals which may be prescribed by priests after consultation with ancient literature. At home the senior women carry out rituals to the 'house gods' and a mother-in-law has a dominant relationship to her daughter-in-law (Kuper 1962: 98).

Traditionally married women are not expected to work outside the home. Pregnancy is anticipated within the first year of marriage. Antenatally women are expected to eat nourishing food but not overeat and to do housework to help keep her muscles flexible and ensure a small baby. The normality of uncomplicated pregnancy is accepted but certain precautions, such as avoiding cold, are undertaken. Special care is prescribed during an eclipse and women are expected to be tranquil during pregnancy. Despite these and other beliefs and practices, over seventy percent of a sample of Durban Indian women nearly thirty years ago obtained Westernised antenatal care, whereas the majority delivered at home with traditional midwives (Kark and Chesler, 1962).

Labour and birth are considered to be both painful and dangerous and a free expression of emotion is acceptable. According to Hindu custom a woman should never be left by herself during labour and apart from a 'midwife' her mother and other experienced kinswomen should be present through the confinement (Kuper, 1962). Giving birth is women's business and is also viewed as ritually polluting (Harper, 1964). The date and time of birth are important as they indicate whether or not the baby is born at an auspicious time and special rituals may be carried out if it is inauspicious. Rituals may also be performed if a birth is considered abnormal such as the baby born with the cord around the neck - a 'garland' (Kuper, 1962: 106), although Kuppusami (1983: 84) explained that hospital births preclude these rituals.

Traditionally family support is anticipated in the postnatal period as the new mother is expected to rest and be in close physical contact with her newborn infant. They are considered unclean after birth and special cleansing and naming ceremonies are held on auspicious days, usually within the first sixteen days of birth.

The newborn baby is subject to evil forces and they are protected in many ways such as a black dot being placed on their forehead. As the 'evil eye' is also feared and may have a detrimental effect on lactation when the baby is seen suckling, the mother should shield her breast from view with a sari.

Although breast-feeding is traditionally desired, colostrum is considered unclean and is expressed and the neonate is given a few drops of cleansing honey and castor oil. The maternal diet is given to foster lactation, prevent colic and promote maternal health and warmth which in turn helps to prevent janni, a psychological disorder.

Water is an important element of purification and the mother is ritually massaged and bathed with a hot leaf bath, being careful to retain warmth. The infant is also massaged with oil and bathed on an older woman's knees (Kuper, 1960 and 1962).

## METHODOLOGY

This was a descriptive study involving an ethnographic approach in order to ascertain how primiparous Indian women experience childbirth. Case study methodology was used.

### Sample

A theoretical sample (Glaser and Strauss, 1967) was used as the research was qualitative in nature.

The Indian women informants were primiparous 'hospital' (non-private) patients who attended the antenatal clinic and gave vaginal birth in the same hospital. Each informant's newborn infant was term - between 37 and 42 completed weeks of pregnancy - alive, and healthy at birth and was discharged home with the mother. These new mothers were between sixteen and thirty-five years of age, thus capturing the most representative group and avoiding the higher risk groups. The informants were not admitted prior to labour except for short term admissions such as induction, false labour, urinary tract infection and short-term insulin or blood pressure stabilisation.

The initial sample was selected from the postnatal ward of a large Natal provincial hospital and after the research was explained, verbal consent to interview obtained and confidentiality assured, an appointment was made to interview clients at home, seven to fourteen days after birth. Most clients were interviewed in the area surrounding the hospital. As a theoretical sample was used, when no new information was forthcoming, a second smaller sample was selected from a private hospital in the centre of Durban. The total sample numbered fifteen, twelve from the provincial hospital and three from the private hospital.

### Data Collection

The method of data collection was by means of one or more informal interviews in the home where the informants were staying. With the

consent of each subject the interviews were taped to allow free flow of conversation. The informants were allowed to describe their experiences of childbirth with little interruption. An agenda had been drawn up to guide the researcher and ensure that the whole process of childbirth was covered, but it was only used if the informant did not include aspects of childbirth. Demographic information was obtained by means of a structured interview once the first phase was completed.

### Pilot Study

A small pilot study was carried out on two informants who fulfilled the sample criteria and as no problems were ascertained they were incorporated into the main study.

## FINDINGS

### SOCIODEMOGRAPHIC FINDINGS

The findings indicate changes in educational status, employment status, home language and household patterns as compared to those reported by Kuper thirty-one years ago. These findings, because of sample size, indicate possible trends only.

### Marital Status

Although two of the fifteen informants were single, the predominance of married informants indicate the continued stability of Indian family life.

### Educational Status

Despite the informants being hospital patients and from the lower socioeconomic group, they all had attained some high school education which facilitated their reading and understanding material about childbirth and childcare.

### Employment Status

Although nine of the fifteen informants worked during part of their pregnancy, only two were definitely returning to work and one to school. This shows a tendency for the mother's place still being in the home and family arrangements were already made regarding the three babies whose mothers were returning to work or school. However, the change of status from pregnant and employed to parent and unemployed appears to be a relatively new trend as seven of the sample had not only to adjust to parenthood but also to being a housewives instead of employees.

### Financial Support and Economic Status

Fourteen of the sample were supported by their husbands or potential 'husbands', the exception being the schoolgirl who was supported by her father. The household incomes were largely 'guesstimates', two being totally unknown, seven being below the household subsistence level (H.S.L.), five being above this and only one being above the household effective level (H.E.L.). Despite the low economic status of the sample only one family appeared to be financially deprived. However, a pooling of family incomes and shared accommodation appears to have helped allay financial deprivation in some families.

### Households Present and Future

Ten of the fifteen informants were staying with their parents or parent's family as would be anticipated with traditional Hindu and Muslim primiparous women immediately after birth. Only four of these were moving to their in-laws

as would be anticipated after a prescribed period in their parental homestead. Four informants were moving to a nuclear household after this period, indicating a possible tendency away from complex households. However, these four would be staying close enough to their families to continue to receive support when needed.

All the informants had support from experienced, unemployed senior kinswomen in the early postnatal period.

#### Homes

All the homes visited had access to a bus service and all but one had a telephone, the exception having limited access to the landlady's telephone. Thus all the informants could communicate with health professionals should the need arise. The informant without a telephone also had no running water or electricity in the home, unlike the fourteen other informants who could more easily maintain their and their baby's hygiene.

#### Language and Religion

All fifteen of the sample were fluent in English, only four being conversant in the vernacular. Only one of the senior kinswomen was more fluent in the vernacular, Hindi, than in English which she spoke with great difficulty. This fluency in English allowed for ease of communication and doubtless facilitated health education.

As anticipated the majority of the sample, ten, were Hindu, three were Christian and two Muslim. Unlike the other thirteen, two of the informants were bringing up their children in their 'husband's' religion which differed from their own, indicating the influence of the 'husband' and the in-laws in regard to a child's religion and related religious practice.

#### Sex and Birthweight of Newborns

Of the fifteen neonates born at term, between 37 and 42 completed weeks of pregnancy, nine were male and six were female. The mean birthweight was 2,89 kg. This tendency to lighter neonates in the Indian community was reported by Salber (1962) when the mean birthweight in her large sample was found to be 2,94 kg.

### IMPORTANT FINDINGS AND COMMON THREADS IN REGARD TO INDIAN WOMEN'S EXPERIENCES OF CHILDBIRTH

Important findings and common threads through the developmental phases of pregnancy, labour and the early puerperium are presented in this section.

#### Support

##### Family Support

This was identified as being common to and valued by all the informants and was evident in pregnancy on admission in labour, postnatally on discharge from hospital and most particularly in the early puerperium at home.

Antenatally ten of the fifteen informants were accompanied by family for the first antenatal visit. The one informant who stated she wanted a family support person to be with her while she underwent various examinations and tests, was refused her request.

On admission to the labour ward, all thirteen informants admitted from home were

accompanied by family. At the provincial hospital, probably because of an open plan labour ward, the informants were not permitted a family support person, which had a detrimental effect on all but one, who wanted no-one with her. They verbalised their fear of labour and delivery by such comments as "this is the scary part", "don't talk about it - too frightening", and "very terrible". They also verbalised the value of having a familiar support person with them with such comments as "someone familiar with you in labour gives you strength to make it" and "someone familiar gives you encouragement". Two of the three informants from the private hospital would also have liked a family member to be present at birth. This was permitted, but the mothers were unsupported in early labour and the relatives could not return in time for the delivery.

Although males have not traditionally been present at Indian births, ten of the fifteen informants wanted their husbands, kinswomen being acceptable alternatives, and three preferred a kinswoman.

Postnatally all informants went home to family support, mainly from senior kinswomen who were unemployed. The importance of family support to the informants is reflected in such statements as "this is my first experience, it's better to learn at home" and "I don't know what I would have done without family". The support involved physical, psychosocial and spiritual care of both mother and baby and was largely given by women. Husband's appeared to give some emotional support as well as the previously mentioned financial support.

#### Professional Support

Most of the informants were satisfied with the care given in the antenatal clinic and appeared to have no problems with the many midwives attending them and the care being fragmented by task allocation. Only two informants were critical of the "Nurses" attitudes, seeing them as authoritarian.

The labour ward midwives were strangers to all but one of the informants and this, together with the unfamiliarity of the labour ward, could have contributed to the stress in the labour ward. Informants commented on the importance of the presence as well as the attitude of the midwife as reflected in the following statement "Sisters help you keep brave .... Sisters very helpful". However, being left alone was frightening as shown by one subject saying "I would have liked someone with me, someone to call, I felt nobody cared." and another "I was much on my own - very frightened.". Another informant was upset as she was "scolded by the nurses for lying on my back in labour" and another appreciated the "nurses being friendly".

Early postnatal support in hospital was not always available as evidenced by six of the informants having no support when breast-feeding. One subject commented that "the nurses were too busy and could not help". This is hardly surprising as the majority, ten, were discharged within twenty-four hours and three within thirty-six hours. Only two stayed in hospital for longer because the infants had become ill after birth.

None of the informants received professional support at home up to the time of the interviews, between seven to fourteen days after birth.

Although six of the fifteen informants had had contact with a community nurse prior to discharge, none had a contact telephone number nor were they aware that they could have received professional support with regard to breast-feeding and neonatal problems. No domiciliary midwifery service is provided. General practitioners and to a lesser extent the hospital were attended by some women and their neonate when problems arose.

#### Education and Communication

Antenatal education was received by all the sample. However, not all felt well or realistically prepared for labour as evidenced by only two informants recalling education about episiotomies and other 'minor' procedures. Most informants did not feel adequately prepared for parenthood as demonstrated by only five recollecting education on breast-feeding, two of these finding the videos shown in breast-feeding week most helpful. All, except one, supplemented their knowledge with literature. Eleven of the fifteen informants received education from the family.

The advantage of adequate preparation for labour was voiced by one informant who was briefed by her sister - "I had confidence and felt in control because of this knowledge." This was in contrast to another informant who felt she "knew nothing" and who also wanted information which was not forthcoming from the staff.

Education and communication in the postnatal wards was difficult because of early discharge. It was difficult for these women to assimilate new material as reflected in one informant's statement that she was "too drowsy to take in what was being taught". The most commonly remembered aspects of education were episiotomy care and the need to return for a postnatal check-up.

#### Unpleasant Experiences

Some of these were unanticipated which compounded the distress of the mothers concerned. Antenatally, just over half the sample found the taking of blood specimens unpleasant and often unexpected. Only one informant who attended the provincial hospital had a Papanicolaou smear, which varied from an "uncomfortable" to a "painful" experience. This was anticipated and seen as an ordeal to be endured.

Unexpectedly, eleven of the fifteen informants did not complain unduly of labour pain. Of the four who had severe pain, two had an induction and one an augmentation of labour. Only one of the total sample stated that the vaginal examinations were very painful and only one of the fourteen who had episiotomies complained of pain. However, three of the ten informants who had artificial rupture of membranes had a degree of pain. Fourteen of the fifteen informants delivered in lithotomy position and this was commented on adversely by all as reflected in such statements as "tied legs up ... I was suffering" and "very terrible, very painful ... legs tied up". Five of those with episiotomies felt pain on suturing.

Postnatally eleven of the fourteen who had episiotomies complained of severe unanticipated pain in the postnatal wards and this pain continued in the first week of the puerperium at home. The informants reflected

on their pain and some of its consequences as follows: "it was so painful, I couldn't sit", "I was unable to go up the stairs" and "the stitches were so sore I had to see the doctor". Five of the subjects went to their general practitioner with problems related to their episiotomies, three of them being infected. One of the latter had to have a further consultation at the hospital. Episiotomies made the informants view themselves as sick in the early puerperium and resulted in pain, mobility problems, infection and also contributed to breast-feeding problems. Episiotomies appeared to reduce the enjoyment of, and adaptation to, early motherhood.

Two of the mothers had probable breast engorgement as a result of not initiating breast-feeding and the breast problems resulted in both consulting their general practitioners. Two had nipple problems, one with blisters and the other appeared to have inverted nipples.

#### **Breast-feeding and Neonatal Problems**

As breast-feeding is the desired method of feeding in the Indian community, it causes emotional distress when it is unsuccessful. By seven informants were totally breast-feeding at the time of the first interviews, five from birth and two from the time they had arrived home where they had been helped to initiate and establish breast-feeding by senior women in the household. Two babies were totally artificially fed as their mothers had never managed to initiate breastfeeding and six babies were partly breast-fed. The factors which contributed to this problem in more than half the sample could include insufficient antenatal education, lack of initiation of breast-feeding in labour ward, short stay in the postnatal ward and inadequate professional supervision, no professional help at home, the use of bottles in one institution, breast and nipple problems, episiotomy problems and problems with the neonates.

Of the fifteen neonates, four were low birthweight being below 2500g, two became ill in hospital, three were taken to the doctor from home with relatively minor problems and two were taken to the hospital with more serious problems. This high proportion of neonatal problems in term babies born vaginally is not only of professional concern but caused maternal anxiety.

#### **Socialisation to Motherhood**

The new status of becoming a mother was common to all the informants, the other major adjustment being a change in status from employed to unemployed in seven of the subjects. Five of the informants had rehearsed motherhood through helping to bring up small babies. Motherhood was largely learned from the role model of the senior women who undertook most of the care of the newborn and helped to foster breast-feeding. The informants continued their role as daughter and/or daughter-in-law in the early experience of motherhood and would only actively continue their role as wife at the end of the puerperium for Islamic households and more traditional Hindu informants or in the later puerperium in the other subjects.

#### **Sociocultural Practices**

These were most commonly identified in the early puerperium and involved both the mother and their babies. The informants did not rigidly

follow prescribed norms as alternates were sometimes more practical or necessary. As described above older kinswomen cared for the babies and also looked after the new mothers who did not undertake household duties in the early puerperium.

As already mentioned breast-feeding was the desired method of feeding for all the informants and none mentioned colostrum as being harmful. A traditional maternal diet, such as masala and herbs, was eaten in the puerperium to enhance lactation, to promote warmth and health and also to avoid neonatal colic.

Newborns appeared to be viewed as unclean after birth and vulnerable to evil forces. Some of the babies from the more traditional Hindu families were protected from these forces by a black dot, made from the soot of burned ghee (clarified butter) from a traditional clay lamp, being placed on the forehead. Some of the babies of the Tamil speaking families had a tiny penknife pinned unobtrusively on the baby's pillow as a protection. The Muslim informant had put a black bead bracelet on her son's wrist stating that the blackness repelled the black forces of evil.

In regard to birth pollution all the Hindu informants were having or had had birth cleansing and naming ceremonies for their newborns on auspicious days within the first fortnight after birth. The mothers also had a cleansing bath to remove pollution and they were allowed to undertake more household tasks after these cleansing ceremonies. The two babies being brought up in the Islamic faith were named shortly after birth and had already had their polluting hair shaved off within the first three days after birth. The babies of Christian families were being named after dedication ceremonies in their churches.

The Hindu and Christian informants' babies were massaged with oil and bathed traditionally with hot water poured over them while on an older kinswoman's knees. All the babies slept in bodily contact with their mothers and no 'prams' and only one baby bath, not used, were evident.

It was not only the babies who received traditional baths, so also did eight of the mothers who were massaged and then bathed with a hot leaf bath. Five of the fifteen mothers recall standing astride a small traditional coal fire on which lobaan (frankincense) had been sprinkled. This was found to give comfort to their traumatised perineums. Unfortunately, the researcher did not ascertain what folk medicines were given, if any, to the mothers and babies and mainly obtained information regarding the puerperium.

As already discussed in the sociodemographic findings, the place of stay in the puerperium was often for pragmatic rather than traditional reasons.

#### **Midwife or Obstetric Nurse**

The researcher did not set out to identify the changing status of the midwife but came to a somewhat tentative conclusion in this regard. Midwives, 'traditional' and 'professional' who had delivered mothers or grandmothers of the informants at home were always called midwives by the informants or other senior kinswomen present at the interview.

Informants from the provincial hospital called the midwives "nurse" or "sister" and appeared to view the doctor as the main referral person. As these informants were ultimately under medical management these midwives may in fact be taking on the role of obstetric nurse as commented on by Kirkham (1983: 83 to 84). However, more status appeared to be given to the midwife at the private hospital as she was always called "sister", but still not midwife. This higher status may be because the doctors were not involved in the first antenatal visit and did not routinely monitor the hospital patients in the labour ward, this being the responsibility of the midwife.

## **CONCLUSIONS AND RECOMMENDATIONS**

In this article Natal Indian women's experiences of childbirth have been described and analysed. Some of the problems identified may not only be detrimental to these women's experiences but may also contribute to maternal and neonatal morbidity.

Despite marked changes in the Indian community some traditional patterns of behaviour persist such as family support and culturally prescribed behaviour particularly in the early puerperium in regard to both mother and baby.

#### **Recommendations**

In the light of the findings from this research some aspects of midwifery practice and organisation of services need to be reviewed and changed. Although the first priority of the midwife will always be to reduce perinatal and maternal mortality and morbidity, she should also practice in such a way that women's experiences of childbirth are enhanced.

Recommendations for changes in practice and further research are:

#### **Lay or/and Family Support Persons**

The principle of allowing an acceptable lay or/and family support person to accompany primigravid/parous women antenatally, throughout labour and postnatally in the hospital should be considered. A female lay support person in labour has been shown to be beneficial to both mother and baby (Sosa et al, 1980). Also a 'doula' as described by Raphael (1973) and as tried out by Ross et al (1987) has been shown to be of value in establishing and maintaining breast-feeding. As family members appear to be available and desired in the Indian community, research needs to be undertaken as to the effects of their presence on labour outcomes and breast-feeding.

#### **Professional Support**

The continuous supportive presence of the midwife throughout labour as recommended by O'Driscoll and Meagher (1986) or, at the very least, Shields' (1978) recommendation of the midwife being present in response to the client's needs, should be ensured. At home, in the early puerperium, a domiciliary midwifery service would assist in the prevention and early management of problems as would an early home visit by the community nurse. Precise information regarding the role of the community nurse in regard to infant feeding and care together with the contact name and telephone number of the closest family health clinic should

be made available to every new mother prior to discharge. Telephonic contact, if home visits are not possible, could be initiated early in the puerperium by the community nurse.

#### **Breast-feeding, Maternal-Infant Interaction and Parenting**

Appropriate antenatal education with the use of videos and simulation with dolls should be instituted, because of short postnatal hospitalisation.

Initiation of breast-feeding in the first hour after birth when the infant is in the alert-awake phase is strongly recommended (Ball, 1987 and Ross et al, 1983). The mother should have unhurried contact with her baby after birth (Klauss and Kennell, 1982). Bottle-feeding in hospital should be taboo. A mother should not be discharged without initiating breast-feeding. A 'doula' or family member could assist the busy staff with the initiation and establishment of breast-feeding and the facilitation of infant care in hospital and in the community (Raphael, 1973 and Ross et al, 1987). An explanatory discharge booklet should be given to each client. As previously recommended, early professional community support should be implemented. A post for a lactation nurse could be established to better equip lay workers and health professionals. Voluntary organisations such as La Leche League could be utilised.

#### **Health Education and Communication**

Aspects relating to breast-feeding and parenting have been discussed previously. Women should be better prepared for labour, with special regard to common medical interventions (Ball, 1989; Cartwright, 1979; Kirke, 1980 and Kitzinger, 1981). Midwives should ensure that sufficient understandable information is given throughout the process of childbirth and should also facilitate communication. As this population is largely literate, more use could be made of explanatory booklets.

#### **Unpleasant Experiences**

These should be avoided or modified as required. Blood should be taken in privacy to prevent anxiety in waiting clients. The Papanicolaou smear should perhaps be delayed to the second, less stressful, visit. As many medical interventions in labour have no proven value in normal labour such interventions should be selective rather than routinised (Hofmeyer and Sonnendeck, 1987). Labour and birth positions comfortable for the mother and physiologically advantageous for mother and baby should be utilised (Sleep, 1989). The lithotomy position should only be used when essential. Episiotomies should be elective and not routine. Methods of suturing and the criteria for the person cutting, suturing and supervising this procedure should be investigated. Episiotomy care and control of pain, in hospital and at home, should be in line with research such as that carried out by Sleep and Grant (1988 a and b) and gentle pelvic floor exercises should be encouraged (Montgomery, 1986). Traditional practices such as standing astride a coal fire with lobaan (frankincense) should be investigated.

#### **The Establishment of a Midwife's Birthing Unit**

The possibility of selected healthy clients being looked after by midwives who refer to a medical practitioner as needed, should be considered in

regard to antenatal, intrapartum and postnatal care. The aim of this unit would be to enhance maternal and fetal/neonatal care and satisfaction. It would also foster the independent practice of the midwife and it should be cost-effective.

#### **Sociocultural Practices**

Traditional practices such as family support, traditional diets, massaging and bathing mother and infant, folk medicines, the use of a coal fire with 'lobaan' and various religious practices should be recognised, investigated and actively encouraged where found to be beneficial (Williams et al, 1985).

#### **Conclusions**

Although the findings in this study are based on women's perceptions, which may not always reflect the care given, they have shown areas of midwifery and community practice which need to be reassessed and improved.

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