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The experiences of midwives from a transcultural caring  
perspective in Nuwakot, Nepal.

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## **ABSTRACT**

This study is a minor field study and is sponsored by Swedish Development Cooperation Agency. Nepal is one of the poorest countries in the world and struggles with continuing reducing the national maternity mortality rate in order to satisfy WHO millennium targets. In order to improve the maternal care in Nepal an understanding of midwives experiences is needed. This study aims to explore midwives experiences from working in the Nuwakot region in Nepal from a transcultural caring perspective. The study uses a qualitative methodological approach. Unstructured interviews were performed during April 2015 at health posts in remote mountain villages in the region of Nuwakot, Nepal. Seven midwives, two men and five women were involved. By analyzing the interviews with a qualitative content analysis several categories emerged. The result shows that midwives working in a rural area of Nepal today experience several challenges in their work based on cultural influences; challenging family hierarchy, dangerous home deliveries, villagers lack of education, patients arriving too late, patients distrust in medicine and lack of resources but happy to help. The conclusion is that in order for Nepal to keep improve their maternal care, midwives needs to develop an understanding of the patient and the family's cultural beliefs. The result can be used to reflect on how the patient's cultural beliefs can affect the midwives when performing their work in a rural area of Nepal. It can also be used to develop the midwifery education in Nepal by improving midwives' meeting with patients and their families with cultural needs.

Keywords: *Midwives experiences in Nepal, content analysis, transcultural, culture.*

# TABLE OF CONTENT

<b>INTRODUCTION</b> .....	<b>1</b>
<b>BACKGROUND</b> .....	<b>1</b>
<b>Factors influencing maternal care in Nepal</b> .....	<b>1</b>
<b>Culture care theory</b> .....	<b>2</b>
<b>PROBLEM STATEMENT</b> .....	<b>2</b>
<b>AIM</b> .....	<b>3</b>
<b>METHOD</b> .....	<b>3</b>
<b>Participants</b> .....	<b>3</b>
<b>Data collection</b> .....	<b>3</b>
<b>Data analysis</b> .....	<b>3</b>
<b>Ethical considerations</b> .....	<b>4</b>
<b>RESULT</b> .....	<b>5</b>
<b>Findings</b> .....	<b>5</b>
<b>Challenging family hierarchy</b> .....	<b>5</b>
<b>Dangerous home deliveries</b> .....	<b>6</b>
<b>Villagers lack of education</b> .....	<b>6</b>
<b>Patients arriving too late</b> .....	<b>7</b>
<b>Patients distrust in medicine</b> .....	<b>8</b>
<b>Lack of resources but happy to help</b> .....	<b>9</b>
<b>DISCUSSION</b> .....	<b>9</b>
<b>Method discussion</b> .....	<b>9</b>
<b>Result discussion</b> .....	<b>10</b>
Key findings.....	10
Cultural care preservation .....	11
Cultural care accommodation .....	12
Culture care repatterning.....	14
Emic and etic dimensions of caring .....	15
<b>CONCLUSION</b> .....	<b>15</b>
<b>REFERENCES</b> .....	<b>17</b>

## **INTRODUCTION**

Midwives in rural areas of Nepal stand on the front line to provide care, with a limited amount of resources in a land with harsh geographical landscape and strong influence by traditions and culture. With a low amount of institutional births, midwives play an important role in Nepal's struggle to continue reducing the national maternal mortality rate to meet the WHO millennium targets. Previous research shows that midwives in rural areas face complex cultural challenges and that medical advice can interfere with villagers' beliefs. Since it is the foundation of the nursing profession to understand patients' life-worlds and their lived experiences, analyzing midwives experiences through a transcultural theory can contribute to a better understanding of Nepal's maternal health care.

## **BACKGROUND**

WHO (World Health Organization, 2013) report on women's health shows that approximately 287 000 women die every year due to childbirth and complications in pregnancy and 99% of them are in developing countries. Bogren, Teijlingen & Berg (2013, p.1104) reports that Nepal is by the Millennium declaration committed to increase the skilled attendants at birth to 60%. WHO (2014, pp.1-3) reports that even if the maternity mortality rate in Nepal has decreased from 23, 1% to 6, 9%, studies show that during 2013 only 35, 7% of all births took place with skilled attendance.

### **Factors influencing maternal care in Nepal**

Kaphle, Hancock & Newman (2013, p. 1174) informs that even if the number of institutional births are rising in Nepal, there are still many women giving birth in their community, with assistance from neighbors and family which increases the risk of life-threatening diseases. Morrison, Thapa, Manandhar, Basnet, Budhathoki, Tambahangphe, Costello and Osrin (2014, p. 4) writes that the pregnant women's choice of place to deliver the baby is highly influenced by her family members. The women had social pressure to behave in support of their marital home and the husband was often the one to make the decisions. The women status in the home restricted their opportunity to give birth at a health post and lack of support from the family members often caused the women to deliver at home. Neupane and Doku (2011, p. 867) writes that the number of prenatal care visits and the start of prenatal care for pregnant women were partially associated with their background variables and the socio-demographic variables. After three months of pregnancy most of the women started their prenatal care, 46%, while 28% had no care at all.

Shrestha, Adachi and Petrini (2014, p. 428) reported that women with lower education had higher risk of developing moderate anxiety. The primiparous mothers need more information and education related to immunizations, childhood diseases, infant feeding and infant care to reduce infant mortality. Kaphle, Hancock & Newman (2013, p. 1178) study showed that women's knowledge of physical complications during pregnancy and childbirth made that the women feel fear of the uncertain outcome and that increased the expectation that God could help. However, the authors clarify, that the tradition is often

blamed for perinatal mortality, rather than blaming medicine for not accommodating and understanding the traditions and culture.

Morrison, Thapa, Hartley, Osrin, Manandhar, Tumbahangphe, Neupane, Budhathoki, Sen, Pace, Manandhar, Costello (2009, pp. 28-29) study indicates that the women preferred private practitioners, pharmacies and traditional healers. There was mistrust among the people of the local government health services, doubt in the skills of the health personnel and lack of trust in the quality of the medicine provided. Kaphle, Hancock and Newman (2013, p. 1178) research also confirms that village people in Nepal don't have faith in medical care and service providers have strong trust and faith in their traditional healers. In the study of Kaphle, Hancock & Newman (2013, p. 1176) the findings showed that the local tradition, culture and spiritual beliefs emerged as the most important things to understand in women's beliefs regarding childbirth and pregnancy risk and safety.

### **Culture care theory**

Leininger (1993, pp. 15-17) writes that the culture and traditions can have high influence in health behaviors and the experience of both giving and receiving care. Leininger (1993, p. 28) explains that through her theory Culture Care Diversity and Universality, the goal is to provide "culturally congruent nursing care". Leininger (1993, pp. 20-21) further clarifies that religion, kinship, beliefs, values, technology, philosophy of life as important cultural and social factors. Leininger (2001, p. 14) also explains transcultural care by the construction of emic (folk) and etic (professional) care. Together they form the two sides of cultural care where emic represent the local, folk traditional care and etic stands for the educational, institutional care provided by nurses.

Leininger (1993, pp. 19-20) explains three modes of cultural care; care preservation, where the provided care aims to retain and preserve the cultural values, care accommodation for when the care aims to help adapt and negotiate for the people to share the optimal health outcome, and care re patterning where care aim to change or modify health behavior. Leininger (2001, p. 3) writes that there can be no cure without caring, but there can be caring without cure.

Leininger (2001, p. 7) describes that nurses experience patients as culture strangers who shows signs of confusion, frustration, anger or of being misunderstood. These experiences and others are factors that both patients and nurses of different cultures need to examine so that their way of function together improves. The theory of Culture Care encourages nurses to discover and study these factors so that the nurses do not feel so ineffective and helpless with the culturally different factors between the patient and the nurse. By discovering these factors the patients' benefits more from nursing services.

## **PROBLEM STATEMENT**

Shrestha, Adachi and Petrini (2014, pp.427-428) concludes that the cultural practice pose a high risk for life-threatening illness for mothers and newborns. Kaphle, Hancock and Newman (2013, pp. 1174-1178) describes the importance of understanding the

patients cultural beliefs and how it might interfere with their maternal care, to align medical knowledge with cultural practices. While studies as Shrestha, Adachi and Petrini (2014) and Kaphle, Hancock and Newman (2013) explains the importance of understanding the maternal patients experiences through cultural beliefs, there are today no studies regarding the importance of understanding healthcare workers experiences.

## **AIM**

By exploring the experiences of midwives working in a rural area of Nepal, we aim to create a deeper understanding of the transcultural complexity of providing care in a field influenced by traditions and culture.

## **METHOD**

By exploring the experiences of midwives working in a rural area of Nepal a qualitative design was elected that characterizes the research. Kvale & Brinkmann (2014, p. 41) describes that the qualitative research interview aims to understand the topics from the lived everyday world from the interviewee's own perspective. As a professional interview it brings an approach of its own subject but the structure is often the same as a casual conversation. Further Nyström (2012, p.156) explains that qualitative research aims to create an understanding of the life-world and contains participants' observation, diaries and other texts. The authors of this study used unstructured interviews and the material from the data collection has been processed based on a qualitative content analysis with an inductive approach. Lundman & Hällgren-Graneheim (2012, pp. 187-188) writes that qualitative content analysis focuses on the interpretation of texts and is primarily used in human science, behavioral science and health science. The method is useful in various research areas as it can be applicable to various types of text and the interpretation can be done at different levels. An inductive approach to the research implies an unbiased analysis of the text which can be based on participants' stories of their experience.

## **Participants**

Villages to perform interviews were chosen by their geographical location in the district of Nuwakot by altitude, ranging from 400m to 2500m over sea level, and different accessibility by road. The authors were trekking with a mountain guide and Sherpa's for 11 days on a route planned to pass as many villages with health posts as possible. The including criteria for participators were that they were educated midwives working in the chosen villages with maternal care. Based on this including criteria seven persons were asked to participate in the study and all of them chose to attend. Of the seven persons that participated two of them were males and the rest women. Age of the participators was ranging from 30 to 55 years.

## **Data collection**

Data was collected 19th - 28th of March 2015 in the district of Nuwakot. All of the interviews took place in villages health posts in a separate room. The interviews were registered by audio recording and the duration of the interviews varied from 21-42 minutes. During six interviews translators were used and in one interview the

participant spoke English and translator was not needed. Unstructured interviews were used and to keep the interviews flow the authors had a memorandum at hand and asked possible follow-up questions. The opening question during the interviews was “Could you please tell us about your work here?” Bryman (2002, p. 300) explains that when using unstructured interviews, the researcher has a list of reasonable themes that the study will contain, as a memory reminder. The interviewed person has the freedom to design the answer in his or her own way.

## Data analysis

All the interviews were transcribed verbatim and were then read by the authors several times to get an understanding and complete picture of the interviews. The authors marked meaningful units that answered and coupled with the purpose of the study. Then the authors highlighted meaningful units into condensations. Then different codes appeared and based on these codes emerged categories. Lundman & Hällgren-Graneheim (2012, pp. 190-191) explain this in different stages, the meaningful units are significant parts of the text and consist of sentences, words and paragraphs of text that belong together by their content. After picking the meaningful units the process continues with the condensation, which is a process to make the text shorter even if the essence is preserved. A code is a label on a condensation that briefly describes its content and several codes creates a category. Below there is an example from the authors’ analysis process (Table 1).

Table 1. Analysis of data

Meaningful unit	Condensation	Code	Category
Most of the villagers believe in, you know ghosts, and you know traditional healers, they you know, they sacrifice goats, sheep, to make away their ghosts from their house, so they stop coming here, it’s still people conservative.	Most villagers are conservative and believe in ghosts, sacrifice animals and turn to traditional healer	Believe in ghost, sacrifice, conservative	Distrust in Medicine
They come in health post and say ”you’re medicine is not work” and yeah, when I go to traditional healer, then I cure it. They say then I know nothing	Patients say traditional healer cure and medicines are not working	Medicine don’t work, traditional healer cure	
They think that in health post there are no good medicines, even same medicine, here and in the medical, they go and buy medicine in pharmacy, they don’t take medicine from this place, they believe that when they pay it is better than free things.	Patients rather buy medicine from pharmacy, they don’t believe in free medicines from health post	No good medicine, buy medicine from pharmacy, free things not good	

## Ethical considerations

Informed consent entails informing the research participants about the main features of the design and the overall purpose of the study, as well as of any possible benefits and risks from participation in the investigation. It further involves obtaining the voluntary participation of the people involved and also informing them of their right to withdraw from the research project at any time. It includes information about the participants data will be kept confidentially and that they can take part of the result as well (Kvale and

Brinkmann 2014, pp. 107-108). The participants received a document in Nepalese language which described the study and contained of all the above clauses and all the necessary information about the minor field study were presented. They also took note of the oral information given by the authors with the help of the interpreter. The results were kept anonymous and figures have been used to replace names and locations.

The researchers have a responsibility to reflect and illuminate the possible consequences their study may cause, not only for the persons taking part in the study but also for the larger group they represent. From a utilitarian ethical perspective, the importance of the knowledge gained and the sum of potential benefits to a participant should outweigh the risk of harm to the participant and thus warrant a decision to carry out the study well (Kvale and Brinkmann 2014, p. 110). The authors have considered the possible consequences and were aware of the worries in performing this study. By highlighting the risks and compare it to the gained knowledge, the authors and their supervisor chose to perform this study. Interviewing midwives in their villages required a high level of respect for the autonomy and all participants were able to choose where to perform the interview. An ethical consideration has been taken for the participants according to their social environment and individual perspective.

## **RESULT**

### **Findings**

The thematic content analysis revealed six areas that were seen as obstacles to the midwives ability to perform their work, challenging family hierarchy that prevented midwives from giving care, lack of education among the villagers, arriving to late to the health post, lack of resources and distrust in medicine. The interviews were performed in the Nuwakot region in villages that were ranging from 300m to 2500m above sea level, villages located at a higher altitude had less infrastructure and little accessibility by road. In the “low access” villages participants expressed more concerns and problems in their work.

### **Challenging family hierarchy**

Several participants described that the family members had great influence in the patients’ decisions making and that the husband is always the final decisions maker. Husbands were also said to react most violently when not agreeing with the advices given at family counseling. When participants were teaching in family counseling, their advices would sometimes interfere with the families own cultural beliefs about how to cook the food, aspects of hygiene, where to give birth and the use of birth prevention. A male participant described that the lack of education and understanding among the villagers could lead to violent reactions. After advising a family not to get any more children because of the health risks, a patients husband threatened to beat him and questioned him, ”why do you say these things to my wife!”.

The strong family hierarchy was also described to become an obstacle for several participants when the family did not allow them to help the patient. A participant described a situation where she was called to help a woman that had just given birth but

the placenta had not come out. When she arrived she was not allowed to help the patient until 3 pm because the family decided that a Traditional healer should first perform his work. Even after 3 Pm and even until the next day she was not allowed by the family to intervene, by this time the woman had become unconscious and the midwife told the family to quickly carry her down to the birthing center for treatment. But family members disagreed to carry since they thought the patient would die on the way anyway. The patient was left to die in her home and the participant felt sorry and sad because she felt she had the experience to save her life, "I thought I could have saved her life but their negligence killed her". A male participant described similar experiences when patients were left alone in their homes by their families and worried neighbors called him for help. "Yesterday we saw a child with the fever and the cold, and the neighbor called. No others, no family or mother, person from the next house called". The same participant also explained about a situation where he was called 2-3 hours after a home delivery. The patients mother had assisted in the birth and he was told that mother had some bleeding during the birth, he asked if the placenta had come out; "According to them it came out and at that time the mother was outside, they carried her inside to warm place and started breastfeeding. After 30 minutes they came again and said that the placenta was not out. I was worried that they had said yes and then no" When he arrived 15 minutes later the woman had already died. "I told her to go to district hospital and she agreed but he guessed that is some family problems".

### **Dangerous home deliveries**

Participants all described that they were working with getting women to health post or birthing center to give birth through mothers' communities or with the help of volunteers. In most villages midwives no longer went to patients homes to assist with birthing; instead they referred them to come to the birthing center. But women are still giving birth in their homes and are then being cared for by the family based on their cultural traditions. Participants described that a home delivery could include that the family made a bath for the newborn within 24 hours and the mother was not allowed to touch things during 11 days. The mother could only be cared for by other women and she had to stay in a separate part of the house. Participants expressed concerns about the high risks for infections when women are giving birth in a smoky and dusty home, and unclean tools are used to cut the umbilical cord. One participant expressed that he tried to explain for his patient that home delivery is risky; "if you come to the health post we save both you and your babies health". Even if several participants described that home deliveries are decreasing and that educated villagers bring their pregnant women to health facilities, long distance and poor economic situations still forced women to give birth at home.

### **Villagers lack of education**

Most villages where interviews were performed are occupied by the Tamang people speaking their own language with different dialects. The levels of education among the villagers were described by the participants to range from poor to basic level. Villages at higher altitude were reported to have a lower level of education and less knowledge in the Nepalese language. One participant stated that "prevent is better than cure" and

several participants in this study expressed the need of education among the villagers to be able to do their work in a more preventive manner.

The lack of understanding the Nepalese language caused barriers for the participants in their work since they themselves did not speak Tamang language. Advising patients without a common language required a high amount of midwives time and body languages together with pictured instructions were used to convey their advices to patients. "There is not enough time to explain, if you don't understand then it takes long time, you have to use body language and show". In the lower altitude villages' participants reported that almost all villagers spoke Nepalese and that the situation was significantly better than 10-15 years before. Participants were now able to teach the patients that passed the advices to her family and they could share their ideas.

Participants described that the government provides basic education and was mandatory to level nine, which included that they were taught in the effect of cultural beliefs. But participants explained that in this region, especially at high altitude, not all can go to education because they to work or live too far off from the village. There were also organizations providing education in some villages and one participant also reported that they organized health education monthly in the local school; "We have to improve their knowledge, this is our impact".

The lack of education among villagers were explained to make them rely more on their cultural traditions instead of following midwives advice; "When I advise they say yes but when they go home they don't follow". All participants agreed that raising the level of education among the villagers is the primary objective. If all villagers had a basic level of education and spoke Nepalese language, participants thought that their advices and counseling would be more effective and several health complications could be avoided. One participant reflected over the situation of education levels in his village in terms of; "It's seems like we are going back to the 13-1400 centuries".

### **Patients arriving too late**

Several participants claimed that villagers come late to the health post, usually they would first visit their traditional healer and when they we're not getting better they turned to the health post. The postponed seek of medical treatment gave participants concerns that sometimes valuable time is lost. A participant explained about a situation where a pregnant mother was about to give birth, the water had not gone and the baby had not yet started to come out. He told the woman's family to carry the woman down to the health post for further treatment, but instead the family first turned to the traditional healer "At 8-9 pm the traditional healer came and did his job. The Traditional healer used his hand inside and pulled out the baby. And after a few hours the mother vomits and went unconscious. After 2-3 hours both the mother and baby were dead".

Participants described that they encourage pregnant women to go to the health post; the government is rewarding pregnant women. If they fulfill four checkups and give birth at the health post they receive 1000 Nepali rupees and a set of clothes for the baby and the mother. "That's why people go there, first for the money, second it's good for you".

This however, caused concerns for a participant working at a private health post as they could not reward the pregnant women and few patients come to the health post.

The participants working in the lower altitude villages all expressed that now is better than past and in all villages severely injured persons usually come directly to the health post. Educated villagers understood that they need to go to the health post and families took their pregnant women to birthing centers or better facilities in Kathmandu. Villagers were also keener to follow advices and counseling given by the midwives.

### **Patients distrust in medicine**

Several of the participating midwives described situations where villagers both distinctly and subconsciously expressed their distrust against the health posts and medicines. Two participants expressed that the villages they were working in were highly conservative, and they experience a significant feeling of being distrusted. Villagers told participants that their medicines were not working and that a traditional healer could solve their problems better. The traditional healer was explained to use sacrifices to get rid of "ghost problems" and villagers blamed that it was free to go to the traditional healer, contrary participants described that health posts were also free and that the traditional healer always claimed something in return, "They say the traditional healer is free but it's not free, they have to give money or work as payment"

Skeptics against medicine were also described by participants working in lower altitude villages with good economic status. This was explained through that the villagers believed that the government would only hand out medicine for free because it was not real medicine. Even if health posts supplied several medications such as antibiotics, vaccinations and iron supplements, villagers rather turned to the local pharmacy to buy the same kind of medicine. If the participants did not give a patient any medicine they experienced to be distrusted because villagers expressed they were not real health care personnel and were only staying in the health post to gain salary from the government. "Ah you don't know anything, you are just here to get money and you don't know anything, you don't know how to give medicine". A male participant expressed that the villagers viewed him in a negatively way and that they thought he "only came for something" when he tried helping patients in their home.

In villages where cultural beliefs had high influence, participants described that they had found ways to cooperate with the local traditional healer, when describing medicines they instructed the patients to take them immediately after visiting their traditional healer. If they instructed patients to take the medicine first or not visit their traditional healer at all, patients did not believe in the medicine. One participant also told the traditional healer to immediately send patients to the health post after finishing his rituals.

During a birth taking place one participant described that she was caring for the patient at the same time a traditional healer was present doing a "light and quick ritual". She did not experience that the presences of the traditional healer or ritual caused any complications to her work; "People in this village have very deep believes, they do traditional things for their satisfaction".

## **Lack of resources but happy to help**

Some participants explained that they had the knowledge but couldn't perform their work. The lack of health care personnel, facilities, medicine, transportation and oxygen was described by several participants to become a barrier in their work; "There is a lack so many resources, like oxygen and suction equipment, also problem of transportation". They also explained that the risks of not having enough resources to take the correct measures or getting an ambulance when complications arise gave them feelings of fear and worriedness.

Participants explained a high workload consisting of vaccinations, cleaning programs, deliveries, family planning, medicines and all other patients in the village. They felt worried that there was no time but also no limitations of their workload. Being alone in the health post, participants had to focus on midwifery and vaccinations among the other tasks. One participant expressed that she had an immense responsibility but the government could not help her because the government is still poor.

But even if working with limited amounts of resources, all participants expressed feelings about their work in positive ways. Common for the participants was that they felt happy to help and that they always did the best they could for the patients. Even when being alone in health post with a limited amount of resources and high workload midwives expressed that it still felt good to work and that the villagers were good people; "If we help them nicely, they will be happy and we are happy". Giving education in mothers' communities and helping pregnant women with their fears during delivery were described as positive moments in their work. Volunteers were also described as a positive element, helping midwives with health education in the villages.

One participant stated about the village where he was working that "Their children is our children", a term that worked in two directions. Seeing the children in the village being healthy brought positive feelings to him, but it also inflicted sad feelings when he was not able to help them.

## **DISCUSSION**

### **Method discussion**

Critics argue that qualitative research is too subjective; research is also done on a small number of people with an unstructured interview form and for example in a small residential area which makes it difficult to generalize the results to other environments (Bryman 2002, pp. 269-270). However, the authors were aware of this and chose actively anyway to have a qualitative approach to the study since it's hard otherwise to capture midwives' experiences. The method was discussed with the authors' supervisor and carefully selected to suit the purpose of the study. According to Leininger (1993, p. 21) a quantitative method is extremely difficult to use when studying complex culture expressions and meanings such as hope, compassion, empathy and other constructs. Since this study's aim was to explore the experiences of midwives working

in a rural area of Nepal to create a deeper understanding of the transcultural complexity a qualitative design was chosen.

All research aim to find new knowledge and it usually has more alternative interpretations. Researchers must demonstrate the credibility related to the research results, and in addition to the veracity of the results is the credibility often about how the researcher's pre-understanding has left its mark on the analysis (Lundman & Hällgren-Graneheim 2012, p. 196). For the text to show its truth, the researcher should in the analysis process try to behave in a transparent manner. This means that the researcher allows the text to show itself in all its complexity (Friberg 2012, p.167). The authors were well aware of this when performing the analysis process, but despite awareness the authors pre-understanding might influence the result in the analysis because of the meeting as a phenomenon. During the analysis the authors worked together and discussed the result a lot of times.

Often in qualitative research there is an asymmetric power. If power is inherent in relationships and human conversation, the point is not that power should necessarily be eliminated from the research interview, the interviewer should instead reflect on the role that power plays in the production of knowledge (Kvale & Brinkmann 2014, pp. 51-52). The authors have considered the asymmetric powers influence on the result and don't believe that it shows in the presented data. There were sometimes during interviews that the participant misunderstood the question or couldn't speak freely because of language difficulties but otherwise the interviews findings were not characterized by asymmetrical power.

It can be difficult for interviewers to gain enough knowledge about the culture that the interviewee has. Cultural factors can influence the relationship between interviewee and interviewer. If the researcher encountering a new culture, he or her must be acquainted with the culture and learn things to prevent that the study end up on the wrong track. Besides understanding the culture, the social issues of translation are important. The interpreter must be carefully selected and should be culturally acceptable as well as proficient in the language (Kvale & Brinkmann 2014, 184-185). Before doing the interviews the authors red previous research and gained information about some of the cultural beliefs among Nepalese population. However, it was difficult to learn it all since there are many different types of religions and cultural beliefs in Nepal. The interpreter was chosen by using the contact person the authors had in Nepal.

## **Result discussion**

### **Key findings**

This study illuminates important factors of understanding midwives experience in their daily work in a rural area of Nepal, with very limited resources and strongly influenced by traditions and cultural beliefs. The midwives expressed difficulties in responding to the patient and her family in their cultural beliefs. Midwives also identified other areas that affected their work and were associated with the cultural beliefs. In some villages the low level of education among the villagers affected midwives work and patients didn't take advantage of the midwives' medical knowledge. Instead there was distrust in medicine and the patients' often choose to contact a traditional healer before the

midwife. The lack of resources made it hard for midwives to perform their work and the long distance sometimes caused patients' to deliver at home. But despite all this, midwives expressed the joy of working as a midwife and they all wanted to continue to improve the maternal care in Nuwakot.

### **Cultural care preservation**

This study shows that midwives in Nepal work in varying extent of giving care that aims to preserve the cultural values of their patients. While some participants described patients' culture and traditions mostly as an obstacle, other midwives worked to retain the cultural values and autonomy of the patients. The care provided by the later midwives in this study blends into how Leininger (2001, pp. 20-21) explains care preservation where the aim is to retain and preserve the patients' cultural beliefs, values and well-being.

The family hierarchy showed in this study to be of high importance for the patients decisions-making. This is consistent with the findings of Morrison et al. (2014) and highlights the importance of making the family feeling included in the care, both during the patients' pregnancy and delivery. When midwives visit patients' home to assist at delivery, they do not only need to protect the health of the patient and the newborn, but also their integrity and cultural values. With home deliveries being a past tradition in Nepal, family members might experience that it is compulsory for them to be involved in the caring of their pregnant family member. The authors believe that midwives must be open to what the family experience in the terms of health and caring, to understand what caring means for them and thereby gain a deeper understanding for the patient and family needs. A few participants expressed that they would not go to patients' homes to assist in delivery cases, a decision that creates a risk that the care becomes static and not individually suited to the single patients' needs. The authors believe that by treating every patient as a unique human being and involving their cultural needs in the caring, midwives could contribute to a wider transcultural nursing where the patient is the centre of caring actions.

All participants in this study recommended their patients to seek medical care first if they were sick or pregnant; but at the same time they gave the patients a choice whether or not to visit their traditional healer. Literature is lacking about traditional healers in Nepal but the authors compile them to persons performing non-medical care, referred to by some participators in terms of "witch doctors". In some situations participants let patients perform their traditional rituals with the help of a traditional healer during deliveries since they felt that patients had deep cultural believes and the rituals would gain their experience of well-being. By consciously trying to understand the patients' cultural beliefs and traditions, midwives can also identify the needs of both patient and family and influence in their experience of receiving care. Midwives should also be open to learn and embrace knowledge from the patient and family members about their own social dimensions and cultural values, which might be at risk in a situation when a family member needs health care.

Leininger (2001, pp. 38-40) writes that understanding the patients' knowledge and their view of the world is imperative to design and implement culturally congruent care that

promotes health and wellness. This study shows that communication through speaking became a barrier for the participants since they did not speak the same language as many of their patients. The authors believe that a better language skill from both midwives and the patients could contribute to a transcultural care. Participants explained that a high workload and insufficient amount of time made it very hard for them to assign enough resources to patients that had problems with communication and understanding. But even if the patient and midwife did not always speak the same language, the authors believe that a better understanding for the patients' life world can still be reached. Dahlberg & Segesten (2010, pp. 208-209) writes that nurses need to be open and pliable for the patient's life-world. By approaching patients with a phenomenological approach and open mind, much could be learned about the patients' culture even without literally speaking. When spoken words cannot be used, nurses need to use their other senses such as seeing, hearing and feeling. The authors separate speaking of words and hearing since even if you do not speak the same language, a lot can still be told by listening to how and when the patients speak. Physical expressions, such as laughter, crying, sadness, happiness, worriedness etc. can all be expressed without speaking a single word. Embracing and understanding the patients' cultural values and beliefs is important for nurses to be able to give a cultural based care.

### **Cultural care accommodation**

Care accommodation is when the care aims help to adapt and negotiate for the people to share the optimal health outcome. The concept also aims to help people of a designated culture to negotiate or to adapt, with others for a satisfying or beneficial health outcome with professional care providers. The professional care workers actions such as being supportive, assistive or facilitative enable to retain the care values (Leininger 1993, p. 20). The findings from this study shows that participants strive to give the best possible maternal care at times that required them to negotiate with patients' cultural values and traditions. Even though all participants recommended their maternal patients to come to the health post or birthing centre for both checking and delivery, many patients still gave birth at home. This was explained by the participants to be either the patients' own choice, inflected by the family members or by long distance to medical care. Participants experienced home delivery as a high risk of infections and danger when babies were born with complications, findings that comply with the results of Kaphle, Hancock & Newman (2013). Further, this study shows that home delivery could also include that the family made a bath for the newborn within 24 hours which was not recommended by the midwives. At the same time the home could be experienced by patients and family as a safe place and the caring of the newborn baby was based on far-reaching traditions. This situation created a contradiction between medical advices and the patients' own cultural perception which required the midwives to work with a high level of transcultural understanding. Even if caring for the patient in the home is not the optimal from a health aspect, midwives must negotiate with the patient to make the care as effective as possible. If the patient gives birth at home, the midwife needs knowledge in how he/she should respond to the patient and family's cultural beliefs. The authors want to illuminate the importance of the midwife and patient need to meet halfway in order to make their meeting become caring.

Health care workers should be aware of that they always have some kind of prior understanding, but being open-minded and flexible for another person's uniqueness means to meet the other without as much as possible prior understanding. The life-world perspective emphasizes flexibility and openness to the patients' lived world and an ethical aspect is in session (Dahlberg and Segesten 2010, p. 155). In this study the authors are aware of how complex the situation is, as some participants stated that they would not go to a patient's home to assist in a birthing, while others expressed that they were always happy to help. Caring with a cultural based perspective puts demands not only to assist the patient but also to understand why the patient rather would like to give birth at home. Being open-minded includes being willing to understand and accept the patient and her family's culture, but some participants seemed to limit the preservation of culture for when culture indicated to be a threat against the patients' health. It complies with Dahlberg and Segesten (2010, p. 118-119) that states that relatives and family can be a beneficial resource for the patient, but limits must also be considered to what extent they should be allowed to influence the patients care.

Cultural care accommodation or negotiation can involve such as religious practice, culture food preferences, child care, kinship needs and treatment practices that are held to be imperative to provide satisfying or beneficial care (Leininger 2001, p. 42). A few participants in this study described situations when they were not allowed by the family to help the patient. The husband was described to be the decisions maker in the family and reactions from the family during counseling could sometimes be violent. This highlights the importance of that family members understand not only what the midwife is advising, but also why to provide a beneficial care. Explaining for a family that they should not get more children was described as a complicated task by participants and shows the need of midwives to respond to the patient's desires and view the situation from her life-world perspective with a holistic view. Informing the patients and the families of the risks involved with getting more children, while still allowing them to take their own decision could be a possible way to negotiate for a better health outcome and at the same time respect the autonomy of the patients.

Cultural care must blend with cultural values, beliefs and life-ways of people. There can be no curing without the giving and receiving of care (Leininger 2001, p. 20). The findings showed that some participants let the patient contact the traditional healer first and they respected the patient's wish of performing spiritual rituals, before or when receiving care. Through this the meeting with the patient became more caring and patients accepted and received their care. Midwives sometimes cooperated with the traditional healer and they both performed their work at the same time to enable the best possible care for the patient and her well-being. Some midwives also explained that they told the traditional healer to refer the patient to the health post as quickly as possible after visiting the traditional healer.

Participants described that the Nepali government has initiated a reward for pregnant women to lower the premature death rates. If pregnant women come for health checks and delivery at health posts or birthing centers, they are paid and receive clothing for themselves and the baby. In advance they also get free checking and medical care during their pregnancy. However, participants described that pregnant women were primarily coming for the money and not for the health benefits. This is strengthened by

the fact that private health posts that could not pay pregnant women neither received any maternal patients, instead patients choose to seek help from governmental health posts. The authors believe that a strategy of rewarding maternal patients will help to lower the premature deaths in Nepal but at the same time it indicates that the care provided is not sufficiently cultural based. The Nepali government is basically paying their own citizens to use their supplied free medical care. The authors believe that by supplying education and understanding the peoples' cultural beliefs in based in their life-world a better understanding and congruent care could be reached. The influence and importance of an increased transcultural care could be pervading through the whole maternal health care system of Nepal.

### **Culture care repatterning**

Leininger (1993, p. 20-21) states that care repatterning is when the caring aims to change or modify a health behavior. This study points out that midwives in Nuwakot region are working in a cultural repatterning behavior, advising, counseling and caring measures that all aim to educate, change and modify caring behaviors. The participants explained cultural beliefs as an obstacle to their medical care. The cultural influences were also explained by midwives to influence negatively and made patients less keen to follow medical advices. The authors suggest that by learning about the patients' cultural rituals and beliefs a greater understanding could be achieved. This study also shows that midwives did not understand the Tamang language which was spoken by most villagers. The inability to communicate appears to be a possible missing link to facilitate the meeting between the midwife and patients. The authors believe that increased knowledge in language and information customized to the patients and family's educational level would benefit in caring for the patient with a transcultural perspective.

All participants in this study expressed that they were happy to help and that they felt that the children of the village were their own children. When midwives went through situations where they were disabled to help by the patients' cultural beliefs or families, they all expressed feelings of sadness and worriedness. But they also expressed that they did not hold any grudge against the families, instead they continued to do all they could for their patients. The authors believe that midwives must have patience and allowing it to take time when trying to accomplish health behavior changes.

Dahlberg and Segesten (2010, p. 121) writes that relatives can be a crucial factor for the patients' ability to regain and keep a perception of health, but they can at the same time also inflect negatively. In this study results shows that relatives can work both as a strengthening resource for the patient, but they can also become a barrier which prevents patients from receiving medical care, which can be life-threatening. The patients' social structure where the family has a strong hierarchy demonstrates that midwives need to keep in mind that the whole family should be involved as much as possible in the caring for the patient and specifically in the culture care repatterning. Changing patients' and families perception of caring where cultural and traditions are strong must be allowed to take time and be based on a mutual understanding. The midwife needs to meet the patient and her family with an open mind and let change grow from their own life world.

This study describes that many of the villagers in Nuwakot have distrust towards the health post, medicines and the government in Nepal. The participants' experiences that the lack of a basic education among the villagers made them believe and rely on their cultural beliefs. This is consistent with previous research by Kaphle, Hancock and Newman (2013) who explain in their study that village people instead of trusting in medicine had a strong faith in their traditional healers. Participants in this study explained that if all villagers had a basic level of education they thought that they would be able to work in a more preventive manner. Education was also said to be an important part in understanding cultural influences and learning not to follow traditions, which puts basic education in the dimension of culture care repatterning.

The authors believe that barriers explained by midwives such as culture, language, distance, family hierarchy must be identified and analyzed. By identifying obstacles that midwives experience in their daily work in the district of Nuwakot of Nepal, the maternal care in can reach a new higher standard and further improve the maternity mortality rate.

### **Emic and etic dimensions of caring**

This study showed that the families influenced on the patient decision making and it affected the patients' care. This agrees with recent research by Morrison et al. (2014), they describes the women low status and how different family members influences on the patient's decision making. In this study it was also shown that the lack of education among villagers was an obstacle for midwives when they were giving advice to the patients. The authors think it's important for midwives to be able to respond to the patient and her family members. However, the author's reflections are whether midwives previous education contained some form of training in responding to patients and their families with cultural beliefs. Leininger (2001, pp. 33-37) describes the constructs of emic which means the insider's knowledge and etic which is described as the outsider or stranger's viewpoint. Together they form the two sides of cultural care.

## **CONCLUSION**

This study shows that the caring of maternal patients in Nepal could benefit from a transcultural caring perspective pronounced by midwives. The caring by midwives in Nepal today can already be applied through Leiningers (2001, pp. 48-49) culturally congruent nursing care in the three dimensions of cultural care preservation, cultural care accommodation and cultural care repatterning. This study highlights the importance of midwives in Nepal to identify, implicate and express the cultural dimensions of caring. Transcultural dimensions must be recognized and identified as a natural part of maternal caring in Nepal.

Patients in Nepal need to be reached both by distance and by communication, the midwives need to learn and understand the patients' culture, social dimensions and traditions. Education is the foundation to build the future of Nepal and the authors suggest that it is an important part of the road to a mutual understanding between midwives, patients and families. But the authors also express that even if education is the way to improvement in maternal care, it can work as the opposite to culture. It must

be kept in mind that a transcultural understanding is necessary, not only within the health care sector.

Further research is necessary to determine how transcultural caring could be recognized and cultural caring theories integrated into the education and practical caring of Midwives in Nepal.

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## Appendix 1

Below are examples of table analysis for all five categories;

Meaningful unit	Condensation	Code	Category
Family members have high influence in the patients decision-making	Family members high influence on patient	Family high influence	<b>Challenging family hierarchy</b>
Family has a lot in influence in the decisions making, specially the husband, he is the decisions maker.	The Husband is the decisions maker	Husband decision smaker	
Sometimes people want more children and a bigger family, in family planning it's better to have one or two kids, and this education makes them a bit unhappy. They react.	Family react to education about not getting more children	Education, unhappy, want more children, family reactions	
Mothers community gives advice, explains health post is safe place to give birth	Mother community explains health post is safe	Health post safe	<b>Dangerous home deliveries</b>
Family make bath for newborn within 24h, home is not clean, smoky and dusty, increased risk of infection for mother and child	Bath for newborn and the unclean home is risk for infections.	Bath, unclean home, infection risk	
Before people think there is no birthing center here, now there is more people coming day by day. One of the reasons that, much up and down and long distance so they have to give birth at home.	Long distance makes women give birth and home but now more people come to birthing center	Long distance, home delivery, more people coming	
We launch in local school, every month, one health education, improve in villagers their knowledge, it is our impact.	Health education in local school once a month is our impact	Health education, improve knowledge, impact	<b>Villagers lack of education</b>
Few villagers are educated. They have medium level, not so high. But not all the villagers, not the older.	A few villagers have medium level of education and the older no education.	Few educated, medium level of education, older no education	
More patients come and there is no enough time to explain, if you don't understand then it takes long time, you have to use body language and show the things. All the things have to be done by few people	Lack of understanding takes long time, use of body language, few people when more patients come	No time, language barrier, body language, few people	
Most patients are cultural beliefs, like "dieminanry", first they treat with "dieminanry", sacrifice (Witch doctor) then, they are not cured, they come here to health post	Patient first treat with Witch dr. and when not cured they come to health post	First witch dr., not cured then health post	<b>Patients arriving too late</b>
To check their body in time, they supposed to check 4 times during delivery time. If they come these times they receives money from the government. And when they come here to delivery they get 1000 rupies, and clothes for mother and child. These things are provided by the government.	Government provide money and clothes for pregnant woman for doing 4 checkups and delivering at health post.	Government pay for check-ups, clothes for baby and mother	
Most of the patient is going to *****, but not coming, this health post, because this is a private we cannot, we cannot pay them money.	Private health posts can't pay pregnant woman and patients don't come	Health post can't pay, patients not coming	
Most of the villagers believe in, you know ghosts, and you know witch doctors, they you know, they sacrifice goats, sheep, to make away their ghosts from their house, so they stop coming here, it's still people conservative.	Most villagers are conservative and believe in ghosts, sacrifice animals and turn to witch dr.	Believe in ghost, sacrifice, conservative	<b>Distrust in Medicine</b>
They come in health post and say "you're medicine is not work" and yeah, when I go to witch doctor, then I cure it. They say then I know nothing	Patients say witch dr. cure and medicines are not working	Medicine don't work, witch dr. cure	
They think that in health post there are no good medicines, even same medicine, here and in the medical, they go and	Patients rather buy medicine from pharmacy, they don't	No good medicine, buy medicine from	

buy medicine in pharmacy, they don't take medicine from this place, they believe that when they pay it is better than free things.	believe in free medicines from health post	pharmacy, free things not good	
In a month I have to go in the village, for three days cleaning program, and three days vaccination, in a month, and also they come here for safety delivery, I have to do, and also the family planning, and other types of patients I have to help here. And I have to wait for children that is under five, and give medicine, so many things to do.	Feel there is so many things to do, vaccination, cleaning program, deliveries, help other patients and medicine.	So many things to do	<b>Lack of resources but happy to help</b>
I have so many responsibilities and some of them even the government cannot help now days because the government is still poor.	So many responsibilities and the government can't help because it's still poor	Responsibilities, poor government	
I normally give vaccinations, working with the pregnant women and their children. And I give some educations to the women in the villages now days they have mothers coming and communities giving education to them, this is the positive things.	The positives things are working with vaccinations, pregnant women and mother communities.	Positive things, vaccination, pregnant women, mother communities	