

**A MODEL FOR INCORPORATING “INDIGENOUS” POSTNATAL CARE
PRACTICES INTO THE MIDWIFERY HEALTHCARE SYSTEM IN MOPANI
DISTRICT, LIMPOPO PROVINCE, SOUTH AFRICA**

By

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DECLARATION

I Roinah Nkhensani Ngunyulu declare that **“A MODEL FOR INCORPORATING “INDIGENOUS: POSTNATAL CARE PRACTICES INTO MIDWIFERY HEALTH CARE PRACTICES IN MOPANI DISTRICT OF LIMPOPO PROVINCE, SOUTH AFRICA”** is my own work, that all sources that I have used or quoted have been indicated and acknowledged by means of complete references, and that this work has not been submitted for any other degree at this or any other institution.

.....

R.N. NGUNYULU

.....

DATE

DEDICATION

This thesis is dedicated to:

- My father-in-law Masenyani Jackson Ngunyulu, who was eager to see me graduating but rested in peace before the study is completed.
- My daughter, Queen Victoria Ngunyulu who passed away during data collection.
- My Sister-in-law Ndaheni Irene Ngunyulu who passed away during the early stages of report writing.
- My Sister (co-worker) Priscilla Mabobo who motivated and encouraged me during the proposal development stage but passed away before completion of the study.

Special gratitude goes to my dear husband, Magezi Elliot Ngunyulu (Makambeni), my sons Nkateko Glen and Kulani Chris, and my daughter Tlangelani Sharlote. Thank you so much for the support, motivation and encouragement you provided throughout the study.

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ABSTRACT

Model development for incorporating “indigenous” postnatal care into a midwifery healthcare system is of utmost importance in ensuring the provision of culturally congruent care. There has been only limited evidence of the availability of a model which addresses “indigenous” postnatal care practices in midwifery health care systems. As a result, the nurses operate from a modern healthcare point of view only, rather than combining the two worldviews. The main aim of the study was to develop a model for incorporating “indigenous” postnatal care practices into the midwifery health care system in Mopani District, Limpopo Province of South Africa. The study was conducted in three phases. During the first phase the meaning of the concept ‘incorporation’ was analysed. The results guided the researcher during data collection in the second phase, consisting of in-depth individual and focus group interviews to explore the experiences and perceptions of postnatal patients, family members, traditional birth attendants, registered midwives, Midwifery lecturers and the maternal and child healthcare coordinators. The findings confirmed that currently the “indigenous” postnatal care practices are not incorporated in the Midwifery curriculum, books or guidelines for maternity care. As a result there is lack of knowledge amongst midwives regarding the “indigenous” postnatal care practices and it is difficult for them to provide culturally congruent care. Due to inadequate knowledge midwives are displaying negative attitudes towards the family members, traditional birth attendants and patients from diverse cultures. The participants confirmed that there is no teamwork between the registered midwives and the traditional birth attendants (family members). The study findings also confirmed that currently there are no follow-up visits by the midwives for patients during the postnatal period. The midwives are imposing their health beliefs and practices onto the patients on discharge after delivery, without the involvement of the family members or the traditional birth attendants, resulting in sub-standard postnatal care, leading to postnatal complications and an increasing maternal mortality rate. Based on the findings of phases one and two, a model for incorporating “indigenous” postnatal care practices into a midwifery healthcare system was developed and described. The implications for further studies suggested the evaluation and implementation of the model in the healthcare institutions, nursing colleges, clinics and hospitals as an

initial step to assist the Department of Health in Limpopo Province in incorporating “indigenous” practices into healthcare systems.

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LIST OF ABBREVIATIONS AND ACRONYMS

TBA,S	:	Traditional Birth Attendants
HIV	:	Human Immunodeficiency Virus
AIDS	:	Acquired Immuno Deficiency Syndrome
WHO	:	World Health Organization
UNICEF	:	United Nations Children's Fund
SANC	:	South African Nursing Council
MDG, S	:	Millennium Development Goals
NEA	:	Nursing Education Association
DoH	:	Department of Health

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CHAPTER 1

ORIENTATION TO THE STUDY

1.1 INTRODUCTION

This chapter highlights the process that was followed during the development of a model aimed at incorporating “indigenous” postnatal care practices into a modern Midwifery Healthcare system. Currently there is no model that addresses “indigenous” postnatal care practices in the country’s midwifery healthcare system, as globally they have been viewed as anomalies or witchcraft, with nursing professionals, including registered midwives, being trained within the biomedical paradigm (Bouwer, Dreyer, Herseiman, Lock & Zeelie 2006:55). As a result, nurses have operated within the modern healthcare point of view, only occasionally combining the “indigenous” worldview to provide culturally congruent care (Bouwer et al 2006:55).

The integration of “indigenous” postnatal care practices into a midwifery healthcare system is of utmost importance in ensuring the provision of culturally congruent care. Recent studies into its provision have, however, recommended the incorporation of “indigenous” practices into western healthcare practices through education and research (Ngunyulu & Mulaudzi 2009:56). Similar views were reiterated by Makhubele and Qalinga (2009:155) and Hewson, Javu and Holtman (2009:5), that “indigenous” knowledge should be incorporated in the midwifery syllabus to ensure that midwives learn alternative “indigenous” practices during the postnatal period and so improve the quality of maternal and child care. Team work between the midwives and the traditional birth attendants might be enhanced and maintained. The family members and traditional birth attendants might be empowered with knowledge and skills regarding postnatal care, resulting in provision of safe postnatal care.

Basic midwifery training has been incorporated in the South African Nursing Council Regulation R425 of 22 February 1985, as amended, one of the

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programme's objectives, in section 6 (20 (a)), being that on completion of the course of study the student should be able to: (1) show respect for the dignity and uniqueness of humans in their socio-cultural and religious context; and (2) understand them as a psychological, physical and social being within their contexts. Meanwhile, one of the Limpopo College of Nursing curriculum objectives is that "at the end of first year of study in Midwifery, learners should be able to discuss psychological and cultural implications of pregnancy, labour, delivery and postnatal period on the family"; however, the assessment criteria to meet this objective were not clearly documented (Limpopo College of Nursing Curriculum 1997:76), leaving lecturers to compile their own assessment criteria to assist in implementation of this objective. Although regulation R425 stated that current midwives were obliged to provide total care to patients from different cultural groups, there has been insufficient evidence to indicate that cultural competencies are one of the skills that were evaluated during Midwifery examinations (R2488 1990:3).

There has been lack of emphasis on culturally congruent care in current midwifery regulations (R2488 1990:3), and the "indigenous" practices regarding postnatal care were not included in the *Guidelines for Maternity care in South Africa* (2007:42) or *Nursing Strategy for South Africa* (2008:8). Fraser, Cooper and Nolte (2010:20) did write on cultural awareness, cultural differences and cultural stereotyping, but the researcher felt this is inadequate to enable registered midwives to render culturally congruent care during antenatal care, labour, delivery or postnatal care. Hence, the researcher was motivated to elicit the perceptions and experiences of interested stakeholders, notably postnatal patients, family members, traditional birth attendants, registered midwives, midwifery lecturers and maternal and child healthcare coordinators, and obtain information that would assist in the development of a model for incorporating "indigenous" postnatal care practices into a midwifery healthcare system and curriculum.

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1.2 BACKGROUND AND EXTENT OF THE PROBLEM

The increasing rate of maternal mortality is of serious concern around the world, including South Africa (Osubor, Fatusi & Chiwuzie 2006:159). According to the World Health Organisation (WHO) and the United Children's Fund (UNICEF) more than half a million women die every year because of complications related to pregnancy and childbirths (WHO 2008:1; UNICEF 2008:1; Ngula 2005:14). Maternal death has been defined by WHO as the "death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of duration and site of pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes" (WHO, 2008:1). Preventing death of a mother has a critical impact on health of children, spouse and other family members, and the target for Millennium Development Goal (MDG) number 5 has been to reduce the maternal mortality ratio by three quarters, between 1990 and 2015 (Campbell & Graham 2006:1284).

Based on the purpose of this study the researcher concentrated on postnatal care, during which a number of serious complications and maternal deaths occur (Singh, Padmadas, Mishra and Pallikadavath 2012:6). The most frequently experienced problems during postnatal care include perineal pain, postpartum haemorrhage, puerperal sepsis, postpartum depression, fatigue and bowel problems (Yang, Ginsburg, Simons 2012:146 and Abhiyan 2012:16). With the HIV/AIDS pandemic the risk of postpartum infections has also increased (Turan, Miller, Bukusi, Sande & Cohen 2008:588); therefore, provision of culturally congruent care during the postnatal period might assist in the prevention of infections, serious complications and even deaths, related to pregnancy and childbirth. Currently there are several "indigenous" postnatal care practices that should be avoided in order to prevent postnatal infections. These include poor personal and environmental hygiene in some families, such as cutting the cord using an unsterilized razor blade, or in one case of postpartum haemorrhage the traditional birth attendant (TBA) taking soil into the hut and advising the woman to sit on top of it until bleeding stopped (Ngunyulu & Mulaudzi 2009:63). In contrast

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to the harmful practices described here, there are “indigenous” practices that are potentially helpful in enhancing the physical and emotional well-being of postnatal patients. The following are examples of helpful “indigenous” practices that are employed by family members and traditional birth attendants when taking care of postnatal patients: the woman is excluded from all house chores, the baby is kept warm at all times, the woman is served with warm special diet “xidlamutana” a finely grinded corn porridge which promote production of breast milk for infant feeding, if she has an episiotomy, she is encouraged to clean the wound with warm water daily, and compresses using “munywana” for fast healing of the perineal wound (Ngunyulu & Mulaudzi, 2009:58). The same view was shared by Geckil, Sahin and Ege (2006:67), who viewed the postnatal phase as a period in which pregnant women and their babies were vulnerable to illness and even death. It was, therefore, important that midwives become skilful and knowledgeable in dealing with physical, emotional, spiritual and “indigenous” related ailments and high risk practices that might affect the woman during pregnancy, labour, delivery and postpartum period..

An insufficiency of “indigenous” knowledge amongst midwives has affected decisions made by midwives when communicating with postnatal patients, especially when giving health advice on discharge. The misunderstanding of health advice by postnatal patients has caused delays in recognition of complications and the seeking of medical attention, resulting in death and/or disability (Warren, Daly, Toure & Mongi 2008:80). According to Kendrick and Manseau 2008:407) “indigenous” knowledge has been the information base for a society which facilitated communication and decision-making regarding the care of postnatal patients. Therefore, this base amongst midwives could facilitate communication and decision-making in provision of culturally congruent care. The issues of culture and “indigenous” knowledge are interrelated, so when a registered midwife is able to understand the beliefs, values, norms and practices of postnatal patients he or she should be able to provide more culturally congruent care.

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Such improvements to maternal health would help in the achievement of other Millennium Development Goals, particularly those related to poverty eradication, female empowerment, child survival and infectious diseases (Campbell & Graham 2006:1285). The incorporation of “indigenous” healthcare practices in postnatal care could save the lives of hundreds of thousands of women worldwide, and empower registered midwives with knowledge and understanding of the different cultures they may be working with. “Indigenous” practices such as keeping the woman and the new-born baby in the grannies hut, preventing the woman from doing household activities, preparing warm soft porridge called “xidlamutani” and not allowing other family members including the husband to enter the grannies hut, are helpful in enhancing the physical and emotional well-being of the postnatal woman and the baby.

‘Culture’ refers to inherited, learned, shared and transmitted ways of life, including knowledge of values, beliefs, norms and practices in which individuals and groups of people have been socialised (Maganda 2012: 51, Johnsen, Hansen 2007:421; Heikkila, Sarvimaki, Ekman 2007: 359; George 2008:407). A person’s cultural world includes the following aspects: age, gender, disability, political view, dietary habits, ethnicity, sexual relations, education, preferred language, work status, socio-economic factors, religious beliefs and practices and other areas (Leininger & Mac Farland 2006:204). Every woman has her own cultural context which needs to be understood by healthcare practitioners, including midwives, if they are to meet her unique needs.

On the other hand, ignoring the cultural differences, values and beliefs amongst postnatal patients might lead to misdiagnosis, harmful care, non-adherence to treatment, staff frustration and anger. These in turn may result in serious complications, disability and even death (Leininger & McFarland 2006:205). A similar view has been shared by Eckermann, Dowd, Chong, Nixon, Gray, Johnson & Binan, (2006:4), who revealed that nursing care that was culturally based contributed to physical, mental and social wellbeing of individuals, families and even communities. Respect for a patient’s values, norms and beliefs might have

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better outcomes in provision of quality patient care, as evidenced in Raju (2006:23) study of the “ageing in India in the 21st Century: A Research Agenda”.

The need for incorporating culture into nursing care and nursing education was suggested long ago before the 1960s, by Leininger (1995:5) in her theory of the ‘sunrise model’ of transcultural nursing, which states that nurses, including registered midwives, are expected to have the appropriate knowledge and skills to understand of cultural expressions and specific symbols (Leininger 1997:342). However, in general they have been reluctant to recognise this (Leininger & McFarland, 2006:79), resulting in delayed achievement of recommended developmental milestones towards incorporation of “indigenous” care into Western healthcare being slow (Tuck, Moon, & Alloca, 2012: 409; Siantz & Meleis 1996:12).

There is a demand for registered midwives to become culturally sensitive in order to meet the needs of, and to enhance and maintain cultural safety for, a diversity of patients (Kruske, Kildea & Barclay, 2006:75). For registered midwives to deliver culturally sensitive nursing care, they must remember treat each patient as a unique product of past experience, with her own cultural beliefs, values that she learned, and that will be transmitted from one generation to the next (Giger & Davidhizar, 1995:8). Furthermore Peu, Tshabalala, Hlahane, Human, Jooste, Madumo, Motsomane, Nemathaga, Nzimakwe, Oosthuizen, Ritcher, Selaedi, & Xaba, (2008:12) also stressed that to ensure cultural sensitivity, nurses should treat the clients as unique individuals with dignity, observing and respecting their rights. Leininger and McFarland (2006:18) maintain that care is embedded in people’s culture, and without care there would be no curing. They argue that every culture has both “indigenous” and Western healthcare practices, but there is a great demand in discovering the “indigenous” postnatal care practices before culturally congruent care practices can be adopted.

One strategic approach undertaken by WHO (2008:2) designed to reduce maternal mortality rate was to empower individuals, families and communities to increase their control over maternal health. Another strategy was to exploit all

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opportunities to strengthen the knowledge base, self-care and care-seeking within the community, particularly regarding a woman's postpartum needs, and to create new opportunities for the provision of culturally congruent nursing care by the midwives. A multidisciplinary team approach is another strategy advocated for the implementation of primary healthcare. This approach seeks integration of "indigenous" knowledge and modern healthcare (McGill, Felton 2007:50), whilst, for Geckil et al. (2006:70), the training and education of midwives in culturally congruent care was recommended following a study of the traditional postpartum practices of women and infants in South Eastern Turkey. In India, the training of family members and traditional birth attendants on the care of postnatal women has long been an aim in improving maternal and child healthcare practices (Raju 2006:200).

Hewson, Javu and Holtman (2009:16) pointed out that "there is a need to acknowledge the role played by "indigenous" healthcare practitioners as well as those practicing complementary healthcare methods". In addition, they further recommended that "indigenous" healthcare practitioners should receive basic training regarding care of postnatal women (Tuck, et al 2012: 409).

Due to inadequate training in culturally congruent care, some current midwives still view "indigenous" postnatal practices as non-religious, unprofessional and anomalous while, others as 'witchcraft'. Such views result from a lack of appropriate understanding of the cultural beliefs, values, attitudes and practices of diverse postnatal patients (Tuck, et al 2012: 409).

1.3. RESEARCH PROBLEM

In South Africa, some changes in attitude have been noted, for instance with recognition of the TBA in the Traditional Health Practitioners Act No 22 of 2007, and legislation for the promotion and regulation of liaison between traditional health practitioners and other registered health professionals. However, the necessary promotion and liaison strategies required were not clearly defined.

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Similarly, whilst Section 6 of the Traditional Health Practitioner's Act no 22 of 2007 (2007:10) reads that, "Council might approve minimum requirements pertaining to the education and training of Traditional Health Practitioners in consultation with relevant departments, quality assessment bodies or a body of Traditional Health Practitioners accredited by the Council for this specific purpose", at the time of writing this function has not been implemented.

Prior to adoption of universal suffrage in the 1990s, South African nursing care providers used mainly a western model, but as the profession became more sensitive to its multicultural composition, with the various ethnic groups bringing their own cultural beliefs, values, norms and practices into the national healthcare system (Parucha 2005:1), the pressure to combine the western methods with "indigenous" ones grew. Patients from different cultural groups realised that they now had a right to both "indigenous" and western care during the postnatal period, and what Blue, Brown, Hederson, Basu, Reimer, Lynam, Semenink and Smye (2003:196) have defined as 'cultural safety', that is assurance "that the system reflect[s] something of your culture, your language, your customs, attitudes, beliefs and preferred ways of doing things". In this study, cultural safety of postnatal patients, carried out by culturally sensitive midwives, is regarded as the most important outcome of culturally congruent nursing care.

With maternal mortality being one of the serious health challenges facing South Africa,(Gabrysch, Lema, Berdriana, Bautista, Malca, Campbell & Miranda 2009:724), there is an urgent necessity to recognise and address it. According to Geckil et al. (2006:67), a number of serious complications and maternal deaths occur during the postnatal period due to postpartum infections, including HIV/AIDS. Furthermore they pointed out that during the postnatal period, women and their new-born babies are vulnerable to postpartum infection, illness and even death. One of the measures to address this challenge is to incorporate "indigenous" postnatal care practices into a midwifery healthcare system (Hewson et al 2009:155). Globally, "indigenous" postnatal care practices have been regarded as of lower status than western ones, and South African registered

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midwives have been trained within the western paradigm. Consequently, they still concentrate on western postnatal care practices and reject, either wittingly or unwittingly, “indigenous” healthcare practices (Ngomane & Mulaudzi, 2010:35)

1.4. AIM OF THE STUDY

Against this background, the motivation behind the study was to develop a model which might serve to guide the Department of Health and Social Development in the incorporation of “indigenous” postnatal care practices into a midwifery healthcare system, as well to fill a gap (lack of “indigenous” postnatal care practices) in the research literature on a topic of great importance to the profession and society in general. For the model to be holistic, the perceptions and experiences of postnatal patients, registered midwives, midwifery lecturers, maternal and child healthcare coordinators, family members and traditional birth attendants was necessary. Therefore, the objective was related to practice integration.

1.5 OBJECTIVES OF THE STUDY

The objectives of the study may be broken down into three phases, as follows:

- **Phase one:** To describe the meaning of incorporating “indigenous” postnatal care practices into a midwifery healthcare system.
- **Phase two:** To explore and describe the perceptions and experiences of postnatal patients, family members, traditional birth attendants, registered midwives, midwifery lecturers and the maternal and child healthcare coordinators regarding the incorporation of “indigenous” postnatal care practices into the midwifery healthcare system.
- **Phase three:** To develop and describe a model for incorporating “indigenous” postnatal care practices into the midwifery health system.

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1.6 RESEARCH QUESTIONS

For the purpose of this study the following research questions were posed:

- What is the meaning of incorporating “indigenous” postnatal care practices into a midwifery healthcare system?
- What are the perceptions and experiences of postnatal patients, family members, traditional birth attendants, registered midwives, midwifery lecturers and the maternal and child healthcare coordinators regarding the incorporation of “indigenous” postnatal care practices into a midwifery healthcare system?
- How could a model for incorporating “indigenous” postnatal care practices be developed?

1.7 PARADIGMATIC PERSPECTIVE

A paradigmatic perspective is described by Bogdan and Biklen (2003:22) as a way of looking at the world, the assumptions people have about what is important and what makes the world work. They further indicated that a paradigm is a loose collection of logically related assumptions, concepts and propositions that orientates thinking and research.

If the assumptions of the researcher highlighted in this study were carried out logically they could lead to the development of a theory. They were controlled by the paradigm of the discipline, and as a result the researcher’s paradigmatic perspective is reflected in meta-theoretical, central theoretical, theoretical and methodological assumptions, discussed as follows:

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1.7.1 Meta-theoretical assumptions

Meta-theoretical assumptions on issues significant to the study are as follows:

- **Humanity**

The researcher believes in the spirit of *ubuntu*, which states that human beings are not islands or living in isolation, but rather people amongst other people and people because of other people. They are because they are, and they need to relate with other people. People are expected to provide care to other people (George 2008:412). In this study the registered midwives should consider the cultural beliefs, norms, values and practices of postnatal patients in order to ensure the provision of culturally congruent care.

- **Environment**

The researcher believes that the postnatal patients from different cultural groups have the right to receive care in an environment that is culturally safe and respectful. In order to ensure this, midwives should recognise patients of different cultures, and create an environment that reflects something of their culture, language, customs, attitudes, beliefs and preferred ways of doing things (George 2008:412).

- **Health**

The researcher believes that registered midwives should have knowledge of different cultural groups in order to provide culturally congruent care, thus enabling them to promote and maintain the health of the mother and her new-born infant during the postnatal period. There should be incorporation of “indigenous” postnatal care practices into the midwifery healthcare system through model development (Gunnayi & Hewson 2008:159), which would enable them to practice within the context of their cultural knowledge.

- **Nursing**

The researcher believes that all patients, including postnatal patients, have the right to receive culturally congruent nursing care. Every person belongs to a

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specific culture, with its own beliefs, values and patterns of caring and healing that the nurse should know when providing patient care (Parucha 2005:5). Leininger and McFarland (2006:18) concur with this view, and in her assumptions she reflects that care is embedded in a person's culture, and without care there is no curing. Midwives should be committed to prevent diseases and illness for the postnatal patients through health promotion and rehabilitation of the postnatal patients with complications. Culturally based nursing care would contribute to the wellbeing of individuals, families and communities, thus, midwives are expected to respect other people's cultural views during the provision of nursing care to postnatal patients.

1.7.2. Central theoretical statement

The interviews were held with postnatal patients, family members, traditional birth attendants registered midwives, midwifery lecturers and maternal and child healthcare coordinators. Understanding their perceptions assisted the researcher to develop a model for incorporating "indigenous" postnatal care practices into a midwifery healthcare system.

A model for incorporating "indigenous" postnatal care practices into midwifery healthcare system might be regarded as one of the milestones towards implementation of the Traditional Health Practitioners Act, 22 of 2007 in South Africa; the study was also significant to nursing, midwifery and transcultural nursing in that there is a high priority on increasing nurses' knowledge and skills through research.

The knowledge gained from this study should assist in training of midwives, through addition of culturally congruent care information in the current Limpopo College of Nursing Curriculum. The results should also assist the Department of Health and Social Development in Limpopo Province to enhance the mutual working relationship between the family members, traditional birth attendants and registered midwives, and slow down or reverse the increasing rate of maternal

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deaths. The knowledge and skills gained from the study should bring change to the practice of midwifery, thus improving the quality of care during postnatal period through the provision of culturally congruent care. Health disparities should be reduced because cultural safety would be enhanced and maintained (Lancelloti 2008:179).

The researcher was of the opinion that a model for incorporation of “indigenous” postnatal care practices into a midwifery healthcare system could lead to meaningful and beneficial healthcare and help meet the cultural healthcare expectations of postnatal patients. Based on the findings, implications for further studies would be made towards the refinement of midwifery practice as they currently rely mainly on western views. Patients need healthcare that could be a combination of “indigenous” and western practices.

The provision of culturally congruent care could prevent unnecessary deaths due to avoidable postnatal complications, and thus reduce the maternal and infant mortality rate. Culturally sensitive midwives will be able to educate family members and traditional birth attendants regarding early recognition of complications such as post-partum bleeding, infections and importance of early seeking of medical assistance, which is crucial in saving lives of postnatal patients (Lancelloti, 2008:179). Furthermore, quality patient care could prevent legal suites, stereotyping and unfavourable consequences such as cultural clashes, cultural imposition practices and cultural pain (Leininger & McFarland 2006:113). The findings could motivate researchers worldwide to conduct further studies on how to incorporate “indigenous” practices into professional healthcare practices.

1.7.3. Theoretical assumptions

It is necessary to clarify key concepts as used and understood in this study:

- **Model**

A ‘model’ was defined by Walker and Avant (2005:28) as “any device used to represent something other than itself; it has been a graphic representation of a A model for incorporating indigenous postnatal care practices into midwifery healthcare system.”

theory”. They indicated that the parts of a model should correspond to the parts of a theory. In this study, a model to incorporate “indigenous” postnatal practices into a midwifery healthcare system has been developed following the steps of concept analysis by Walker and Avant (2005:28), and the conceptual framework by Dickoff, James and Wiedenbach (1968:415).

- **Incorporation**

The *South African Concise Oxford Dictionary* (2009:584) defines ‘incorporation ‘as take in or to include or be included as a part or member of a united whole. In this study, the researcher developed a model for incorporation of “indigenous” postnatal care practices into the midwifery healthcare system.

- **“Indigenous” knowledge**

According to the *South African Concise Oxford Dictionary* (2009:586), ‘indigenous’ means growing, originating or occurring naturally in a particular place. According to George (2008:406), “indigenous” practices have been practices that were learned, shared and transmitted from one generation to another. Kendrick and Manseau (2008:7) wrote that “indigenous” knowledge was the base for the society which facilitated communication and decision making, and it was a local knowledge that was unique to a given culture or society. “Indigenous” knowledge information systems have been dynamic and are continually influenced by internal creativity and experimentation, as well as by contact with external systems (Kendrick & Manseau 2008 7). In this study, the term ‘ “indigenous” knowledge ‘refers to that the registered midwives should have regarding cultural beliefs, values, norms and practices of postnatal patients from different cultural groups. It might facilitate communication and decision-making amongst midwives, family members and traditional birth attendants during the provision of culturally congruent care.

- **Postnatal care practices**

Postnatal care has been defined by (2012:3); Fraser et al (2010:651-2) as the care provided to the mother and new-born immediately after the expulsion of the placenta and membranes up until six weeks after delivery, during which time the

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woman has entered a period of physical, psychological and emotional recuperation. In this study, postnatal care means the care that is provided by the midwives, family members and traditional birth attendants that could facilitate improvement and maintenance of health status of women and infants over this time.

- **Nurse**

A nurse is a person educated and licensed in the practice of nursing, and concerned with the diagnosis and treatment of human responses to actual or potential health problems (Anderson et al. 1994:1086). In this study, nurses without a midwifery qualification were excluded; that is. the terms nurse and midwife are not interchangeable.

- **Midwife**

A midwife is described by the South African Concise Oxford Dictionary (2009:736) as a nurse who is trained to assist women during childbirth. According to the International Confederation of Midwives, the WHO and Federation of International Gynaecologists and Obstetricians, a midwife is a:

professional nurse who, was regularly admitted to a midwifery educational program fully recognised in the country in which it was located, has successfully completed the prescribed course of studies in midwifery and has acquired the requisite qualifications to be registered and/or legally licensed to practice midwifery” (in Anderson et al 1994: 998).

In this study, a midwife is a professional nurse with trained in midwifery, who assists pregnant women during the antenatal phase, labour and delivery.

- **Midwifery**

Midwifery has been defined by the South African Nursing Council (SANC) as a:

caring profession practiced by persons registered under the Act, which supported and assisted the healthcare user and in particular the mother

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and the baby, to achieve and maintain optimum health during pregnancy, all stages of labour and the puerperium (SANC 1990:6).

According to the *American Heritage Dictionary* (2007) and Anderson et al. (1994:999), midwifery is a healthcare system in which providers care for a childbearing women during pregnancy, labour and birth, and during the postnatal period. This study focuses on the care provided during the postnatal period.

- **Healthcare system**

A healthcare system was defined by Anderson, Anderson and Glanze (1994:711) as a complete network of agencies, facilities, and providers of healthcare in a specified geographical area. This study focuses on the midwifery healthcare system, as the completed network of agencies, facilities and all providers of healthcare during the postnatal period.

1.7.4. Methodological assumptions

The interpretive research paradigm was selected as suitable for the study, defined by Blouin, Molenaar and Pearcey (2012:103), Neumann (2003:75) and Lincoln and Guba (1994:118) as appropriate to understanding values, beliefs, and meanings of social phenomena, and, thereby, human cultural activities and experience. Crossan (2003:5) indicated that the interpretivistic researcher believes in recognising, interpreting and understanding the complex relationship between individual behaviour, attitudes, external structures, and the social and cultural environment.

Appropriate to the interpretive paradigm was a qualitative approach, falling within a postmodern science philosophy. It required the researcher and participants to explore, identify, describe, discuss, interpret and re-construct their meanings and knowledge. This was in contrast to positivism, which “embraces a conception of truth in which verifiable statements concur with the ascertainable facts of reality” (Creswell 1998:80; Henning, Van Rensburg & Smit 2004:17). Positivism calls for pure experimental research where everything is tested and verified through

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examination and observation of external reality. The positivist also believes in the assumption that there are universal laws that governed social events, and uncovering these enables him or her to describe, predict, and control social phenomena (Kim 2003:10).

On the other hand, interpretivists believed that reality regarding these universal laws does not exist in a vacuum, because an individual's behaviour is influenced by various factors such as cultural beliefs, norms, values, attitudes and practices (Marshall & Rossman 1999:28). The researcher also believes in constructivism and respecting other people's opinions. According to Lincoln and Guba (1994:126), constructivism focuses on the understanding, opinions, perceptions, experiences and cognitive processes of individuals. They also turn their attention outwards to the world of inter-subjectively shared, social constructions of meanings and knowledge. In this research study, there was construction of a model for incorporating "indigenous" postnatal care practices into a midwifery healthcare system, with the researcher encouraging a sharing of ideas, communication, negotiation and construction of meanings amongst the participants.

The researcher also sought to understand the perceptions of different stakeholders in midwifery care regarding the incorporation of "indigenous" postnatal care practices into midwifery healthcare system. Focus groups and in-depth individual interviews were used to identify and describe the perceptions and experiences of postnatal patients, family members, traditional birth attendants, registered midwives, midwifery lecturers and the maternal and child healthcare coordinators. The interpreted and constructed data was utilised during the model development process.

During the focus groups and in-depth individual interviews, the participants were made aware that currently midwives rely on professional care only, instead of combining the two healthcare systems, and that there was a high maternal and child mortality rate in South Africa. The researcher posed a few questions to stimulate discussion on the incorporation of "indigenous" postnatal care practices into a midwifery healthcare system. The participants were made aware that they

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were free to voice any opinion they held. The data obtained during the focus groups and in-depth individual interviews was analysed and interpreted, and used as a basis for the researcher constructing a model to incorporate “indigenous” postnatal care practices into a midwifery healthcare system.

1.8 RESEARCH DESIGNS AND METHODS

A qualitative, exploratory, descriptive and contextual research approach for theory generation has been conducted within the context of midwifery. The research design and methods comprised the research strategies for model development, the population, sample, sampling methods, sampling size, inclusion criteria, pilot study, setting, gaining access to the setting, data collection methods, data analysis and measures to ensure trustworthiness.

1.8.1 Research design

The research design for model development comprised three phases:

- The objective of the first phase was to determine the meaning of incorporating “indigenous” postnatal care practices into the midwifery healthcare system.
- The objective of phase two was to explore, identify and describe the perceptions of postnatal patients, family members and traditional birth attendants, registered midwives, midwifery lecturers and the maternal and child healthcare coordinators regarding the incorporation of “indigenous” postnatal care practices into a midwifery healthcare system (empirical perspective)..
- The objective of phase three was to develop and describe a model for incorporating “indigenous” postnatal care practices into a midwifery healthcare system, following the conceptual framework by Dickoff, James and Wiedenbach (1968:423).

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1.8.2 Data analysis

Qualitative data analysis is defined by Polit and Beck (2008: 508) as “the process of fitting data together, of making the invisible obvious, of linking and attributing consequences to antecedents, of conjecture and verification, of correction and modification, of suggestion and defence”. In qualitative research, data analysis is not a separate phase but occurs simultaneously with data collection, examining words rather than numbers (Babbie & Mouton 2001:359; Brink 2006:184 Polit & Beck 2008:50). The data analysis process is described in greater detail in Chapter Two.

1.9 ETHICAL CONSIDERATIONS

The research study was presented before the Ethics Committee of the University for approval and a letter to seeking permission to conduct the study was obtained from the Department of Health Limpopo Province Ethics Committee. For the different population groups, letters of permission have been obtained from the relevant stakeholders, with verbal and written consent obtained from the participants themselves before commencement of data collection.

The principle of respect for human dignity included the right to self-determination, which meant that the participants had the right to decide voluntarily whether to participate in the study, without the risk of any penalty or prejudicial treatment for not doing so (De Jong, Dondor & Frints, 2011:90). The researcher provided a full description to the participants about the nature of the study, the researcher’s responsibilities and the likely risks and benefits (De Jong, et al. 2011:90; Polit & Beck 2008:172).

The principle of justice included the participants’ right to fair treatment and the right to privacy and risk benefit assessment. They were treated with respect and dignity, and persons with diminished autonomy were protected. They were and shall be treated fairly and equally before, during and after the study. The researcher has ensured that their selection was based on the requirements of the

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conducted research study and that the research was not more intrusive than it needed to be. The participant's privacy has been maintained throughout the study (De Jong et al. 2011:89).

The researcher has conducted risk/benefits assessment and determined whether the benefits of participating in the study were in line with the financial, physical, emotional or social costs for the participants (Johnstone: 2002:21).

Informed consent requires the participants to have adequate information regarding the research, be capable of comprehending it, and have the power of free choice to enable them to consent or decline participation voluntarily (Polit & Beck, 2008:176). The participants were informed that the researcher was registered with the South African Nursing Council and had the following qualifications: Diploma in Nursing (General, Community and Psychiatric) and Midwifery, Nursing Administration, Nursing Education, Bcur I ET A and Master's Degree, and they were given the following information: participant status, study goals, type of data, procedures, nature of commitment, sponsorship, participant selection, confidentiality pledge and contact information (see appendix C). The researcher also provided the participants with contact details in case they had challenges or concerns and wished to communicate with the researcher easily at any time (Polit & Beck 2008:177).

The principle of non-maleficence includes freedom from harm and discomfort and the right to protection from exploitation. To ensure this, the researcher intentionally refrained from, avoided, prevented and minimised any actions which could have caused harm or discomfort to the participants (De Jong, et al. 2011:89). The participants were assured that information they provided and their participation would not be used against them in any way and that they were free from exploitation. The researcher evaluated how comfortable the participants were during participation to detect any risk that could have occurred during the study, as well as the benefits thereof (Pera & Van Tonder 2005:33).

The principle of veracity and fidelity involved confidentiality and privacy, with the researcher ensuring that there was a trusting relationship with the participants by telling the truth all the time.

1.10 STRENGTHS

The researcher has identified some of the “indigenous” practices that were employed by the family members and traditional birth attendants during the postnatal period. The researcher has identified the importance of model development for incorporating “indigenous” practices into midwifery health systems, to ensure the provision of culturally congruent care postnatal patients.

1.11 DISSEMINATION OF INFORMATION

The researcher made arrangements with the chiefs and indunas prior to presenting the research reports to the families of the postnatal patients who participated in the study. The research report will be presented orally to the participants as part of their feedback. Papers will be presented at conferences, both national and international, to which the researcher will submit the abstract of 500-1000 words. The research report will also be published as article/s in accredited journals (Polit & Beck 2008:708).

1.12 ORGANISATION OF THE REPORT

The report is organised as follows:

Chapter one provides an orientation to the study; Chapter two presents the Research Methodology; Chapter three conceptualises the “incorporation” of “indigenous” postnatal care practices into a midwifery healthcare system; Chapter four contains the Data analysis and interpretation; Chapter five outlines the development and description of the model for incorporating “indigenous” postnatal care practices into a midwifery healthcare system following the conceptual

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framework of Dickoff, James and Wiedenbach (1968:423); and Chapter six draws a conclusion and implications for further research.

1.13 SUMMARY

The first chapter has provided an introduction and background to the research problem, aims, objectives, questions, paradigmatic perspective, meta-theoretical, central theoretical, theoretical and methodological assumptions, research design and methods, research strategy, data analysis, development and description of a model, ethical considerations, strengths , dissemination of information and how the study was written.

Chapter two, will deal with the research design and methods of the study.

CHAPTER 2

RESEARCH METHODOLOGY

2.1 INTRODUCTION

This chapter describes in detail the research strategies for model development, the population, sample, sampling methods, sampling size, the inclusion criteria, the pilot study, the setting, gaining access to the setting, data collection methods, data analysis and measures taken to ensure trustworthiness.

2.2 RESEARCH DESIGN AND METHOD

A qualitative, exploratory, descriptive and contextual research design for theory generation has been followed in this study, conducted within a midwifery context. The study aims at developing a model for incorporation of “indigenous” postnatal care practices into the midwifery health system. A description of the research strategy follows:

2.3. PHASE ONE: CONCEPT ANALYSIS

Concept analysis was selected as a suitable method to be followed during model development, defined by Walker and Avant (2005:63) as “the process of examining the basic elements, structure and functions of a concept”. It rendered precise theoretical as well as operational definitions for use in model development, description and research, and enabled the researcher to clarify those terms in nursing that have become catchphrases and lost their meaning. The following steps were used during concept analysis: Selection of a concept; determining the aims or purposes of analysis; identifying all uses of the concept; determining the defining attributes; identifying model contrary and boundary cases; identifying antecedents and consequences; and defining empirical referents (Walker & Avant

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2005:74). The process of concept analysis is described in more detail in Chapter Three.

2.4 PHASE TWO: THE PERCEPTIONS AND EXPERIENCES OF POSTNATAL PATIENTS, FAMILY MEMBERS, TRADITIONAL BIRTH ATTENDANTS, REGISTERED MIDWIVES, MIDWIFERY LECTURERS AND THE MATERNAL AND CHILD HEALTHCARE COORDINATORS REGARDING THE INCORPORATION OF “INDIGENOUS” POSTNATAL CARE PRACTICES INTO MIDWIFERY HEALTHCARE SYSTEM (EMPIRICAL PERSPECTIVE)

The study was qualitative, defined by Polit and Beck (2008:762) as: “the investigation of phenomena, typically in an in-depth and holistic fashion, through the collection of rich narrative materials using a flexible research design”. Qualitative research methods were used to explore and describe the perceptions and experiences of stakeholders in a midwifery healthcare system (Burns & Grove 2009:22; De Vos, Strydom, Fouche & Delpont 2007: 271 and Creswell 1998:2)

Exploratory research is described by Brink (2006:120) as research that is conducted aimed at exploring the in-depth knowledge and understanding, of experiences and perceptions of a selected population groups through asking of questions and probing again and again until data saturation occurs. Brown (2006: 51) states that “exploratory research provides insights into and comprehension of an issue or situation”. In this study, the researcher conducted focus group and in-depth individual interviews to explore and describe the perceptions and experiences of the different groups regarding the incorporation of “indigenous” postnatal care practices into a midwifery healthcare system (Powel, Trisha, Reginah, Shann, Tolivet, Cooper & Schindler 2001: 67; Mouton 1996:102).

Descriptive research has been defined as research that “has its main objective the accurate portrayal of the characteristics of persons, situations, or groups, and/or the frequency with which certain phenomena occur” (Polit & Beck

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2008:752). Shields and Hassan (2006:313) write that descriptive research collects “data and characteristics about the population or phenomenon being studied”. In this study, the researcher explored and described the perceptions and experiences of the six population groups regarding the incorporation of “indigenous” postnatal care practices into a midwifery healthcare system.

According to Farlex (2008:30), contextual research means “relating to, depended on, or using context relating to or determined by or in context based on a particular phenomenon”, whilst Bogdan and Biklen (2003:4) write that the researcher goes to the particular setting out of concern for the context. They further indicate that the phenomena can be better understood if observed in the setting in which it occurred (Bogdan & Biklen 2003:4; Lincoln & Guba 1985:189). In this study, the researcher conducted research within the context of midwifery.

2.4.1 Population and sampling

Burns and Grove (2009:343) defined the population as “the particular type of individual or element, such as women who have just delivered in maternity ward and clinics, who were the focus of the research”.

The population comprised of six groups of people. The first population group for this study comprised of postnatal patients, as they are the people who required culturally congruent care. The second population group comprised of family members, as they are responsible for taking care of postnatal patients. The third population group comprised of the traditional birth attendants, as they are responsible for conducting home deliveries and taking care of postnatal patients. The fourth population group comprised of registered midwives, as they are taking care of postnatal patients. The fifth population group comprised of midwifery lecturers, because they are involved in the training of student midwives and they possessed knowledge regarding midwifery curriculum. The sixth population group comprised of maternal and child healthcare coordinators, because they are responsible for the management of maternal and child healthcare services.

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Sampling method is defined by Burns and Grove (2009:349) as “the process of selecting a group of people, events, behaviours or other elements that represent the population being studied”. The purposive sampling technique was considered suitable for this study because it focused on those involved in the planning, provision, receipt, monitoring and management of postnatal care (Polit & Beck 2008:343). According to Burns and Grove (2009:361), the sampling size should be large enough to identify relationships among variables or determine differences between groups. In this study the focus groups and in-depth individual interviews were used during data collection. According to Brink (2006:152), focus group interviews should consist of 5 (five) to 15 (fifteen) participants whose opinions and experiences are requested at the same time. However, the size of the population has been determined by the data saturation, described by Streubert and Carpenter (1999:22) as “the repetition of discovered information and confirmation of previously collected data”.

Burns and Grove (2009:345) describe the inclusion sampling criteria as “those characteristics that a subject or element must possess to be part of the largest population”. Because data was collected from different population groups, each population had its own inclusion criteria.

- Postnatal patients included in the sample were gravid two and more, just delivered, all age groups, from any cultural group and were still in the maternity ward awaiting discharge. The reason for selection gravid two or more is because they had already experienced the postnatal period during the previous deliveries.
- Family members to be included in the study were grandmothers who were involved and responsible for home deliveries and taking care of postnatal patients.
- Traditional birth attendants to be included in the study, they should be known by the Chief as people responsible for the care of women during pregnancy, labour and postnatal care. The Chiefs of the selected villages assisted the researcher to identify the traditional birth attendants..

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- Registered midwives must have five years or more of working experience in the clinic and/or maternity ward.
- Midwifery lecturers involved nurses who had registered with the South African Nursing Council as midwives and a nurse educator with knowledge regarding midwifery curriculum and who had been teaching midwifery at the selected Nursing College.
- Maternal and Child Healthcare coordinators who had knowledge of the planning and management of care for postnatal patients.

2.4.2 Setting

The study was conducted at Limpopo Province, located in the northern part of South Africa and made up of five districts: Capricorn, Mopani, Sekhukhune, Vhembe and Waterberg. Greater Giyani sub-district in the Mopani District was selected; because, it was the nearest and easy for me to attend evening appointments during data collection. Mopani district is made up of five sub-districts: Ba-Phalaborwa, Greater Giyani, Greater Letaba, Maruleng and Greater Tzaneen sub-district. Greater Giyani sub-district is made up of rural areas with a population of different cultures. Sotho, Venda and Tsonga speaking people are the dominant groups. The setting for data collection was determined by the type of population group. A conducive/quiet environment was selected for the in-depth individual and the focus group interviews. For example, for the postnatal patients and registered midwives, the interviews were conducted in a maternity ward, counselling room at the selected hospital. For the family members and traditional birth attendants the community hall of the selected village were used as suitable environments. For the midwifery lecturers, data was collected at the council chamber at a selected nursing college. For the maternal and child healthcare coordinators data was collected at the auditorium in the Department of Health and Social Development Limpopo Province, Mopani District.

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Creswell (1998:112) describes access and rapport as gaining permission from individuals and obtaining access to information from people who have experienced the phenomenon. In this study the researcher received permission letters from the Research Ethics Committees of the University of Pretoria, Department of Health and Social Development, Limpopo Province, the Chief Executive Officer of the selected hospital, the Executive Director of Mopani District Primary Healthcare services, the unit manager of maternity ward, the clinic managers, the chiefs of the selected villages and the individual participants.

The participants were invited by written letters with an information leaflet and informed consent attached. The information on the nature, purpose and procedures of the study was provided. Thorough explanations were given the participants prior the commencement of the study. The researcher ensured that the participants fully understood what was involved in the research study before they agreed to participate in it.

All the participants who did agree to take part were contacted individually, the aim being to initiate a mutual and trusting relationship through regular contacts using telephone calls and emails. The regular contacts with the participants prior to data collection assisted the researcher, who verified the telephone numbers provided during the time of consent. The researcher made appointments followed up by repeated calls to remind them about the date and time of interviews (Burns & Grove 2009:514). Travelling allowances were provided for those who travelled a certain distance to the research setting, and refreshments were provided during the interview meetings (Burns & Grove 2009:514). The participants were made aware that all information obtained during the interviews would be kept confidential.

2.4.3 Data collection methods

Data collection involves selection of participants and gathering data from them (Brink, 2006:153; Burns & Grove 2009:393). Focus group interviews were selected

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as a suitable method for data collection for the postnatal patients, family members, traditional birth attendants. Focus groups are described by Burns and Grove (2009:513) and Polit and Beck (2008:395) as carefully planned data collection methods designed to access rich information regarding the participants' perceptions in a focused area and setting that is non-threatening. The group dynamics helped them to express and clarify their views in ways that were less likely to occur in in-depth individual interviews (Burns & Grove 2009:513). They also helped the researcher identify and describe the perceptions and experiences of the participants regarding the incorporation of "indigenous" postnatal care practices into midwifery healthcare system (De Vos, et al. 2007:419). Based on the purpose of this study, each focus group interview consisted of five to fifteen people (Brink 2006:185; Burns & Grove 2009:513). In-depth individual interviews were conducted with the registered midwives, midwifery lecturers and the maternal and child healthcare coordinators. Burns & Grove (2009:154) describes in-depth individual interviews as the tool that involves one to one conversation between the researcher and the participants and can be used to obtain good qualitative information which contains deep insight into the perceptions and experiences of the participants. A semi-structured interview guide was used during interviews, with specific questions written down.

2.4.4 Pilot study

The pilot focus group interview was conducted with the registered midwives, midwifery lecturers and the maternal and child healthcare coordinators, the purpose being early detection and management of problems that could have arisen during the actual data collection process (De Vos et al 2007:211). Based on the findings for the focus group interviews pilot study, the researcher identified that the use of focus group interviews for the three groups would not be feasible as they were short staffed in their working environments, resulting in tight schedules. Hence, the researcher planned to conduct in-depth individual interviews with them. In-depth individual interviews were conducted with registered midwives, midwifery

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lecturers and the maternal and child healthcare coordinators, because they were not part of the population samples.

At this stage the researcher addressed the goals and objectives, resources, research populations, procedures of data collection, the data collection itself, and possible errors that might occur. The preliminary exploratory studies assisted the researcher in the planning of the research project regarding transport, finance and time factors. This informed the researcher about the unforeseen problems that occurred during the study (De Vos et al 2007:213).

- **Study of the literature**

In order to be fully conversant with existing knowledge regarding the topic the researcher read the latest relevant books and journals (De Vos et al 2007:212), and searched for an overview of the actual, practical situation in which the proposed study was being conducted and population groups would be interviewed.

2.4.5 The interview process

On arrival at the setting for different population groups for focus groups and in-depth individual interviews, the researcher greeted the participants with a smile, demonstrating a warm welcome to build a mutual and trusting relationship. The researcher introduced herself to the different population groups and encouraged the members of each to introduce themselves and get to know each other. The explanations regarding the title, nature and purpose of the study were also introduced to the participants. They were assured about anonymity and confidentiality during and after the study, encouraging them to become more comfortable and express different opinions and perceptions of the phenomenon being studied.

Permission to use an audiotape and take field notes was also obtained from the participants. On commencement of the focus groups and in-depth individual interviews the researcher made sure that the environments were free from noise

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and interruptions and switched on the audiotape. The following questions were used as a guide during the interviews:

- What are your perceptions and experiences regarding the incorporation of “indigenous” postnatal care practices into midwifery healthcare systems?
- How can we incorporate “indigenous” postnatal care practices into midwifery healthcare systems?

The role of the researcher during the interviews was to facilitate the process in a permissive and non-threatening environment. The researcher also ensured that all the participants were actively involved and participating during the study (Kasturirangan & Krishnan, 2004:147). Dominant behaviour was avoided during the interviews. The researcher probed deeper to encourage the participants to express their experiences and perceptions, and took field notes to back up the audiotape recordings.

The number of focus group interviews for each population group was determined by data saturation. For the postnatal patients, family members’ data saturation was reached during the second focus group interview, for the traditional birth attendants it was also reached during the second focus group interviews. During focus group interviews the researcher encouraged the participants to interact with each other, formulate ideas and talk about the incorporation of “indigenous” postnatal care practices into a midwifery healthcare system (Burns & Grove 2009:515).

In order to encourage active participation and involvement during interviews the researcher explained to participants that she was there to learn from the group members and not as an expert. The researcher also avoided over-dominance (Burns & Grove 2009:515) and displayed good communication and listening skills, mutual respect, neutrality and a non-judgmental person. The assistant moderator and moderator were included in the interviews (Burns & Grove 2009:515).

Towards the end of the interviews the researcher ensured that the participants were not left with unfinished stories, by asking questions such as “could you

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explain a bit more?” The researcher also stressed that the information would be kept confidential and they would receive fair and equal treatment throughout the interview process. Data was collected until data saturation was reached (Burns & Grove 2009:353). At the end of the focus group and in-depth individual interviews the researcher thanked the participants for being actively involved and participating during the study and for the information they provided. After giving a vote of thanks the researcher switched off the audiotape.

2.4.6 Data analysis

Qualitative data analysis is defined by Polit and Beck (2008:508) as:

the process of fitting data together, of making the invisible obvious, of linking and attributing consequences to antecedents, it was a process of conjecture and verification, of correction and modification, of suggestion and defence.

In qualitative research, data analysis was not a separate phase but occurred simultaneously with data collection. Qualitative data analysis examines words rather than numbers (Babbie & Mouton 2001:359; Brink 2006:184; Polit & Beck, 2008:508). In this phase, only data which was collected during the interviews plus focus group on the perceptions and experiences of different stake holders in midwifery care regarding the incorporation of “indigenous” postnatal care practices into Midwifery Healthcare system was analysed. Data analysis was conducted following the three steps of data analysis listed by Polit and Beck (2008:508), as follows:

- **Transcribing Qualitative Data**

The researcher transcribed data from the audiotapes and field notes, ensuring that the transcriptions were accurate, reflected the totality of the interview plus focus group experience, and facilitated analysis. To ensure the reliability of data coding, the researcher had a co-coder who confirmed the data from the audiotape (Brink 2006:185). To facilitate analysis during the transcription process the researcher

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indicated who was speaking in the written text, for example “R” for the researcher and “P” for participants (Polit & Beck 2008: 509). The researcher also indicated overlaps in speaking turns; time elapsed between utterances such as sighs, sobs and laughter, and emphasis of words. To ensure confidence quality and accuracy of the transcribed data, the researcher transcribed the data on her own (Polit & Beck 2008:509). This would also bring the researcher closer to and more familiar with the data.

- **Developing a category scheme**

After transcribing the data, the researcher read and organised it carefully, identifying underlying concepts and clusters of concepts. These assisted in forming a strategy for classifying and indexing the data, and developing a high quality category scheme. The researcher converted the data into smaller and more manageable units that could be reviewed and retrieved. The category scheme has been developed based on the scrutiny of the actual data (Polit & Beck 2008:510).

- **Coding qualitative data**

After developing a category scheme, the researcher read the data in its entirety and coded it for correspondence to the categories. In order to fully comprehend the underlying meaning of some aspect of the data, the researcher read the categories three to four times. The researcher and other members of the research team coded the entire data set and achieved the highest possible coding consistency across the interviews (Polit & Beck 2008:511).

The data was grouped according to the findings from six different population groups. Challenges experienced by postnatal patients emerged as the main theme during analysis and interpretation of data from postnatal patients. One theme with two categories emerged during the analysis of data from family members and traditional birth attendants (challenges experienced by family members and traditional birth attendants during postnatal care). The results of the

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study have been described in detail in Chapter Four during the discussion and interpretation of results.

2.4.7 Measures to ensure trustworthiness

Trustworthiness was described by Lincoln and Guba (1985:300) as rigour in qualitative research without sacrificing relevance. According to Polit and Beck (2009:511), a method of measuring trustworthiness includes five aspects namely: credibility, dependability, confirmability, transferability and authenticity.

- **Credibility**

Credibility referred to confidence in the truth of the data and how well the data processes, analysis and interpretations address the intended focus of the study (Lincoln & Guba 1985:301; Polit & Beck 2008:539). To increase the probability that credible findings were produced the following activities were conducted: prolonged engagement, persistent observation, and triangulation, peer debriefing, member checking (Creswell 1998:201; Lincoln & Guba 1985:301).

- **Prolonged engagement**

Prolonged engagement refers to the investment of sufficient time with the participants to achieve certain purposes, learning the culture, testing for misinformation introduced by distortions in either the self or the participants, and building trust. The purpose of prolonged engagement is to render the inquirer open to the multiple influences, mutual shapers and contextual factors that impinge upon the phenomenon being studied. In this study, the researcher spent sufficient time with the participants by visiting them a day before the scheduled interview, to become orientated, get to know the culture and establish rapport and a trusting relationship with them. The researcher also visited the different research settings before the commencement of the interviews and identified issues that might have been a challenge during the interviews. In order to obtain rich and meaningful data with thick description, the researcher explained to the participants that the

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information provided during the interviews would be kept confidential and not used against them (Lincoln & Guba 1985:301).

- **Persistent observation**

Persistent observation involves identification of those characteristics and elements in the situation that is most relevant to the research problem or issue being pursued and focused on them in detail. It provides depth to the research study. In this study, the researcher wrote down field notes, observed, identified and assessed those salient factors and crucial, typical happenings that were relevant to the incorporation of “indigenous” postnatal care practices in the midwifery healthcare system, and focused on them (Creswell 1998:201; Lincoln & Guba 1985:304). The researcher asked probing questions and received rich and in-depth data from the participants. This encouraged them to generate more ideas, viewpoints, opinions, perceptions and experiences of the phenomenon (De Vos, et al. 2007:351).

- **Triangulation**

Triangulation was used to improve the probability that findings and interpretations would be credible. According to Lincoln and Guba (1985:305), triangulation refers to the use of multiple and different sources, methods, investigators and theories. In this study, the researcher invited two experienced researchers to act as peer reviewers during the interviews and data analysis (Creswell 1998:202; Neumann, 2003:138). They assisted the researcher by guiding the interviews, with one as moderator and the other as assistant moderator.

- **Peer debriefing**

Peer debriefing refers to “the process of exposing oneself to a disinterested peer in a manner paralleling an analytic session and for the purpose of exploring aspects of the inquiry that might otherwise remain only implicit within the inquirer’s mind” (Lincoln & Guba 1985:308). In this study, the researcher presented the collected data to other experienced researchers in order to ensure honesty (Creswell 1998:202; Lincoln & Guba 1985:308).

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- **Member checking**

Member checking requires the researcher to return to the participants who participated during the study and discuss the interpretation of the collected data (Creswell, 1998:202; Lincoln & Guba, 1985:314). One of the purposes for conducting member checking was to give the participants the opportunity to correct errors and challenge interpretations. The researcher made appointments with family members and traditional birth attendants, where they were requested to listen to the tape recorder, in order to verify the overall interpretation and meaning towards the final conclusion of the study. Member checks also provided an opportunity to summarise the collected data, regarded as the first step towards data analysis (Lincoln & Guba 1985:314). In this study, after the interviews, the researcher discussed the interpretation of research findings with the participants to find out whether they were accurate and give them an opportunity to volunteer additional information. They also helped the participants recall additional points they had not made during the interviews (Lincoln & Guba 1985:315).

- **Dependability**

Dependability refers to the stability (reliability) of data over time, over conditions and over occasions (Polit & Beck 2008:539). To achieve dependability the researcher submits the collected data to two different researchers to examine it officially and then they compared the results to confirm it is correct (Stommel & Celia 2004:288). It was one of the criteria used to establish trustworthiness by performing an audit of the study by peer researchers (Brink 2006:125). In this study, the official examination of the collected data was made by the researcher, peer researchers, the participants, the promoter and the co-promoter.

- **Confirmability**

Confirmability refers to objectivity, which has the potential for congruence between two or more independent people about the data's accuracy, relevance, and how to interpret it (De Vos et al 2007:352; Polit & Beck 2008:539; Stommel & Celia 2004:288). To achieve confirmability the researcher used audit trails in which the

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approaches to data collection, decisions about data to collect and about the interpretations of data were carefully documented so that another knowledgeable researcher could have arrived at the same conclusions about data as the primary researcher (Stommel & Celia 2004:288). The researcher ensured that the findings reflected the participants' voices and the condition of inquiry, not the biases, motivations or perspectives of the researcher (Polit & Beck 2008:539). The researcher also ensured that there had been an internal agreement between the researcher's interpretation and the actual evidence (Brink 2006:125). There was consensus between the researcher, the participants, the promoter, the co-promoter and the co-coder.

- **Transferability**

Transferability refers to the generalisability or the extent to which the findings can be transferred or have applicability to other settings and target populations (De Vos et al 2007:352; Stommel & Celia 2004:289). In order to achieve transferability the researcher has provided a thick description of the nature of the study participants, their reported experiences, and the researcher's observation during the study (Stommel & Celia 2004:289). The researcher has identified and described sufficient data and compiled the report such that it became easier for the consumers to evaluate the applicability of the data to other settings/contexts (Polit & Beck 2008:539).

- **Authenticity**

Authenticity refers to the extent to which the researcher has given a fair, faithful, honest and balanced account of social life from the viewpoint of someone who lives it every day, showing a range of different realities (Polit & Beck 2008:540). Authenticity emerged in a report when it conveyed the experiences and perceptions of participants regarding the incorporation of "indigenous" postnatal care practices into a midwifery healthcare system (Neumann 2003:185). In this study the researcher has provided a true report that invites readers to share

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experiences regarding the incorporation of “indigenous” postnatal care practices in a midwifery healthcare system (Polit & Beck 2008:540).

2.5 PHASE THREE: MODEL DEVELOPMENT AND DESCRIPTION

Model development, and description was based on the findings of Phase One (concept analysis) and Two (exploration and description of the perceptions and experiences of postnatal patients, family members, traditional birth attendants, registered midwives, midwifery lecturers and the maternal and child healthcare coordinators. Conceptualisation of the concepts identified during phase one and two was conducted following the conceptual framework by Dickoff, et al. (1968: 423). This method consists of six aspects: *Agency: Who or what performs the activity?; Patient or recipient: Who or what is the recipient of the activity? Framework: In what context is the activity performed?, Terminus what is the end point/purpose of the activity? Procedure: What was the guiding procedure, technique, or protocol of the activity? Dynamics: What was the energy source for the activity, whether chemical, physical, biological, mechanical or psychological, etcetera?.* A detailed description of model development is provided in Chapter Five.

2.6 SUMMARY

Chapter two has provided a detailed description of how the study was conducted, in order to achieve the research objectives. The research design for this study was qualitative, exploratory, descriptive and contextual approach for model development. The in-depth description of research strategies for model development has been provided. Phase one aimed at determining the meaning of incorporating “indigenous” postnatal care practices into midwifery healthcare system through concept analysis. Phase two aimed at exploring, identifying and describing the perceptions and experiences of different stake holders in midwifery care (Empirical perspective). Phase three aimed at development and description

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of a model for incorporating “indigenous” postnatal care practices into midwifery healthcare system. To conceptualise the concepts, they were identified in phases one and two according to the conceptual framework of Dickoff, et al (1968:423).

Chapter Three deals with concept analysis and describes the meaning of incorporating “indigenous” postnatal care practices into a midwifery healthcare system.

CHAPTER 3

CONCEPT ANALYSIS

3.1 INTRODUCTION

Chapter Two described the research methods that were followed during the study. The purpose of this chapter is to analyse the concept “incorporation” that would enable the researcher, the participants and the readers to understand the meaning of incorporating “indigenous” postnatal care practices into a midwifery healthcare system. The theoretical meaning of the concept ‘incorporation’ was analysed following the process of concept analysis by Chinn and Kramer (2008:192) and Walker and Avant (2005:74). The empirical aspect of the concept is analysed in Chapter Four from the perceptions and experiences of the postnatal patients, family members, traditional birth attendants, registered midwives, midwifery lectures, and the maternal and child healthcare coordinators. The researcher outlines the process that was followed during concept analysis, followed by detailed analysis of the steps of concept analysis of Chinn and Kramer (2008:192) and Walker and Avant (2005:74).

3.2 OBJECTIVES

The objectives of this chapter are:

- To analyse the concept ‘incorporation’ following the process of concept analysis by Chinn and Kramer (2008:192) and Walker and Avant (2005:74).
- To describe the meaning of the concept ‘incorporation’.
- To guide the process of data collection, data analysis and interpretation in chapter 4.

3.3 CONCEPT ANALYSIS PROCESS

Concept analysis was selected as a suitable method during analysis of the concept 'incorporation'. According to Walker and Avant (2005:63), concept analysis is “the process of examining the basic elements, structure and functions of a concept”, whilst for Beckwith, Dickinson and Kendal (2008:1833) it is “a branch of empirical linguistics, as it contains the assumption that a definition of a term may be found which pertains to its representation in a natural language”. The reasons for choosing concept analysis during model development were that it rendered very precise theoretical as well as operational definitions for use in model development and research Walker and Avant (2005:74). It also enabled the researcher to clarify concepts that are similar (model case) to it (Rodgers & Knaf 2000:78). Lastly, concept analysis has been useful in model development and nursing language development (Walker & Avant 2005:74). The theoretical perspective of the meaning of the concept was described following the process of concept analysis by Rodger and Knaf (2000:78), Chinn and Kramer (2008:192) and Walker & Avant (2005:65). It may be broken down into eight steps:

- Selection of a concept
- Determining the aims or purpose of analysis
- Identification of all uses of the concept that the researcher has discovered.
- Determining the defining attributes
- Identification of a model case.
- Identification of antecedents and consequences
- Defining empirical referents

3.3.1 SELECTION OF A CONCEPT

The researcher selected a concept that was important, useful, interesting and reflected the topic. In this study the researcher analysed the concept 'incorporation' as manageable. The selection of primitive terms that could be defined only by giving examples was avoided. The researcher also avoided the

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selection of 'umbrella' terms as they would be too broad and cause confusion (Chinn & Kramer 2008:192; Walker & Avant 2005:66).

3.3.2 Determination of the aims or purposes of analysis

After concept selection the researcher determined the aims or purposes of analysis, as follows:

- To clarify and describe the meaning of incorporation of "indigenous" postnatal care practices into a midwifery healthcare system.
- To develop a theoretical definition of the concept 'incorporate' that have directed the data collection process and the development and description of a model for incorporation of "indigenous" postnatal care practices into a midwifery healthcare system.
- To discuss and interpret the results for concept analysis that would assist in developing and describing the model for incorporating "indigenous" postnatal care practices into a midwifery healthcare system.
- The meaning of the concept clarified the basic elements, structure and functions of the concept 'incorporation' (Chinn & Kramer 2008:192; Walker & Avant 2005: 66).

3.3.3 IDENTIFICATION OF USES OF THE CONCEPT

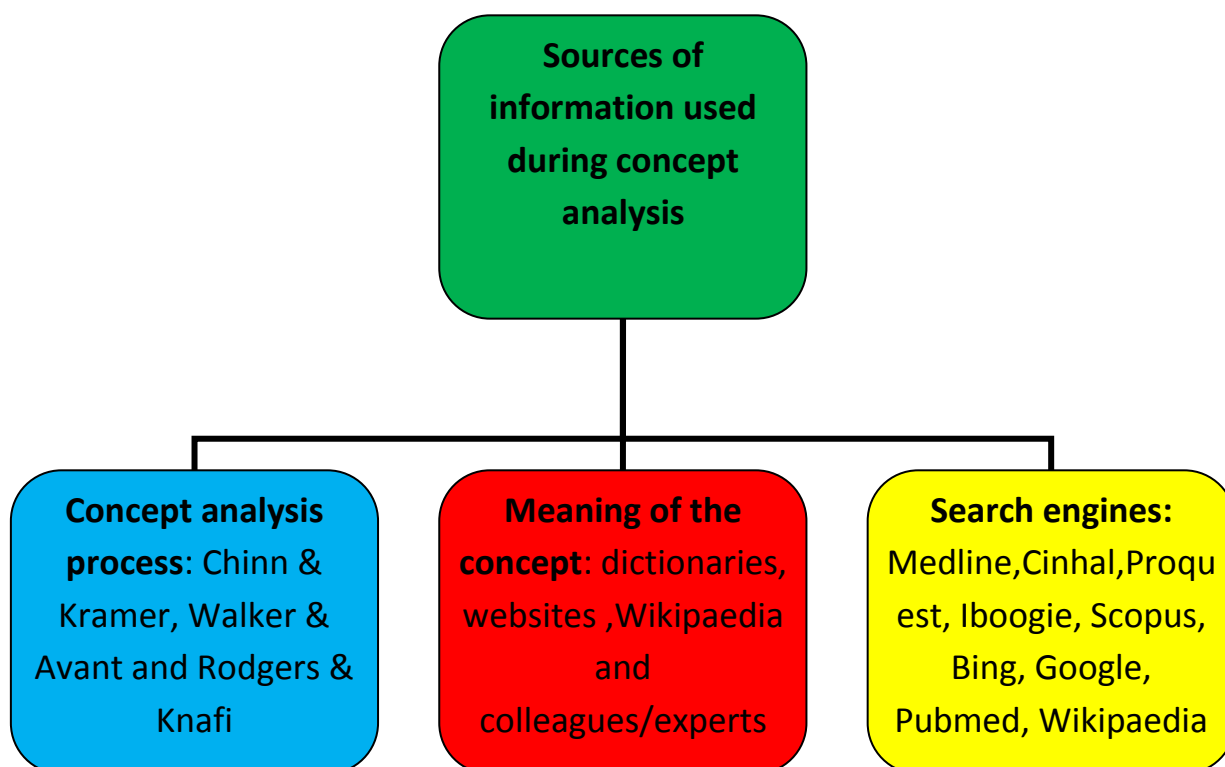
After determining the aims or purposes of analysis, the researcher identified the uses of the concept 'incorporation'. The researcher used dictionaries, thesauruses, colleagues and available literature and identified as many uses as practical. A literature review assisted the researcher to support and validate the ultimate choices of the defining attributes (Chinn & Kramer 2008:193; Walker & Avant 2005:67). The table below illustrate the approach used to conduct literature review:

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Table 3.1 Illustrate the approach used to conduct literature review:

Author/year/country	Type of article	Search terms	Inclusion criteria
Makhubele & Qalinga (2009) South Africa	"Integrating" Socio-cultural knowledge in life skills education for the prevention of health and social pathologies	Incorporate, include, integrate, take into, combine, embrace, unite, amalgamate, mix.	All research studies which deals with issues of integration including or o add as part of something else.

The figure 3.1 below illustrates the conceptual framework showing the sources of information used during concept analysis:



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Figure 3.1: Illustrates the conceptual framework for the sources of information used during concept analysis.:

According to *Concise Oxford Dictionary* (2009:584), uses of the concept 'incorporate' include:

To constitute into legal connection. To put or introduce into a body or mass as an integral part, for an example to incorporate revisions into a text. To take into or include into one body or uniform or a mass, for an example his book incorporates his early essay. To form or combine into the body or uniform substance, as ingredients. To embody, for an example, his book incorporates all his thinking on the subject. To form into a society or organization.

In this study, the concept can be used to introduce, put or take into, embody and combine the "indigenous" postnatal care practices, so that they form a legal connection into a midwifery healthcare system.

Livingstone (2008:343) describes the concept as "to consolidate two or more things into one body, learning of values and attitudes that is incorporated within a person", and "to unite or merge with something that is already in existence, making it into a whole or include it as part of a whole". In this study, the "indigenous" postnatal care practices and the Western healthcare practices in midwifery can be consolidated, united and merged into one system.

Buckinghamshire (1991:215) writes that the concept has been described in different ways using similar concepts, such as: "embody, include, combine, comprise, embrace, integrate, consolidate, unite, amalgamate, assimilate, coalesce, emerge, mix and blend".

The *Harper Collins English Dictionary* (2009:2) described the concept as the "act of uniting several persons into one fiction called a corporation, in order that they may no longer be responsible for their own actions only, but collaborate and interact with each other as a team".

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Based on the above-mentioned uses of the concept the model for incorporating “indigenous” postnatal care practices into midwifery healthcare system might assist in ensuring that the “indigenous” postnatal care practices would be included, emerged, combined, mixed and unified within a midwifery healthcare system.

3.3.4 Determine the defining attributes

According to Chinn and Kramer (2008:194) and Walker and Avant (2005:68), determining the defining attributes has been at the heart of concept analysis. The aim was to show the cluster of attributes that were most frequently associated with the concept and that allowed the researcher the broadest insight into it. During definition of the attributes the researcher made notes of the characteristics of the concept that appeared repeatedly. It enabled the researcher to name the occurrence of a specific phenomenon as differentiated from another similar or related one (Chinn& Kramer 2008:194; Walker & Avant 2005:68).

The following were the characteristics of the concepts that were appearing repeatedly: include, unite, combine, integrate blend (mix) and merge. The characteristics of these concepts helped the researcher to differentiate them from other similar or related concepts, such as assimilate and amalgamate.

- Blend: to “mix” (Buckinghamshire 1991:215). According to (Anderson, et al. 1994:215) a blended family formed when children from previous marriages are incorporated into the new marriage. The use in this study is of a blended healthcare system that can be formed when the “indigenous” postnatal care practices are incorporated into a midwifery healthcare system.
- Integrate: “to make or to be made into a whole, incorporate or be incorporated, to mix, to amalgamate” (*Oxford English Dictionary* 1992) .According to *Concise Oxford Dictionary* (2009:599): combine or to be combined to form a whole. Bring or come into equal participation in an institution or body”.

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- Include: “to add as part of something else, to put into as part of a set, group or category, to contain as a secondary or minor ingredients or element, to be made up of or contain” (*Oxford English Dictionary* 1992).
- Combine: “to join together, to unite or cause to unite” (*Oxford English Dictionary* 1992).
- Embrace: to “comprise or include as an integral part, to take up to or to adopt” (*Oxford English Dictionary* 1992).
- Unite: to “make or to become an integrated whole or a unity, to join unify or to be unified in purpose, action, beliefs, etc., to enter or cause to enter into an association or alliance, to adhere or cause to adhere, fuse, to possess in combination or at the same time” (*Oxford English Dictionary* 1992).
- Amalgamate: to “combine or cause to combine, unite” (*Oxford English Dictionary* 1992).
- Assimilate: “to make alike, for an example incorporating new experiences into person’s patterns of consciousness” (Anderson, Anderson & Glanze, 1994:134).
- Unify: “to make or become one, unite” (*South African Concise Oxford Dictionary* (2009:1284).
- Coalesce: “to grow together, to unite or become together in one body or mass, merge, fuse, blend” (*Oxford English Dictionary* 1992).
- Mix: to “combine or blend ingredients, liquids, objects, etc. together into one mass, to become combined, joined, to go together, to come or to cause to come into association socially, to compliment, to cross breed” (*Oxford English Dictionary*:1992).

3.3.5 Identification of a model case.

A model case has been defined by Walker and Avant (2005:69) as “an example of the use of the concept that demonstrates all the defining attributes of the concept”. In support of the above-mentioned definition, Rossouw (2003:96) has indicated that a model case should contain all the important connotations or characteristics

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of the concept. The boundary cases usually contain some of the characteristics of the concept but not all, whilst the contrary cases do not have essential characteristics of the concept (Rossouw 2003:96). Based on the identified, uses and the defining attributes cases of the concept, the theoretical definition of the concept 'incorporate' *might be the "process of integrating, including, unifying, mixing, embracing, coalescing, assimilating, amalgamating combining and introducing the "indigenous" postnatal care practices into midwifery healthcare systems, with the aim of improving the standard of care during the postnatal period."*

In this study the researcher has identified model (pure) case of the concept, the paradigmatic example based on the uses, the defined attributes and the theoretical definition of the concept (Chinn & Kramer 2008:195; Walker & Avant 2005:69). The following model case was identified from literature:

A 68 years old granny arrive at the hospital (maternity unit), at 10h00 visiting hour. The purpose for her visit was to collect a postnatal woman and her new-born infant.. On arrival she asked if the woman and her infant are ready for discharge, a midwife indicated that they are ready but, she have to wait, because she is still giving her some health advises. Instead of involving the granny (person responsible for providing home-base postnatal care), during the health education, she only talked to the postnatal woman. One her health advice was to warn the postnatal woman not to take any advice from the grannies or traditional birth attendants, because the traditional practices are harmful to the woman and her new-born infant.

. Registered midwives in clinic and hospitals, struggle to absorb, include, subsum,, assimilate, integrate or swallow up "indigenous" practices during the provision of nursing care because they were trained within the western healthcare point of view only. They still believe that they are the only healthcare professionals that are able to

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provide quality patient care because they received midwifery training. Therefore they regard “indigenous” practices as non-religious and of low status, they can’t work as a team with the traditional birth attendants.

According to Hewson, Javu and Holtman (2009:5). Makhubele and Qalinga (2009:55) and Ngunyulu and Mulaudzi (2009:56), “indigenous” knowledge should be included into midwifery curriculum to ensure that midwives learn “indigenous” practices and improve the quality of maternal and child healthcare through the provision of culturally congruent care.

Fraser, Cooper and Nolte (2010:20) included some information on cultural awareness, cultural differences and cultural stereotyping, but the researcher felt that the information is insufficient to empower midwives with culturally competent knowledge and skills. Cultural competence is defined by Purnell and Paulanka (1998) in Giger and Davidhizar (1999:8) as “ the act whereby a healthcare professional develops an awareness of one’s existence, sensations, thoughts, and environment without letting these factors have an undue effect on those for whom care is provided’.

Similarly, Leininger (1995: 5) in her “Sunrise model” of transcultural nursing suggested long ago in the 1960,s that culture should be integrated into nursing care to empower nurses with appropriate knowledge and skills to understand the cultural expresses and specific symbols.

Kruske, Kildea and Barclay (2006:75) reiterated that in order for midwives to be able to meet the cultural needs of diverse patients, the should receive training which is a combination of western and “indigenous” healthcare worldviews.

On the other hand, Tuck et al. (202:409) suggested that western healthcare practices should be incorporated into “indigenous” practices through training of the indigenous healthcare practitioners regarding postnatal care.

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The pressure to combine the western healthcare practices with the “indigenous” practices became high when patients from different cultural groups realised that they now has the right to receive both “indigenous” and western healthcare practices (Parucha, 2005:1).

In contrary to the above statements, Ngomane and Mulaudzi (2010:35) indicated that during the provision of antenatal, labour, delivery and postnatal care, current midwives are either willingly or unwillingly rejecting the “indigenous” practices because they were trained in western paradigm.

3.3.6 Identification of antecedents and consequences

After identifying the model, case, the researcher also identified Antecedents and Consequences. The antecedents and consequences were identified from literature, colleagues who are experts in m field of midwifery, including the uses, the defined attributes, theoretical definition, the model case and the researcher’s experience within midwifery context.

ANTECEDENTS

According to Chinn and Kramer (2008:195) and Walker and Avant (2005:73), antecedents are those events or incidents that should occur prior to the occurrence of the concept. Antecedents assisted the researcher to identify underlying assumptions about the concept ‘incorporation’. In this study, the researcher identified the following antecedents:

- **Awareness campaigns**

Awareness campaigns are described as the useful tools in marketing, advertising, introducing and communicating a new or an unknown issue to a large number of participants (Wong, Huhman, Heltzier, Asbury, Bretthauer-Mueller, McCarthy & Londe 2004:2). Prior to incorporation of “indigenous” postnatal care practices into midwifery healthcare system there should be awareness campaigns to create

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awareness between the registered midwives about the “indigenous” practices that are employed by the family members and traditional birth attendants during the postnatal period. On the other hand, the campaigns will also create awareness in the family members and traditional birth attendants about the postnatal care practices employed by the registered midwives during the care of postnatal patients.

Furthermore the registered midwives, family members and traditional birth attendants *should have an opportunity of marketing and advertising their practices, assist in establishment of rapport, initiation of mutual and trusting relationship enabling the participants to gain recognition from each other's healthcare practices* Haynes, Weiser and Berry (2009:3). Here should be *truth and reconciliation* sessions between the two groups.

Gonzalez-Torre, Adenso-Diaz & Artiba 2004:102) reiterated that *the awareness campaigns can be regarded as the traditional strategy of partner notification, community education as well as locating information*. During the awareness campaigns the registered midwives had to present the Western care practices for the family members and traditional birth attendants to become aware of how the registered midwives were taking care of postnatal patients. The family members and traditional birth attendants should also present the “indigenous” postnatal care practices for the registered midwives to become aware of how the family members and traditional birth attendants are taking care of postnatal patients.

After the presentations each group should have a chance to give comments, offer suggestions and make recommendations. After the comments they come to an agreement on the way forward. This has been supported by Goske, Kimberly, Applegate, Boylan, Butler, Callahan, Coley, Farley, Frush, Hermans-Shulman, Jaramillo, Johnson, Kaste, Morrison, Keith, Strauss and Tuggle (2008:1), who confirmed that the participants might be influenced and encouraged by the awareness campaigns to work together as a team which could bring change in the nursing practice. Hence it might be of utmost importance to conduct awareness

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campaigns prior to the incorporation of “indigenous” postnatal care practices into a midwifery healthcare system.

- **Acceptance of each other**

‘Acceptance’ is defined by the *Oxford South African School Dictionary* (2006:4) as “taking something that somebody offers you or ask you to have”. In order to incorporate “indigenous” postnatal care practices into a midwifery healthcare system successfully, the registered midwives, family members and the traditional birth attendants should first accept each other. Once they become aware about how each group is working during the postnatal care the two groups will begin to accept each other as core workers, rather than regarding others as non-religious, illiterate or practicing witchcraft.

The registered midwives, family members and traditional birth attendants should be ready to accept each other’s norms, values, beliefs and practices in preparation for the incorporation of “indigenous” postnatal care practices into midwifery healthcare system. According to Guzzo and Dickson (1996:310), cohesiveness and effective performance are consequences of acceptance of each other in a team. It is evident that currently the registered midwives, family members and traditional birth attendants are not accepting each other’s norms, values, beliefs or practices; hence there is no cohesion, which results in poor performance. The registered midwives still view the family members and as witches, illiterate, non-religious and anomalies.

There is a clear line of demarcation between the registered midwives, family members and traditional birth attendants; because some registered midwives are not aware of the” indigenous” practices that are employed by the latter when taking care of postnatal patients. On the other hand, neither family members, traditional birth attendants, nor traditional health practitioners are aware of the western healthcare practices that are employed by the registered midwives when taking care of postnatal patients. For successful incorporation of “indigenous” postnatal care practices into a midwifery healthcare system the two groups should be ready to accept each other as co-workers.

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- **Attitudinal changes**

An attitude is a “fixed way of thinking, a point of view, an outlook, belief, stand point, a frame of mind, position, a perspective, stance, a thought or an ideas which might be positive or negative” (Livingstone, 2008:42). Attitudinal change: as a prerequisite to incorporation of “indigenous” postnatal care into a midwifery healthcare system, there should be changes in attitudes between the registered midwives, family members and traditional birth attendants.

The results for concept analysis revealed that currently some registered midwives are displaying negative attitude towards the patients, family members, traditional birth attendants and the “indigenous” practices. Similarly, Bowler (1993:158) in the study titled “They are not the same as us: midwives, stereotypes of South Asian descent maternity patients”, revealed that midwives displayed negative attitude towards Asian women, which resulted in communication difficulties and labelling of them as “unresponsive, rude and unintelligent”. The negative attitude was attributed to the Asian women being immigrants to Britain and having language difficulties (Bowler 1993:160).

Literature confirmed that nurses, including midwives, are failing to provide culturally congruent care to patients of diverse cultures, evidenced by “ethnocentric practices, victim blaming approaches and poor cultural competence” (Wray, Weavers, Beake Rose and Bick 2010:73)), and that for the attitudinal change there should be continuous and on-going training of midwives regarding cultural competence. In New Zealand, cultural safety standards in nursing education were introduced in 1992, based on a belief that the Western trained healthcare professionals had negative attitudes that places the health of patients at risk and resulted in sub-standard care (Papps & Ramsden1996:493).

Meanwhile, in South Africa, research findings confirmed that midwives in different provinces were abusing patients in the form of “scolding’s, shouting, general rudeness, lack of respect to patients in general and their autonomy, in particular and that many experience arbitrary acts of unkindness, physical violence and neglect” (Hewson et al.2009:10).

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In contrast to the above, Wray, et al (2010:70) indicated that 80% of nurses in Australia, which is also a multicultural country, had positive attitude towards patients of diverse cultures, resulting in the provision of culturally congruent care. He further found that only 20% of nurses had negative attitude towards patients of diverse cultures, as evidenced by lack of nurse-patient relationships (Wray, et al. 2010:70)

In this study, the registered midwives were not ready to work hand-in-hand with the family members and traditional birth attendants, who are responsible for the care of postnatal patients. On the other hand, the family members and traditional birth attendants were not comfortable with the treatment they received from the registered midwives, and feel undermined because they were not receiving the respect they expected from them. There was an underlying conflict between the registered midwives and the family members and traditional birth attendants, who in turn felt disrespected by the postnatal patients because they no longer followed their instructions during the postnatal period, preferring to follow only the instructions provided by the registered midwives on discharge from the hospital or clinics. In order to incorporate the “indigenous” postnatal care practices successfully into a midwifery healthcare system, all the groups should change the attitude, accept and respect each other by going back to the spirit of “ubuntu” as outlined by Motshekga (2012:2).

CONSEQUENCES

Consequences: were those events or incidents that occurred as a result of the concept; these are the outcomes of the concept. Consequences assisted the researcher to determine often neglected ideas, variables or relationships that might yield fruitful new research directions (Chinn & Kramer 2008:195; Walker & Avant 2005:73). The following are the consequences of the concept incorporation of “indigenous” postnatal care practices into a midwifery healthcare system:

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- **Empowerment**

Empowerment has been described in the Livingstone (2008:220) as to authorise, enable, allow, permit, license or qualify. Once the “indigenous” postnatal care practices are incorporated into a midwifery healthcare system, the traditional birth attendants and family members will gain new knowledge and skills on how to care for the patients during the postnatal period, as a result they will become confident to work together with the registered midwives. On the other hand the registered midwives will gain new knowledge on how to provide culturally congruent care to improve the standard of postnatal care.

Based on the training that was suggested as an effective strategy in incorporation of “indigenous” postnatal care practices into midwifery system, empowerment was regarded as the consequence or outcome (Weiss 2006:117).

The patients might receive culturally congruent care in a therapeutic environment, the family members and traditional birth attendants will be authorised, allowed, permitted and qualified to provide midwifery care and the registered midwives will experience job satisfaction resulting in the provision of culturally sensitive care (Funnel & Anderson 2004: 127).

- **Teamwork**

Teamwork has been described as a dynamic process and an action that involves two or more participants or healthcare professionals with complementary backgrounds and skills, sharing common health goals and exercising concerted physical and mental efforts in assessing, planning, implementing and evaluating patient care” (Stone & Bailey 2007:259).

The registered midwives, family members and traditional birth attendants will work as a team, having regular meetings to discuss achievements and challenges. The registered midwives’ workload will be reduced because postnatal care will be rendered by family members and traditional birth attendants who are knowledgeable and skilful in early recognition of complications and referrals.

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Once the “indigenous” postnatal care practices are incorporated in midwifery healthcare systems, the registered midwives, the family members and traditional birth attendants will work as a team, displaying teamwork skills which includes the ability to resolve team conflicts and give effective group performance (Stone & Bailey 2007:258)

According to Guzzo and Dickson(1996:308), team work results from a group of individuals who see themselves and who are seen by others as a social entity, who are interdependent because of the tasks they perform as members of a group, are embedded in one or more larger social system and who perform tasks that affect others.

It is also supported by Gaudes, Hamilton-Bogart, Marsh and Robinson (2007:84), who argue that “effective team members are able to work interdependently, supporting each other, displaying group cohesiveness and group reliance, respect and trusting relationship and sharing the responsibility for their outcomes”.

- **Improved standard of postnatal care**

Researchers revealed that nurses, including midwives, who have undergone training regarding cultural competency are able to create a therapeutic environment for their patients, by displaying a feeling of job satisfaction, evidenced by positive attitude towards patients of diverse cultures, enhancing mutual and trusting nurse-patient relationships and meeting the cultural needs of individual patients (Bowler 1993:168; Papps & Ramsden1996:495; Wray et al. 2010: 70;). Through provision of culturally congruent postnatal care. This will reduce complaints from the public regarding sub-standard care, reduce legal costs and improve job satisfaction amongst the registered midwives.

On the other hand, the family members/TBAs and the home-based care providers who have undergone midwifery training will be able to provide quality postnatal care because they should possess the necessary knowledge and skills that will permit them to assess, recognise early and refer of postnatal patients in case of complications (Bulterys et al 2002:5; de Vaate, Coleman, Manneh & Walraven,

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2002:8; Jokhio et al 2005:2094; and Wilson, Gallos, Piana, Lassauer, Khan, Zamora, MacArthur & Coomaramasamy,2011:3; Sibley & Sipe 2007:476).

Table 3.2: Summary of the antecedents and consequences that emerged during concept analysis

ANTECEDENTS	CONSEQUENCES
Awareness campaigns	Teamwork
Acceptance of each other	Empowerment
Attitudinal changes	Improved standard of care (provision of culturally congruent care)

3.3.7 Definition of empirical referents

After identifying antecedents and consequences, the researcher defined empirical referents. Walker and Avant regard defining of empirical referents as the final step in concept analysis.

Empirical referents were defined by Chinn and Kramer (2008:196) and Walker and Avant (2005: 73) as classes or categories of actual phenomena that by their existence demonstrate the occurrence of the concept itself; furthermore the empirical referents are the elements that are observable. In this study the empirical referents have been identified from the perceptions and experiences of postnatal patients, family members, traditional birth attendants, registered midwives, midwifery lecturers and the maternal and child healthcare coordinators regarding the incorporation of “indigenous” postnatal care practices into a midwifery healthcare system.

Identification and defining of empirical referents helped the researcher to develop a new model because they have been linked to the theoretical base of the A model for incorporating indigenous postnatal care practices into midwifery healthcare system.

concept. As a result, it contributed to both content and construct validity of the model for incorporating “indigenous” postnatal care practices into a midwifery healthcare system (Chinn & Kramer 2008:196; Walker & Avant 2005:73). The details of the empirical referents are described in Chapter Four.

Based on the formulated theoretical definition and the identified empirical indicators of the concept, the following might be the operational definition of the concept ‘incorporate’:

In order to incorporate the “indigenous” postnatal care practices into midwifery healthcare system successfully, a person need *to observe and identify the basic things that should occur prior the occurrence of the concept, for an example, awareness campaigns, acceptance of each other, attitudinal changes and the benefits that might occur as a result of incorporation of “indigenous” postnatal care practices into midwifery healthcare system, for an example, improved standard of care (culturally congruent care).*

3.4 SUMMARY

Chapter Three has presented a theoretical and empirical analysis of the concept ‘incorporate’, following the process of concept analysis by Chinn and Kramer (2008: 192) and Walker and Avant (2005: 213). The uses and the characteristics of the concept were determined.

The researcher also identified and described antecedents, and consequences of the concept. The empirical perspective was based on the perceptions and experiences of the postnatal patients, family members, traditional birth attendants, registered midwives, midwifery lecturers and maternal and child healthcare coordinators regarding the incorporation of “indigenous” postnatal care practices into midwifery healthcare system.

Chapter Four will deal with data analysis of the perceptions and experiences of postnatal patients, family members, traditional birth attendants, registered midwives, midwifery lecturers and maternal and child healthcare coordinators

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regarding the incorporation of “indigenous” postnatal care practices into midwifery healthcare system, literature control and the discussion of field notes, observational, theoretical, methodological and personal notes as an addition to the interviews.

CHAPTER 4

DATA ANALYSIS AND INTERPRETATION OF RESULTS

4.1 INTRODUCTION

Having clarified the concept “incorporation”, the purpose of this chapter is to analyse and interpret the elicited perceptions and experiences of postnatal patients, family members, traditional birth attendants, registered midwives, Midwifery lecturers and the maternal and child healthcare coordinators to use in the development of a model for incorporating “indigenous” postnatal care practices into a midwifery healthcare system.

This incorporation was recommended in a study conducted by Ngunyulu and Mulaudzi (2009:49) of “indigenous” practices in postnatal care amongst family members and traditional birth attendants in a village in Limpopo Province. Following comparison with western healthcare practices, the findings revealed that postnatal care is provided effectively at home by grandmothers, family members, traditional birth attendants and Traditional Health Practitioners. They use their expertise, knowledge and skills to enhance the physical and emotional well-being of the postnatal woman, who are discharged within six hours of delivery from hospitals and clinics (Guidelines for maternity care in South Africa 2007:47). These include preventing complications such as postnatal bleeding and maintenance of the nutritional status of the mother and baby. The skills will also be used to protect both by excluding evil spirits, and work to help the mother to rest and maintain physical well-being. However, these practices were not known by the midwives because they were not included in the midwifery curriculum (Ngunyulu & Mulaudzi 2009:49), hence the aim of this study to develop a model for incorporating “indigenous” and western practices.

The first phase towards development of a model was to clarify the concept ‘incorporation’; the findings for concept analysis in chapter three, guided the researcher during data collection, analysis and interpretation, hence the second

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phase was to explore the perceptions of the participants; the third to develop and describe the model based on the findings from phase one and phase within the conceptual framework of Dickoff, et al. (1968:420). As detailed in Chapter Two, the researcher employed in-depth individual and focus group interviews, the research findings themselves, a literature control and discussion of field notes, observations and theoretical, methodological and personal notes. Data was collected until data saturation was reached.

4.2 DATA ANALYSIS

Data analysis is the process of separating data into smaller and manageable parts with the intention of finding meaningful answers to the research questions and objectives and to disseminate the findings (Polit & Beck 2008:69). A total of six focus group interviews and 34 in-depth individual interviews were conducted from six population groups. Two focus group interviews were conducted with postnatal patients, two with family members and two with family members and traditional birth attendants.. Each focus group consisted of five to fifteen participants, selected from one village.

The in-depth individual interviews were conducted as follows: 18 registered midwives (8 from the clinics and 10 from the hospital maternity ward); 11 midwifery lecturers and five maternal and child healthcare coordinators. The details of the population groups are outlined in Tables 4.1 to 4.6 (below). The data for postnatal patients, family members and traditional birth attendants was collected in Xitsonga and translated into English, whilst the data for registered midwives, midwifery lecturers and maternal and child healthcare coordinators was collected in English. The participants from the different population groups represented different ages and cultural backgrounds. A qualitative data analysis process by Polit and Beck (2008: 508) was followed, that is: the process of fitting data together, of making the invisible obvious, of linking and attributing consequences to antecedents, it was the process of conjecture and verification, of correction and modification, of suggestion and defence.

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Data analysis occurred simultaneously with data collection.

4.2.1 Population

The following tables outline relevant details for the different population groups involved in the study.

TABLE 4.1: Profile for postnatal patients

Participants	Age	Number of participants
Postnatal patients	15-20 years	09
	20-30	08
	30-40	06
	40-50	06
	50-60	01
TOTAL		30
Participants	Parity	Number of participants
Postnatal patients	Para 2	06
	Para 3	11
	Para 4	08
	Para 5	04
	Para 7	01
TOTAL		30
Postnatal patients	Cultural background	Number of participants
	Tsonga	25
	Sotho	03
	Venda	02
TOTAL		30

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TABLE 4.2: Family members

Participants	Age	Number of participants
Family members	30-40 years	01
	40-50 years	03
	50-60 years	10
	60-70 years	07
TOTAL		21
Family members	Cultural background	Number of participants
	Sotho	03
	Venda	02
	Tsonga	16
TOTAL		21

TABLE 4.3: Profiles for Traditional Birth Attendants

Participants	Age group	Number of participants
TBAs	30-40 =	01
	40-50 =	02
	50-60 =	12
	60-70 =	08
	70-80 =	03
TOTAL		26
TBAs	Cultural background	Number of participants
	Sotho	04
	Venda	02
	Tsonga	20
TOTAL		26

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TABLE 4.4: Profiles for registered midwives

Participants	Age group	Number of participants
Registered midwives	30-40 =	10
	40-50 =	06
	50- 60 =	02
TOTAL		18
Registered midwives	Type of staff	Number of participants
	Clinic staff =	08
	Hospital staff =	10
TOTAL		18
Registered midwives	Years of experience	Number of participants
	5-10 =	03
	10-20 =	07
	20-30 =	08
TOTAL		18
Registered midwives	Cultural background	Number of participants
	Sotho =	03
	Venda =	01
	Tsonga =	14
TOTAL		18
Registered midwives	Qualifications	Number of midwives
	Registered midwives =	07
	Advanced midwives =	11
TOTAL		18

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TABLE 4.5: Profiles for Midwifery lecturers

Participants	Age group	Number of participants
Midwifery lecturers	30-40 =	01
	40 -50 =	06
	50-60 =	03
	60-70 =	01
TOTAL		11
Midwifery lecturers	Years of experience as a nurse educator	Number of participants
	5 - 10 =	02
	10 – 20 =	07
	20 – 30 =	02
TOTAL		11
Midwifery lecturers	Cultural backgrounds	Number of participants
	Sotho =	03
	Venda =	02
	Tsonga =	06
TOTAL		11

TABLE 4.6: Profiles for Maternal and Child healthcare coordinators

Participants	Age-group	Number of participants
Maternal and child healthcare coordinators	30-40 =	02
	40-50 =	03
TOTAL		05
Maternal and child healthcare coordinators	Positions	Number of participants
	MCWH managers =	01
	MCWH assistant managers =	01
	MCWH coordinators =	03
TOTAL		05
Maternal and child healthcare coordinators	Cultural backgrounds	Number of participants
	Sotho =	02
	Venda =	02
	Tsonga =	01
TOTAL		05

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The participants illustrated in Tables 4.1 to 4.6 were selected purposefully, having been involved in the care of postnatal patients in one way or another. The focus group and the in-depth individual interviews were based on the research question: *What are the perceptions of participants regarding the incorporation of “indigenous” postnatal care practices into midwifery healthcare system?*

4.3 RESEARCH FINDINGS FROM THE DATA

During data analysis, themes, categories and sub-categories of different stakeholders were identified. The presentation of research results was done according to the findings from the postnatal patients, family members, traditional birth attendants, registered midwives, midwifery lecturers and the maternal and child healthcare coordinators. Themes were identified to substantiate each category and its sub-categories (De Vos et al 2007:344; Streubert & Carpernter 1999:37). During the analysis of data from the six population groups a total of 11 themes, 21 categories and 28 sub-categories emerged. The themes, categories and sub-categories emerged as follows:

4.3.1 Postnatal patients

Table 4.7 (below) displays the themes, categories and sub-categories on the perceptions and experiences of postnatal patients (first population group) regarding the incorporation of “indigenous” postnatal care practices into a midwifery healthcare system.

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Table 4.7: Perceptions of postnatal patients

THEME	CATEGORIES	SUB-CATEGORIES
1. Challenges during the postnatal period	1.1 Lack of openness and transparency between registered midwives, the family members and traditional birth attendants	<ul style="list-style-type: none"> • Excluding patients' relatives when giving postnatal care advice on discharge • Clashing postnatal advice
	1.2 Lack of postnatal care supervision and follow up	<ul style="list-style-type: none"> • The postnatal patients under direct care of family members and traditional birth attendants only • Feeling of insecurity by the postnatal patients

Theme 1: Challenges during the postnatal period

Theme one explored and described the challenges experienced by postnatal patients during the postnatal period. Postnatal patients regard themselves as the recipients of care from the registered midwives, family members and traditional birth attendants, between whom they expected communication. They also expect registered midwives to provide supervision of family members and traditional birth attendants. The findings revealed lack of openness and transparency between the registered midwives, family members and traditional birth attendants. It also confirmed there was no supervision of family members and traditional birth attendants during the provision of postnatal care. The postnatal patients revealed that they experienced serious challenges during the postnatal period, as follows:

Category 1.1: Lack of openness and transparency between registered midwives, family members traditional birth attendants

The postnatal patients confirmed that there was no communication between registered midwives, family members and traditional birth attendants. Each group was working alone and in isolation, with the postnatal patients reporting difficulty in being between them. During analysis and interpretation of data from the postnatal patients three sub-categories emerged:

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- **Excluding patients' relatives patients when giving postnatal care advice on discharge**

The postnatal patients expect to receive health education in the presence of the relatives, family members, traditional birth attendants who visited the hospitals or clinics to collect the woman and new-born baby on discharge. The findings indicated that during health education by registered midwives on discharge from the hospital or clinic, the family members and traditional birth attendants were not involved, thus creating conflict between the postnatal women and family members at home. The registered midwives concentrated on postnatal patients only, as evident in these quotes:

The registered midwives are giving health advice to us as patients only. They do not involve our relatives who are taking care of us during the postnatal period. As a result we find it difficult to follow the postnatal care advice because they differ from what we are told at home.

It is difficult for us to come back for postnatal check-up after three days because the grannies do not allow us to move out of the house, even if you try to tell them about the advice given on discharge, they do not understand because they were not involved by the nurses when giving health advice on discharge.

The problem is that as postnatal patients we do not have a say on what should be done or followed during the postnatal period, because the grannies are aggressive, they want us to follow what they tell us to do during the postnatal period. Most of the time this practice clashes with what the nurses is saying on discharge from the clinics/hospitals.

These quotes show that teamwork would enable registered midwives to involve relatives, family members and traditional birth attendants during health education on discharge. This is supported by the South African Nursing Council R2488 no 20(2), which indicates that registered midwife should, where necessary, work in consultation with the family during the care of postnatal patients. Rinehart (2012:4) in WHO Technical consultation on postpartum and postnatal care, also stressed

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that in order to maintain and promote the health of the woman and her baby, and give them an environment that offers help and support, all postnatal and postpartum care should be offered in partnership with the woman and her family. Gerring and Thacker (2004:296) and Gommersal et al. (2007:745) argue that in order for the teams to function effectively there should be availability and accessibility of information amongst the health team members on how the systems are operating. In addition, Forde and Aasland (2012:523) indicate that it is not possible for the teams to work together without openness and transparency, which is described by Curtin and Meijer (2006:120) as the ability of team members to be as open as possible about all the decisions they make and the actions they take within the working environment.

- **Clashing postnatal care advice**

The findings confirmed that lack of openness and transparency leads to clashing of postnatal care advice from the registered midwives, family members and traditional birth attendants. Absence of communication between the two groups results in lack of knowledge amongst family members traditional birth attendants regarding the type of advice given by registered midwives on discharge. On the other hand, registered midwives are not aware of the type of advice given by the family members and traditional birth attendants at home during the provision of postnatal care, resulting in postnatal patients receiving different types of advice at the hospital or clinics and at home. The postnatal patients confirmed that they were receiving Western healthcare advice from the registered midwives on the date of discharge. On arrival home they received the “indigenous” postnatal care advice from the family members and traditional birth attendants. This placed them in a serious dilemma because they did not know which advice to take. This conflict is evident in the following quotes:

At the clinic they advised me to do some exercises in order to ensure good muscle tone and to facilitate involution of the uterus. On arrival at home my grandmother advised me not to do any household activities such as cooking because I'm still very weak and the food will smell [of] breast milk.

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The nurses told me to come back to the clinic for check-up after three days, but when I arrive at home, my mother-in-law told me to stay in the hut for six weeks without coming into contact with the people who are sexually active in order to protect the new-born baby from the evil spirits, so I do not know which advice to follow.

I was told by the sister to feed the baby with breast milk only for six months without giving other things like soft porridge, purity, danone, etcetera, but at home my mother-in-law is preparing xidlamutana for me and very light soft porridge for the new-born every morning.

For my firstborn the nurse told me that the foremilk is good for my baby because it contains all the nutrients that are needed for growth of the new-born. At home, my granny encouraged me to first squeeze the foremilk and throw it away every time before I breastfeed the baby because the foremilk is dirty and is not healthy for the new-born baby.

The sister gave me an injection for family planning on discharge to prevent accidental conception during the postnatal period. My mother-in-law advised me not to resume sexual intercourse until after the menstruations starts again after delivery.

During health education on discharge, the nurse said: “Do not allow the grannies to cut and put black stuff on the fontanelle of the new-born baby, because your baby will die”. On arrival at home my granny invited the family’s traditional health practitioner to come and put the muti on the baby’s fontanelle. When I tried to tell her what the nurses said, she said “not on my grandchild”.

I think there should be truth and reconciliation between the registered midwives, family members/ and traditional birth attendants because currently the two groups are not on good terms with each other. The registered midwives are advising us to be careful about what the family members and

traditional birth attendants. As will tell us to do during the postnatal period because they are dangerous to us and our new-born babies”.

These quotes show that there is a need for incorporation of “indigenous” postnatal care practices into the midwifery healthcare system, so as to enhance communication between registered midwives, family members and traditional birth attendants. This might ensure quality and effectiveness of health education during the postnatal period and prevent confusion. This is supported by Ojwang, Ogutu and Matu (2010:1), in the study titled *Nurses, impoliteness as an impediment to patients, rights in selected Kenyan hospitals*”, where they argue that nurse’s impoliteness violates a patient’s right to acceptable and useful information. McGrath and Kennel (2008:92) state that it is important to involve a doula in the provision of continuous support during the postnatal period, whilst Robin (2010:4), in her study titled: *The obstetric and postpartum benefits of continuous support during childbirth*, also confirmed that postnatal women should receive physical and emotional support of a doula from pregnancy, labour, delivery and puerperium.

Van Wyk (2005:2) (2003:29) have written that in order to avoid clashing advice, which leads to substandard care, the registered midwives should consider the family members and traditional birth attendants as important members of the healthcare system, because they are either the patient’s choice or the last choice when the registered midwives fail to meet their cultural demands. In contrast, Anderson et al. (2004:124) argues that it is of the utmost importance to plan together with the family members on how to care for postnatal patients, rather than educating the patients alone on what to do during the postnatal period. There is a need for involvement of family members and traditional birth attendants when giving health education on discharge to avoid a clash of western and “indigenous” advice, and to ensure quality and effectiveness of health education. It is also necessary to have a doula who is responsible for providing physical and emotional support throughout pregnancy, labour, delivery, puerperium and the postnatal period. Currently in South Africa there are little family members and traditional

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birth attendant's evidence to confirm the availability of doulas in the provision of care during antenatal, antepartum or postnatal care.

Category 1.2: Lack of postnatal care supervision and follow up

The postnatal patients expressed concern regarding lack of postnatal supervision and follow-up visits by the registered midwives, feeling that the postnatal care visits should be conducted in order to provide support, supervision and guidance during the postnatal period. As a result, they were placed under the direct care of family members and traditional birth attendants only, leading to feelings of insecurity. Two sub-categories emerged:

- **The postnatal patients under direct care of family member and traditional birth attendants only**

The postnatal patients confirmed that the registered midwives were no longer making follow-up visits as they had before, resulting in the postnatal patients being under the supervision or guidance and care of the family members and traditional birth attendants during the postnatal period. This is evident in the following quotes:

The nurses must go back to what they used to do before, where the nurses were moving around the villages on a bicycle, visiting the women and their babies at home after being discharged from the hospitals or clinics. Now they are no longer coming, and it is a serious problem to us because now we just struggle alone and we are not sure whether we are doing the right thing or not.

...when I try to explain what was said by the nurses on discharge, my mother-in-law does not even want to hear such stories. She just say "that will not happen to my grandchild, over my dead body".

These quotes reveal a need to ensure support of family members and traditional birth attendants during the provision of postnatal care. Postnatal support can be provided through follow-up visits by registered midwives in order to ensure continuity of care, provide support, guidance and supervision, and to evaluate the effectiveness of health education given on discharge. The follow-up visits might also assist in initiation and maintenance of exclusive breastfeeding, which is

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necessary for prevention of malnutrition and reduction of child mortality rates. This is supported by the South African Nursing Council R2488, 19(1), which states that:

... during the puerperium the enrolled midwife shall attend the mother and the child at least once a day until such time as the condition of both is satisfactory: Provided such attendance shall if possible, be carried out daily for at least five days following the birth of a child.

Registered midwives are obliged to promote breastfeeding unless it is contra-indicated (R2488, 19, 4). One of the objectives in the *Strategic Plan for Maternal, New-born, Child and Women's Health (MNCWH) and Nutrition in South Africa 2012-2016* is to reduce maternal and child mortality rates (DoH 2012:8), and to this end registered midwives should ensure that mothers and their children receive comprehensive community-based services at primary level (DoH 2012:9). According to Yousuf, Mulatu, Nigatu and Seyum (2010:7), in their study titled *Revisiting the exclusion of family members and traditional birth attendants from formal health system in Ethiopia*, close supportive supervision of trained family members and traditional birth attendants is of vital importance in the reduction of maternal and child mortality rates. Similarly in Kenya, postnatal women, did not receive support from the midwives, they were cared for by the family members, who gave them advises on how to take care of themselves and the new born infants during the postnatal period (Awiti-Ujiji, Ekstrom, Ilako, Indalo, Lukwaro. Wawamalwa 2011:160).

There is a need for registered midwives to conduct follow-up visits in order to ensure continuity of care during the postnatal period, as required by the SANC R2488. Currently in South Africa, women are discharged within six hours of delivery (Guidelines for Maternity care 2007:42), leaving postnatal care to be rendered at home by unskilled family members and traditional birth attendants. As (Ngunyulu & Mulaudzi 2009:49). Continuous support during follow-up visits by registered midwives might empower family members and traditional birth attendants with knowledge and skills regarding early recognition of complications and early seeking of medical attention, leading to reduction of maternal and child

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mortality rates. The support visits might assist in initiation and maintenance of exclusive breastfeeding, which is an important strategy in the reduction of child mortality rates in developing countries.

- **Feeling of insecurity by the postnatal patients**

The postnatal patients confirmed that they had feelings of insecurity during the postnatal period, because their lives were being placed under the sole care of family members and traditional birth attendants throughout the postnatal period, without support from registered midwives. Consequently, they felt they were at risk of developing complications and delayed seeking medical assistance for fear that it might lead to unnecessary complications, disabilities and/or even death. The postnatal patients indicated that:

...I once bled with clots during the postnatal period. When I report to the granny who was allocated to take care of me she said that it is normal to bleed during the postnatal period, the uterus is cleaning where the baby was situated. Bleeding continued until I collapsed. Is then that they called an ambulance to take me to the hospital.

...I do not feel safe to be cared for by a family member who is not even trained on how to care for a woman during the postnatal period, because anything can happen to me and my new-born baby, and it will take time for this family member to realise that there is a problem that needs urgent attention.

My first child nearly died due to bleeding from the umbilical cord, which was not tied properly by a traditional birth attendant at birth. She took time to allow me to take the baby to the clinic, on arrival at the clinic, and the sister referred the baby to the hospital urgently because the baby was paper white.

These quotes show a need to empower midwives with “indigenous” knowledge, so that midwives become aware about harmful “indigenous” postnatal care practices, and educate traditional birth attendants and family members about the dangers of the quoted “indigenous” practices. Provision of postnatal care by knowledgeable and skilful traditional birth attendants might ensure patients’ safety and security

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during the postnatal period. Incorporation might also empower family members and traditional birth attendants with knowledge and skills regarding early recognition of complications and danger of postpartum bleeding, as well as the need to seek early medical attention. This finding supports that by the WHO (2008:9), which stated that some women in developing countries are discharged within hours after birth without any indication as to where they can obtain further care or support. As Dhaher, Mikolajczyk, Maxwell and Kramer (2008:1) write, postnatal care is appropriate because up to two thirds of maternal deaths occur after delivery, with women and their new-born babies at risk and vulnerable to complications such postpartum haemorrhage and infection. Warren, Daly, Toure and Mongi (2008) stress that half of all maternal deaths occur during the first week after delivery, with inadequate care during this period a common cause. Johansson, Aarts and Darj (2010:131), in their study titled *First-time parents' experiences of home-based postnatal care in Sweden*, found that postnatal women prefer postnatal care to be accompanied by professional support from the registered midwives. In Tanzania, postnatal home-based care services provided by culturally sensitive midwives have been an effective strategy in the improvement of maternal and child health, resulting in reduction of maternal and child mortality rates (Mrisho, Obrist, Armstrong, Hawa, Mushi, Mshinda & Schellenberg 2008:10). In the USA, Cheng, Fowles & Walker (2006:34) revealed that despite home visits during the postnatal period by registered midwives, postpartum healthcare was still being neglected and policy improvements were required to ensure the provision of holistic and flexible maternal healthcare. In South Africa, there is a need to provide moral support, supervision, guidance, introduction of trained doulas, recognition and training of family members during the postnatal period if there is to be quality care and patient safety and security. The provision of postnatal care by skilled family members, trained doulas and skilled family members and traditional birth attendants might prevent unnecessary complications, leading to reduction of maternal and child mortality rates and achievement of Millennium Development Goals number 4 and 5.

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4.3.2 Family members and traditional birth attendants

The family members and traditional birth attendants (second and third population groups) were grouped together because of the identified similarities in the challenges they experienced during the provision of postnatal care within the community context.

Table 4.8 (below) displays the themes, categories and sub-categories on their perceptions and experiences of the incorporation of “indigenous” postnatal care practices into the midwifery healthcare system.

TABLE 4.8: Perceptions and experiences of family members and traditional birth attendants

THEME	CATEGORIES	SUB-CATEGORIES
1. Challenges experienced by family members and traditional birth attendants during postnatal care	1.1 Lack of support by registered midwives	<ul style="list-style-type: none"> Family members and traditional birth attendants complain that they lack confidence without support from the registered midwives
	1.2 Lack of respect, mutual and trusting relationship between family members, traditional birth attendants and the postnatal patients	<ul style="list-style-type: none"> The family members and traditional birth attendants feel disrespected and undermined when postnatal women ignore their advice during the postnatal period
	1.3 Witnessing maternal deaths at home	<ul style="list-style-type: none"> Family members and traditional birth attendants express feelings of doubt regarding the knowledge and skills of registered midwives during postnatal care Grandmothers taking over the responsibility for caring for the new-born babies after the mother’s death

Theme 1: Challenges experienced by family members and traditional birth attendants during the provision of postnatal care

Theme one explored and described the challenges experienced by the family members and traditional birth attendants during the provision of postnatal care. Family members and are responsible for taking care of women and new-born

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babies immediately after discharge from the hospitals/clinics. They need moral support from registered midwives in order to gain confidence when taking care of postnatal patients. They also expect mutual respect and trusting relationship from the postnatal patients during the provision of care. It is confirmed that there is lack of respect, mutual and trusting relationship between the family members, traditional birth attendants and the postnatal patients. The study findings also confirmed that the family members and traditional birth attendants sometimes witness maternal deaths at home, resulting in feelings of doubts regarding the knowledge and skills of registered midwives during postnatal care. It is also confirmed that some grannies are responsible for taking care of new-born babies after their mother's deaths.

During data analysis of the challenges outlined by family members and traditional birth attendants the following categories emerged:

Category 1.1: Lack of support by registered midwives

According to Livingstone (2008:666), the concept support may relate to *comfort, encouragement, assistance and backing*, with an example given of the notion of *tower of strength*. Meanwhile, in terms the Nursing Act, 1978 (Act No 50 of 1978) (R2488:1), a registered midwife is defined as a person registered or enrolled as a nurse and a midwife, responsible for the provision of care to women during antenatal, labour, delivery, puerperium and postnatal periods. They are expected to provide comfort, encouragement and assistance, and to build up the strength of the family members and traditional birth attendants by conducting home visits during the postnatal period. However, the findings of this study revealed a lack of support to the family members and traditional birth attendants during the provision of postnatal care.

The family members and traditional birth attendants reported that they had not received any support from the registered midwives during the provision of postnatal care. On discharge from the hospital or clinic the postnatal patient was

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handed over to family members without any indication of how to continue with her care during the postnatal period. They further reported that without support from registered midwives they lacked confidence and were caring for the patients alone.

- **Family members and traditional birth attendants complain that they lack confidence without support from the registered midwives**

Confidence is defined as “the feeling that you can do something well” (*Oxford South African School Dictionary* 2012:128). The family members and traditional birth attendants revealed they did not feel confident when taking care of patients during the postnatal period, and the findings revealed that they were working in isolation. Even when they came across serious complications they did not have a midwife nearby to assist with answering questions. They further reported that lack of support visits by the registered midwife was regarded as a confirmation that what they were doing was of low status and non-religious, even that they were practicing witchcraft. As a result they had feelings of inferiority, lacked confidence, and were not free to talk about the “indigenous” practices they employed when caring for patients during the postnatal period. This is evident in the following quotes:

One family member said:

...it can be easy for us as family members who are responsible for taking care of the women during the postnatal period, to get support from the registered midwives, because now we are struggling with the care of postnatal women and their new-born babies alone. They cannot give themselves a chance to come and see the woman and her new-born at home, just to have them moral support.

Another family member said:

Previously we use to see a nurse riding on a bicycle, driving around the villages, visiting all the women and their new-born babies who were discharged from the hospitals or clinics. It was very good support for us as people who are taking

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care of the postnatal women because we were able to ask questions and discuss some challenges that we experience when taking care of postnatal patients.

One of the well-known family member said:

...for anything I do for the postnatal woman I remain with guilt feeling because I'm aware that as traditional birth attendants we are no longer allowed to do home deliveries because the nurses regard us as non-religious, witches and people who are illiterate.

Another experienced traditional birth attendants said:

...nowadays I no longer have that confidence that I use to have previously because we are being undermined by nurses, that is why we always hide everything we do for the postnatal patients...

From these quotes it is evident that the situation in which the family members and traditional birth attendants are functioning during the provision of postnatal care requires incorporation of “indigenous” postnatal care. There should be provision of moral support to family members and traditional birth attendants in the form of home visits, recognition, training, rewards and praise to build up their confidence. The provision of postnatal care by confident, skilled and knowledgeable family members and traditional birth attendants might serve as an effective strategy in the reduction of maternal and child mortality rates. This was also supported by Awiti-Ujiji, Ekstrom, Ilako, Indalo, Lukwaro. Wawamalwa (2011:160), they indicated that family members and traditional birth attendants in Kibera, also did not receive support from the midwives during the provision of postnatal care, they were taking care of postnatal women alone. Hodnet (2012:2), in a study conducted in Canada, titled “*Traditional Birth Attendants are an effective resource*”, found that the use of trained, continuously supported and adequately resourced birth attendants had proven to be an effective strategy in saving the lives of mothers and their babies. In addition, MacArthur (2007:) in a study titled *Traditional birth attendant training for improving health behaviours and pregnancy*

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outcomes, found in Pakistan that training of birth attendants significantly reduced perinatal and maternal mortality rates. Jokhio, Winter and Cheng (2005:2096) found family members traditional birth attendants to be reliable resources for community members because they played an important role in the communities, despite the absence of support systems around them.

Category 1.2: *Lack of respect, mutual and trusting relationship between family members, traditional birth attendants and postnatal patients*

Culturally, a woman at childbearing age is expected to show respect to the grandmother/s, who is/are assigned to take care of her and her new-born baby during the postnatal period. Postnatal women are culturally obliged to follow the instructions and advice given by the family members and traditional birth attendants as a mark of respect, thus enhancing and maintaining a mutual and trusting relationship. However, the family members and traditional birth attendants expressed concern regarding the treatment they received from some of the postnatal patients, saying that the postnatal women were no longer showing respect, or developing a mutual or trusting relationship as was the tradition.

- **The family members and traditional birth attendants feel disrespected and undermined when postnatal women ignore their advice during the postnatal period**

The family members and traditional birth attendants had previously been expected to make a final decision regarding the care of postnatal woman and the new-born. The findings revealed that some postnatal women did not respect the family members and traditional birth attendants responsible for the provision of postnatal care. This was expressed in the following quotes:

One traditional birth attendant said:

....previously I use to keep the woman and the new-born baby in my hut until the end of the second month, but now things have changed. When the woman and the baby are discharged from the hospital or clinic, the father is the one

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who is carrying the baby home, so I just keep quiet because even if I talk, they do not listen to me.

Another traditional birth attendant said:

The way of doing things differ from one family to another, with me in my family. On coming back from the hospital or clinic with the discharged woman after delivery I do not do anything because I am aware that they regard me as a witch, so I'm afraid that if I keep this woman in my hut and something happen to the baby or the mother, they will conclude that I bewitched them, so I just keep quiet because I do not want to be killed by their husbands.

Another traditional birth attendants said:

...she do not even allow me to come closer or to hold the new-born baby, she keeps the baby away from me...

One family member said:

...young men and women are dying every day because they do not follow the taboos during the postnatal period... delayed resumption of sexual relations...

Another family member said:

...when I request her to come to my hut with the new-born for isolation against evil spirits, she said that: "sisters at the clinic told me not to take any other advice except the advice given at the clinic or hospital..."

These quotes reveal a need to enhance a collaborative working relationship between the registered midwives, family members and traditional birth attendants. Such a relationship might ensure openness and transparency, communication and teamwork between the registered midwives, family members and traditional birth attendants. Furthermore, teamwork might reveal the similarities between the "indigenous" and Western postnatal care practices, for example, putting the postnatal woman and the new-born in a grandmother's hut promotes physical rest and emotional wellbeing (Ngunyulu & Mulaudzi, 2009: 53). Similarly, Fraser et al. (2010:225) and Nolte (2011:218) encourage rest and sleep through rooming-in

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and provision of a rest period between the postnatal activities. The realisation of these similarities by the postnatal patients might assist in restoration of the cultural respect, mutual and trusting relationship that prevailed in families between the family members, traditional birth attendants and the postnatal patients. The realisation of similarities will be based on the family members traditional birth attendants This is supported by the Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa (2011:34), which states that: "ensure the right of elderly women to freedom from violence, including sexual abuse, discrimination based on age and the right to be treated with dignity". Despite lack of training in midwifery care, the grandmothers should be treated with respect and dignity by the registered midwives and postnatal patients.

Category 1.3: Witnessing maternal deaths at home

Maternal death is defined by the WHO as:

... death of a woman while pregnant or within 42 days of termination of pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes (WHO 2008:1).

Meanwhile, to 'witness' is "when a person see something happen, and can tell other people about it later" (*Oxford South African School Dictionary* 2010:681). Study findings revealed that some family members and traditional birth attendants had been unfortunate in seeing a woman dying in front of them, on the third day after delivery from the hospital, leaving the new-born twins behind. They expressed feelings of doubt regarding the knowledge and skills of registered midwives during delivery and expulsion of the placenta, and concern that 50% of family members were taking care of new-borns infants after the mother's death. During the analysis of data from the family members and traditional birth attendants regarding witnessing of maternal deaths, the following two sub-categories emerged.

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- **Family members and traditional birth attendants expressed feelings of doubt regarding the knowledge and skills of registered midwives during postnatal care.**

The family members and traditional birth attendants regard registered midwives as highly qualified, knowledgeable and skilled professionals. Traditionally, they expect registered midwives to be able to provide quality patient care in such a way that, once they discharge a postnatal patient, they are convinced that the condition of the patient is satisfactory. On the other hand, the registered midwives still regard themselves as the only professionals who can provide quality patient care because they are trained and registered with the SANC. As a result they still prefer to work in isolation, without the involvement of family members and traditional birth attendants. However, the findings confirmed that the family members and traditional birth attendants sometimes have feelings of doubt regarding the knowledge and skills of registered midwives during postnatal care, because of the complications which occur after discharge from the hospitals or clinics. The feelings were expressed as follows:

One family member said:

...sometimes we realise that the nurses at the hospitals and clinics, even though they say they are educated, they do not do their work properly, because these week I came back from the hospital with a woman who delivered twins, on arrival at home she stayed for a day, the second day she started to be weak suddenly and she fainted. I tried to call the ambulance which came immediately to take her back to the hospital; unfortunately she passed away before she arrived at the hospital....

One experienced traditional birth attendant said:

...I think they left some products of conception inside the uterus, They were expected to compress the abdomen until all the products are expelled, because they are dangerous to the life of a woman as they cause infection...

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Another traditional birth attendant said:

...I saw her when she arrives home on discharge, she was not well, and because she was weak... she was not yet fit for discharge...

These quotes show that there is a need to improve the quality of postnatal care through sharing of knowledge, skills and expertise between the registered, family members traditional birth attendants. The study findings revealed empowerment as one of the consequences of incorporation. Registered midwives might be empowered with knowledge and skills regarding the “indigenous” postnatal care practices, whilst the family member and traditional birth attendants might be empowered with knowledge and skills regarding the Western healthcare practices. As a result there might be harmonious working relationships between the registered midwives and the family members and traditional birth attendants, as they will share ideas on how best to prevent postnatal complications.

The quotes also reveal a need for midwives to examine the postnatal patients thoroughly and ensure that the conditions for both the mother and the new-born baby are satisfactory before discharge (Guidelines for Maternity care in South Africa 2007:43). Even if the woman and the new-born were properly examined on discharge, they still need continuity of care during the postnatal period. Again, it shows a need for daily follow-up support visits by the registered midwives during the first five days after discharge from the hospital or clinic, or until the condition for both the mother and new-born baby are satisfactory (Pandi 2005:21; R2488, 20, 2). In addition, there is a need for training of family members, Family members traditional birth attendants and doulas in the importance of early recognition of complications and early seeking of medical attention during the provision of postnatal care. Sibley and Sipe (2006:472) estimated that “half a million women die every year due to pregnancy related causes”, most during the first week after birth, especially the first 24 hours. Costello et al (2006:2) also discovered that a number of maternal deaths occur at home because of inaccessible hospital facilities, whilst Nour (2008:78) found that 50% happen at home within 24 hours

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postpartum, because the family members cannot easily recognise an emergency or complications, and by the time they do it is too late.

- **Grandmothers taking over the responsibility for caring for the new-born babies after the mother's death**

South Africa as a developing country is faced with a challenge of high maternal and child mortality rates. The leading causes include postpartum bleeding, infections such as HIV and AIDs, pregnancy-related hypertension, birth asphyxia and malnutrition in children. The grandmothers (includes the family members and traditional birth attendants) confirmed that there were a number of women who died during the postnatal period after discharge from the hospitals or clinics, leaving the new-born infants to be cared for care by them. They further indicated that this was a serious challenge because they struggled alone, without support visits from registered midwives. As elderly people they no longer had the physical strength to provide necessary care for the new-born infants.

One traditional birth attendant said:

...now I am faced with the responsibility of taking care of twin infants, because the mother passed away on the third day after discharge from the hospital...

Another said:

...I'm struggling to raise a new-born baby whose mother passed away two weeks after delivery... his father is also in a critical condition at the hospital...

Another said:

...the main cause of death is "makhuma" because, after delivery, the postnatal woman and her husband do not wait until after the commencement of the first menstruation post-delivery, which is an indication that the reproductive system returned back to its normal functioning state...

These quotes reveal a need to ensure the provision of culturally congruent care during the postnatal period, and if carried out by culturally competent registered midwives it might improve the standard of postnatal care. Registered midwives will

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be working as a team with the family members and traditional birth attendants, both groups of whom will also be trained in early recognition of complications and seeking medical assistance. Training has been suggested as an effective strategy to ensure quality of care and reduction in maternal and child mortality rates in developed countries such as Australia (Bryant 2011:9)

In South Africa, there is a need to ensure the provision of quality postnatal care, because many deaths occur during the postnatal period due to bleeding and infections. The WHO (2010:8) calculated that more than 500,000 women die each year due to complications of pregnancy and child birth, most during or immediately after childbirth. Furthermore, “about three million infants die in the first week of life, and another 900,000 die in the next three weeks” (WHO 2012:8).

According to Palitza (2010:1), “the number of orphans in South Africa has risen by 4.9 per cent since 2005”, and “out three million South African orphans, 1, 9 million had lost their fathers, while 713, 000 had lost their mothers.” These children are generally cared for by the family members and/or their relatives. The Health Science Research Council (HSRC) has revealed that orphan hood affects the physical and emotional health of children, resulting in a compromised immune system which places their health at risk of infection (Ludman, Young & Peterson 2010:1). In addition the *Hope and Homes for Children in South Africa* (HHC) report indicates that “roughly 1.4 million children in South Africa live without one or both parents, which calls for the extended family members and the community to provide care. According to UNICEF, South Africa has an estimated 3.7 million orphans, 80% of whom are cared for by their relatives.

Therefore, in South Africa, there should be strengthened strategies to ensure quality maternal and child healthcare during the postnatal period, and to prevent unnecessary deaths due to avoidable postnatal complications. The family members/TBAs confirmed that they needed professional support from the midwives during the care of orphans after the mother’s death.

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4.3.3 Registered midwives

Table 4.9 (below) displays the themes, categories and subcategories on the perceptions and experiences of registered midwives (fourth population group) regarding the incorporation of “indigenous” postnatal care practices into a midwifery healthcare system.

TABLE 4.9: Perceptions and experiences of registered midwives

THEMES	CATEGORIES	SUB-CATEGORIES
1. Inadequate knowledge regarding “indigenous” postnatal care practices	1.1 Negatives attitude towards the family members and traditional birth attendants	<ul style="list-style-type: none"> Family members and birth attendants viewed as illiterate non-religious and practicing witchcraft Lack of acceptance, mutual or trusting relationship Lack of teamwork (line of demarcation)
2 Challenges experienced by registered midwives during the postnatal period	2.1 Increasing maternal and child mortality rates	<ul style="list-style-type: none"> Contributory factors Late booking for antenatal care Ineffective postnatal check up Lack of adherence to protocols/guidelines Postpartum bleeding, infection (HIV/AIDS), pre-clampsia, eclampsia and delays in seeking medical assistance due to different factors
3. Incorporation strategies	3.1 Awareness campaigns	<ul style="list-style-type: none"> Pre-requisite to incorporation
	3.2 Meetings	<ul style="list-style-type: none"> To discuss challenges experienced during the provision of postnatal care
	3.3 Training	<ul style="list-style-type: none"> Registered midwives Family members, traditional birth attendants and doulas
4 Outcomes of incorporation	4.1 Empowerment	<ul style="list-style-type: none"> With cultural competency knowledge and skills
	4.2 Teamwork	<ul style="list-style-type: none"> Between the registered midwives, family members and traditional birth attendants.
	4.3 Improved job satisfaction	<ul style="list-style-type: none"> Due to reduced workload

Theme 1: Inadequate knowledge and skills regarding the “indigenous” postnatal care practices

In this theme the knowledge and skills of registered midwives regarding “indigenous” postnatal care practices were explored and described. Also

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discussed were their attitudes towards the family members and traditional birth attendants, as well as the consequences of negative attitudes, which include viewing family members and traditional birth attendants as illiterate, lack of acceptance and lack of teamwork. The following category emerged:

Category 1.1: Negative attitude towards the family members, traditional birth attendants and patients from different cultural backgrounds

An attitude has been described as a “fixed way of thinking, belief, standpoint, a frame of mind, position, a perspective, stance, a thought or an idea which might be positive or negative” (Livingstone, 2008:42). The registered midwives said that due to lack of knowledge regarding the “indigenous” postnatal care practices they had developed negative attitudes towards the family members and traditional birth attendants. Three sub-categories emerged.

- **Family members and traditional birth attendants viewed as illiterate, non-religious and practicing witchcraft**

In South Africa, there is no training of family members and traditional birth attendants who are responsible for taking care of patients during the postnatal period. The traditional birth attendants and family members are only recognised by the chiefs, indunas, councillors and community members as people who have experience in conducting home deliveries and provision of postnatal care. On the other hand, registered midwives still regard themselves as the only people who can provide quality patient care because they have received midwifery training. As a result it is difficult for registered midwives to accept and to work with family members and traditional birth attendants; they still regard them as illiterate, non-religious and practicing witchcraft because they are not trained in midwifery. In this study, registered midwives confirmed that they had a negative attitude towards the family members and traditional birth attendants who were responsible for taking care of patients during the postnatal period, believing they did not know what they

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were doing. They consequently regarded the family members and traditional birth attendants as different, as evident in the following quotes:

...I think the family members and traditional birth attendants are practicing witchcraft, because they do not want talk about their practices in public, but they prefer working at night, hence they make appointments with their clients during the night...

It is necessary for us as midwives to be trained on cultural issues because currently I still view the family members, traditional birth attendants and their practices as anomalies and witchcraft because I do not know exactly what they are doing.

Because I do not have an idea of what the family members and traditional birth attendants are doing when taking care of patients during the postnatal period, plus they are not trained, so I feel that they are of low status, illiterate, even non-religious and many pregnant women come with complications because of this people, I do not think it is necessary to Involve them when giving postnatal advice.

Once I see a traditional birth attendant, the first thing that comes to my mind is herbal intoxication because I come across many pregnant women who come to deliver at the clinic with herbal medications which are discovered during vaginal examinations.

....I believe that midwives are the only people that can provide quality care to patients during antenatal, labour, delivery and postnatal because they received midwifery training...

One traditional birth attendant said:

I do not think it will be possible for us to start good working relationship with the nurses, because in the first place they still regard us as witches, unreligious and uneducated. That is why even on discharge of a woman after delivery, when we go to the hospital or clinic to collect the woman and her baby; they do not even talk to us, in order to tell us how to take care of the mother and the baby at

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home. Instead they just talk to the woman alone, saying that when the grannies tell you do this, you must refuse because if you agree, the baby is going to die. If the nurses can change their current attitudes and be positive to accept us as people who are taking care of postnatal patients, I think it can work, but before that I do not think it can work.

These quotes show that there is a need for training of midwives within both the “indigenous” and Western healthcare points of view. Consequently, registered midwives might be empowered with culturally competent knowledge and skills. The findings also confirmed that teamwork between the registered midwives, family members and traditional birth attendants might be one of the consequences of incorporation. Knowledge of “indigenous” postnatal care practices might enable registered midwives to identify those practices that are harmful to the health of the woman and the new-born, and be able to negotiate with family members and traditional birth attendants for a safer way of using them. This supports the findings of Noble, Engelhardt, Wicks and Wruble (2009:544) that nurses, including midwives who are trained in cultural competency, display more positive attitudes to patients of diverse cultures than those who are not. For example, midwives with culturally competent knowledge and skills can be able to negotiate with the family members and traditional birth attendants to use one razor blade per client, and to put the traditional medicine on the new-born baby’s fontanelle without cutting, to avoid introduction of infection. This also supports Ngunyulu and Mulaudzi (2009:55) study conducted on “indigenous” postnatal care practices amongst family members and traditional birth attendants: *“I encourage each one of them to come with a razor blade that has never been used”*.

Papps and Ramsden (1996:493) and Ungerer (2002:303) pointed out that the Western-trained healthcare professionals had a negative attitude towards patients from different cultural groups, resulting in poor nurse-patient relationships, negligence and sub-standard care, and it placed the health of the patients at risk. Tebid, Du Plessis, Beukes, van Niekerk and Jooste (2011:968) also found that inadequate knowledge amongst registered midwives regarding culturally

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congruent care leads to serious threats in nurse-patient relationships. Kardong-Eden, Bond, Schlosser, Carson, Jones, Warr and Straunk (2005:178) also pointed to a relationship between nurses' attitudes and level of competency, knowledge and skills in "indigenous" knowledge. Nurse midwives with cultural competency skills have confidence and interest in their work, resulting in the establishment and maintenance of positive nurse-patient relationships (Ojwang, Ogutu & Matu 2010:5).

- **Lack of acceptance, mutual or trusting relationship**

Acceptance was described by the *Oxford South African Dictionary* (2004:4) as "taking something that somebody offers you or ask you to have". The family members and traditional birth attendants have the constitutional right to be accepted by the registered midwives without discrimination, and to receive information that will help them to provide safe postnatal care during the postnatal period. The findings confirmed that the family members and traditional birth attendants were willing to work as a team with registered midwives, but the latter found it difficult to accept them without midwifery training.

During the discussions with the registered midwives, they indicated that it was difficult for them to accept the family members and traditional birth attendants and their practices without knowing what they were doing, because they were not sure whether it was safe or not. Participants mentioned that:

...I admitted one pregnant woman with a dirty cloth a knot tied on her waist, when I ask about this, she indicates that the cloth is having medication for induction of labour, because she is postdates...

It is very difficult to for us to accept the family members and traditional birth attendants without the knowledge of what they are doing and how they are doing.

...It is necessary for us to be trained on how the Traditional Health Practitioner's Act number twenty two of two thousand and seven works. Its boundaries or acts and omissions concerning the pregnant woman, delivery,

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labour and the postnatal period, so that we understand better, may be with understanding it will be easy for us to accept the traditional birth attendants and their practices...

These quotes show that there is a need to enhance acceptance, mutual and trusting relationship between registered midwives and traditional birth attendants. The registered midwives should be orientated to the aim, purpose, objectives and contents of the Traditional Health Practitioners Act no 22 of 2007, thus assisting them to understand the importance of working together with the family members and traditional birth attendants in the provision of postnatal care.

This supports the claim by Morland, Rottingen and Ringard (2010:3) that group cohesiveness involving primary care doctors, other healthcare workers, relevant stakeholders and effective performance are consequences of acceptance of each other in a team. In addition Shah, Salim and Khan (2010) have reported that acceptance and training of family members and traditional birth attendants in Pakistan assisted the midwives to reduce the workload, whilst family members and traditional birth attendant were able to maintain personal hygiene during delivery and recognise danger signs. Kruske and Barclay (2004:2) have revealed that registered midwives should accept the family members and traditional birth attendants because 60% of births worldwide happen outside the hospitals and clinics assisted by either family members or traditional birth attendants. Currently, lack of acceptance between registered midwives, family members and traditional birth attendants leads to lack of team cohesiveness and ineffective performance, as shown by sub-standard care, avoidable postnatal complications and an increase in maternal and child mortality (Costello, Osrin & Manandhar 2004:3).

- **Lack of teamwork (line of demarcation)**

In order to ensure the provision of continuous quality patient care, registered midwives are expected to work together with the family members and traditional birth attendants during the postnatal period. They are also expected to give them a full report on the type of delivery, the condition of the woman and the new-born baby, and how they should continue with the management at home. However, the A model for incorporating indigenous postnatal care practices into midwifery healthcare system.

findings revealed that currently in South Africa there is no teamwork between registered midwives, the family members and traditional birth attendants:

...what I have realised is that there is a line of demarcation between the registered midwives, family members and traditional birth attendants , each and every one is working alone in her corner, and there is no communication between the two groups...

...six hours after delivery we discharge the woman and the new-born baby to the care by people that we do not even trust...

...we do our part at the hospital until the patient is discharged, and the traditional birth attendants and family members are working alone at home when providing postnatal care...

...I do not remember giving report to the relatives, family members and traditional birth attendants, about the condition of the woman and the baby ,and how they should continue with the provision of care at home...

What surprises me is that, we [registered midwives and traditional birth attendant/family members] are responsible for providing care to postnatal patients, but we do not communicate to each other about these patient, the only time that forces us to communicate is when the family members / traditional birth attendants bring the postnatal patients back to the hospital/clinic because she complicated at home, is the time for us as midwives to ask “what happened to the patient?”

These quotes show that there is a need to enhance teamwork between the registered midwives, family members and traditional birth attendants for provision of quality postnatal care. There is a need for registered midwives to change their current attitudes and to start to accept family members and traditional birth attendants as one of the healthcare providers directly involved in the provision of patient care during the postnatal period. This is supported by Roussinos and Jimoyiannis (2011:5), which describes teamwork, as a:

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dynamic process and an action that involves two or more participants or healthcare professionals with complementary backgrounds and skills, sharing common health goals and exercising concerted physical and mental efforts in assessing, planning, implementing and evaluating patient care.

Funnel and Anderson (2004:126), and Stone and Bailey (2007:258) have written that teamwork involves the ability to relate, respect, support, communicate, share common ideas, give reports timeously, resolve team conflicts and achieve effective group performance. In addition, Gaude, Hamilton-Bogart, Marsh and Robinson (2007:84) state that effective team members are able to work interdependently, support each other, display group cohesiveness and group reliance, form respect and trusting relationship and share responsibility for their outcomes.

Theme 2: Challenges experienced by registered midwives during the postnatal period

Theme two explored and described the challenges experienced by registered midwives when taking care of patients during the postnatal period. Registered midwives are expected to provide quality of care to prevent complications that leads to disabilities and/or even death. They work toward the achievement of Millennium Development Goals 4 and 5, hence the increasing maternal and child mortality rates emerged as their first challenge. In this theme the contributory factors are explored and described.

Category 2.1: Increasing maternal and child mortality rates

South Africa as a developing country is faced with the increasing rates of maternal and child mortality. Registered midwives pointed out some of the contributory factors towards maternal and child mortality rates as described below, with five sub-categories emerging.

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- **Contributory factors**

The findings discovered the following as the contributory factors towards the increasing maternal and perinatal mortality rate: post-partum haemorrhage; late booking for antenatal care; infection; ineffective postnatal check-up; lack of adherence to protocols; administrative factors; lack of career-pathing by the midwives; inability to create a therapeutic environment in practice (cultural barriers); the 'big five' causes of maternal mortality (HIV and AIDS, postpartum haemorrhage, pre-eclampsia); and herbal intoxication. This supports the findings of (Piane 2008:26) that 75% of maternal deaths are caused by direct complications, such as, haemorrhage (25%); infection (15%); unsafe abortion (13%); eclampsia (12%) and obstructed labour (8%).

- **Late booking for antenatal care**

Pregnant women are expected to book early for antenatal care, so that they are examined regularly and given necessary advice in preparation for labour, delivery and puerperium. This supports Fraser et al. (2010:190) claim that antenatal care visits are critical during pregnancy, as they are used to impart information, and increase awareness of the mother's own feelings and skills on how to cope with current pregnancy and the new-born baby. In addition, the *Guidelines for Maternity Care in South Africa* (2007:19) stresses that antenatal care is aimed at ensuring positive pregnancy outcomes through screening of problems, assessment of risks in pregnancy, and provision of treatment and information. Despite the strategies in place to ensure safety during pregnancy, the study findings revealed that 50% of women book late for antenatal care, while others arrive for delivery unbooked. This is evident in the following quotes:

Pregnant women come late for antenatal booking because we are shouting at them daily when they come for antenatal visits and delivery.

Midwives do not care whether you are a registered nurse or not, they shout every patient during antenatal clinic delivery.

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These quotes show a need for women to be educated about the importance of early booking for antenatal care which is aimed at prevention of complications through early detection and early seeking of medical attention. From the quotes it is evident that midwives also need moral support and in-service training regarding attitudinal changes, as an important strategy in the creation of a therapeutic environment and establishment of nurse-patient relationships. This supports Ngomane and Mulaudzi (2010:30), and Daniel (2011:1), who have indicated the gestational age at which women come for antenatal care visits are influenced by their cultural values, beliefs, attitudes, perceptions and socio-economic status. For instance, some are afraid to disclose that they are pregnant because they fear witchcraft. Furthermore Aziem, Abber, Ishag, Mohammed and Osman (2012 67) pointed in eastern Sudan antenatal care is named as one of the four pillars strategies in the Safe Motherhood Initiatives

Fraser et al. (2010:231) describe antenatal care as the care provided to a pregnant woman from the time pregnancy is confirmed until the labour commences, and aimed at monitoring the progress of pregnancy to maintain the health of the mother and the unborn baby. Nour (2008:79) also stress the issue of encouraging antenatal care for early identification of high risk pregnancies, early referral and prompt treatment to prevent complications. According to SANC R2488, 8(1a), a registered midwife is obliged to visit a pregnant woman at least once in her own home, examine her once a month until the 28th week, thereafter once a fortnight until the 36th week, and then at least once a week until the commencement of labour. SANC R2488, 8(1b) indicates that the purpose of antenatal care is to detect any abnormalities that could have an adverse effect on pregnancy, labour and puerperium, and if so advise the patient to seek medical advice.

The findings revealed that currently, in South Africa, 50% of pregnant women come late for antenatal booking, whilst others come unbooked when they are in advanced stages of labour, resulting in serious complications and unnecessary deaths. Similarly, in Nigeria, 21.35% of maternal deaths which occur within 24

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hours of admission are unbooked (Ujah, Asien, Mutahir, Vanderjagt, Glew & Uguru 2005:37).

- **Ineffective postnatal check up**

Registered midwives are expected to provide continuous care during the postnatal period until the conditions for both the mother and the new-born baby are satisfactory. According to the *Guidelines for Maternity Care in South Africa* (2007:43), a woman is advised to return to the clinic for a postnatal check-up three days after delivery.

During postnatal check-up visits, registered midwives are expected to check the general condition of the woman properly, including vital signs, urine, fundal height, bleeding (for amount, colour and odour), perineum for healing progress, haemorrhoids, signs of thrombosis and breast problems. Also, they estimate haemoglobin level, provide HIV counselling if omitted during antenatal care, provide information on diet, signs of complications, nutrition and contraception and importance of immunisations and weight monitoring, and assess the emotional status of the mother (*Guidelines for Maternity Care in South Africa* 2007:42). The findings were that 40% women did not come for postnatal checking, a reason being that culturally, in some families, a postnatal woman is not allowed to come into contact with people who are sexually active. However, women who come for postnatal checks are not checked according to the protocol, resulting in most postnatal women deciding not to go again for subsequent deliveries. This is evident in the following quote:

Another thing is that the postnatal checking's are not done properly, for an example women on discharge are advised to come back after three days for postnatal checking's, but if they come registered midwives are lazy to do proper postnatal checking's. They just greet the patient and tell her to come back again for immunisations.

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One postnatal patient said:

I was told to go to the clinic for removal of sutures after my second caesarean section. On arrival a nurse told me to lie on the examination coach. She came holding two forceps; she started removing sutures, without cleaning the wound. There was no trolley next to her, because for the first caesarean section the nurse had a trolley with cleaning solutions. She even washed hands before she started with the removal of sutures. Three days after removal of sutures I had to go back to the hospital for secondary suturing, because the wound was septic.

These quotes show that there is a need to update registered midwives through in-service training on culturally congruent postnatal care, and so that they are reminded periodically about the importance of postnatal checks. This supports Akin-Otiko, Bhengu, B.R. et al. (2011:2), who found that in Nigeria postnatal women are sometimes unable to attend postnatal checks because of the harshness of midwives. In addition, Piane (2008:28) has stated that in developing countries, including South Africa, women do not receive necessary attention during the postnatal period, while high rates of death occur immediately postpartum due to factors related to healthcare, such as unskilled healthcare providers. According to UNIFPA (2010:34), registered midwives should monitor the woman closely immediately after normal delivery and caesarean section for early detection of signs of postpartum haemorrhage.

- **Lack of adherence to protocols/guidelines**

The registered midwives are expected to discharge postnatal woman and the new-born baby six hours after normal delivery and five days after caesarean section, preferably if the condition of both are satisfactory (*Guidelines for Maternity Care in South Africa, 2007:42*). According to SANC R2488, 8(a), “a midwife shall not discharge the postnatal woman and the new-born baby from her care until such time as the condition of both is satisfactory”. Despite the guidelines, some patients are discharged earlier due to inadequate resources, such as shortage of space in the postnatal ward. This is evident in the following quote:

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...I'm aware that postnatal patients should be discharged within six hours after normal delivery, but I'm bound to discharge some of the patients before the end of six hours because there are many deliveries, and there is no space to keep all patients for six hours as indicated in the guidelines for maternity care...

Last night we had fifteen deliveries, now there are ten patients in labour, so we have to discharge all the fifteen patients, so that we create space for the other ten patients who are in labour

The quotes also show a need to increase the number of beds in the maternity wards of the selected hospital and clinics, in order to create more space in the postnatal wards. In addition, there is a need for registered midwives to examine the woman and new-born baby thoroughly after delivery, to ensure that the condition of both is satisfactory on discharge. According to the Strategic Plan for Maternal, New-born, Child and Women's Health (MNCWH) and Nutrition in South Africa (2012:6), registered midwives should also be encouraged to follow the guidelines and protocols to show their commitment to reduction of mortality and morbidity amongst women and children.

- **Postpartum bleeding, infection (HIV/AIDS), pre-eclampsia, eclampsia and delays in seeking medical assistance due to different factors**

A postnatal woman is expected to have normal bleeding after delivery, which progresses from lochia rubra, serosa and alba. For cases in which lochia rubra continues for more than normal, the patient is advised to visit the nearest clinic or hospital for medical assistance before complications arise. Postpartum bleeding was identified as the serious contributory factor towards the increasing rate of maternal mortality. Bleeding was not traditionally considered a complication, but rather thought to be the uterus cleaning where the baby had been implanted. During the discussion with registered midwives regarding contributory factors towards maternal and child mortality, other factors arose, such as infections, including HIV and AIDS, pre-eclampsia, eclampsia, and delays in seeking medical assistance:

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...Sometimes they take things for granted even in serious situations. For an example, culturally, when a woman bleeds post-delivery, they do not take it seriously because they believe that it is normal for womb to clean the area where the baby was situated through bleeding. They will only realise that it is serious when the woman collapse. It is then that they will try to take the woman to the nearest health facility...

...patient-related, administrative, delayed due to lack of transport, not planned in time. Apart from waiting for Emergency Medical Services (EMS), referral criteria loopholes, a woman at level one hospital, need to negotiate with another level and they die before they are referred, lack of necessary drugs for emergencies...

....Big five causes: postpartum haemorrhage. Sepsis, HIV and AIDS pre-eclampsia and eclampsia, woman who died eighty per cent were HIV positive, not adhering to treatment due to denial; do not do safer sex practices, dependent on husbands for survival...

These quotes show a need to promote community participation and involvement in early detection of complications. It supports findings by UNIFPA (2008:107) that educating the woman, relative, neighbour or a traditional birth attendant regarding early detection and seeking of medical assistance for complications such as postpartum haemorrhage is crucial in saving the life of the bleeding mother. Furthermore Gross, Schellenberg, Kessy, Pfeiffer & Obrist (2011:36) also absenteeism, supply shortages and lack of trained staff, leads to poor implementation of antenatal and postnatal guidelines leading to sub-standard care. Again, there is a need for educating postnatal patients about the importance of HIV testing during pregnancy, prevention of mother to child transmission (PMTCT), early booking for antenatal care for early detection and treatment of pre-eclampsia. There is a need for the Department of Health to strengthen referral systems between level 1 and referral hospitals to avoid delays (*Guidelines for maternity care in South Africa 2007:65*).

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This supports Bulterys, Ndan, Jamieson, Dominguez and Fowler (2002:1) and Sharan, Ahmed, Gabahings and Rogo (2011:50), who found that “every year a million women die due to the growing HIV/AIDS related infections during labour, delivery and postpartum period”. Costello et al (2006:34) found that 50% maternal and neonatal deaths occur due to infection resulting from poor hygiene at home, with lack of recognition of complications leading to delays in seeking medical attention. In addition Kaye, Nakalembe and Ndayamagye (2010:12), they reiterated that in Uganda women with pre-eclampsia and eclampsia are at risk of developing persistent hypertension at the end of the postnatal period which leads to chronic hypertension in future. Hunt and De Mesquita (2012:3), Nour (2008:78), also confirmed that post-partum haemorrhage, pregnancy-induced hypertension including pre-eclampsia, eclampsia, sepsis and unsafe abortions, are the leading direct causes of maternal mortality. Hunt and De Mesquita (2012:4) further indicated the cultural barriers and administrative factors that also indirectly contribute to maternal mortality. These include lack of transport for obstetric emergencies and inability of the referring hospital to perform emergency caesarean section. According to Tebid et al (2011:968), cultural differences can lead to neglect of an obstetric emergency by the registered midwives, resulting in serious complications and even death.

Theme 3: Incorporation strategies

In this theme, different strategies for incorporating “indigenous” postnatal care were explored and described, namely awareness campaigns, meetings and training.

Category 3.1: Awareness campaigns

Registered midwives are expected to be aware of the “indigenous” postnatal care practices employed by the registered midwives, family members and traditional birth attendants during the provision of postnatal care, and conversely the family members and traditional birth attendants are expected to be aware of the Western

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healthcare practices used by registered midwives during postnatal care. However, the findings revealed that neither group was aware of the practices used by the other. This situation creates a line of demarcation between them, and let to registered midwives suggesting awareness campaigns on “indigenous” and Western healthcare practices. This is evident in the following quotes:

...Mix midwives, family members’ traditional birth attendants, do the awareness campaigns where the registered midwives meet with the family members and traditional birth attendants. The family members and traditional birth attendants are given a chance to present the type of practices that they employ during the postnatal period or is done in the form of a role play or a drama, with the registered midwives watching and seeing how they are doing things. At the end of the drama the registered midwives also present their practices, how they are taking care of the patients before, during and after labour, then both groups are given a chance to criticise each other, give comments, suggestions and recommendations. Lastly, they agree on how are they are going to work together in taking care of postnatal patients...

...Awareness campaigns, about the Traditional Health Practitioner’s Act no twenty two of two thousand and seven. Incorporate it with the midwives, family members and traditional birth attendants, to enhance the team spirit...

...number one is awareness. Let us meet and make each other aware of the practices. We must not be tired to involve this people that are at home involving family members/TBAs, be partners. Once we show them how they must do it, once we operate separately, it is not possible to reduce maternal and child mortality rate...

These quotes reveal a need to create public awareness of the “indigenous” practices that are employed during postnatal care. Again, there is a need for family members and traditional birth attendants to be orientated to the practices used by registered midwives during postnatal care. Awareness of postnatal care practices in both groups might assist attitudinal changes, and acceptance of each other as healthcare providers working as a team working towards a common goal. They

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would thus be able to give each other information, communicate openly on issues pertaining to postnatal care, enhance and maintain mutual and trusting working relationships. Teamwork, mutual and trusting relationship between the registered midwives, family members and traditional birth attendants is of vital importance in the provision of quality patient care and prevention of postnatal complications.

This supports the findings of Brisbane (2009:16) that awareness campaigns encourage scholars to focus on disease policies at both national and international level. They might also be a useful strategy in encouraging registered midwives and Family members and traditional birth attendants to work as a team during postnatal care. Piane (2009:27) also indicated that in order to achieve Millennium Development Goals 4 and 5, community-based interventions should be provided to create awareness of early detection of postnatal complications to family members, women, relatives, neighbours, family members and traditional birth attendants. In addition, Sebor (2007:14) has argued that awareness campaigns are useful strategies in marketing, as they make consumers more environmentally aware.

Category 3.2: Meetings

The registered midwives are expected to hold meetings with the family members and traditional birth attendants to discuss plans and achievements, as well as challenges and recommendations to address them. The findings confirmed that currently there are no meetings between the registered midwives, family members and traditional birth attendants, but rather each group is working in isolation. Therefore, the registered midwives suggested that in order to successfully incorporate “indigenous” postnatal care practices into midwifery healthcare system they should hold meetings regularly with family members and traditional birth attendants. This is evident in the following quotes:

...there should be official community meetings where all the family members and traditional birth attendants should be invited so that they are given a chance to present the practices that they employ during the postnatal period, so that the registered midwives become aware of these practices. One of the family

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members and traditional birth attendants should be selected to represent the others on presenting the “indigenous” practices during postnatal care. The registered midwives should also present the western care practices to make the family members and traditional birth attendants aware of the western postnatal care practices...

...let us meet with them and they tell us how they are doing it, and we as healthcare professionals approach the family members and traditional birth attendants to teach them how we are doing the care of postnatal patients...

...We need to meet with the registered midwives, first reflect on what is happening currently, realise our shortcomings, reconcile for everything happened previously and start a new relationship and discuss our way forward from there.

These quotes show a need to remove the line of demarcation between the registered midwives, family members and traditional birth attendants by working together as a team during postnatal care. It is evident that incorporation might assist registered midwives, family members and traditional birth attendants to meet regularly to discuss issues pertaining to the provision of postnatal care. During the meetings they might be able to reflect on the current situation, reconcile and start mutual working relationships to ensure safety of patients during postnatal care. The Livingston (2008:415) defines a meeting as a gathering of a group of people with the aim of discussion matters of concern, such as achievements, challenges and implications for improvements. According to Sahlstedt (2012: 93), holding meetings in the workplace is an effective strategy in enhancing team building, boosting individual morale and building a good working relationship. Furthermore, the American Management Association (year) also confirms that holding workplace meetings has the advantage of finding complete resolutions of conflicts, proper follow ups, better understanding of complex problems, consensus and better decision-making.

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Category 3.3: Training

Registered midwives are expected to receive training on culturally congruent care, in order to have culturally competent knowledge and skills and be able to meet the cultural needs of diverse patients. The family members and traditional birth attendants are also expected to receive training on assessment, early recognition of complications and early seeking of medical assistance. The postnatal patients are expected to have a trained doula, responsible for providing moral support through pregnancy, labour, delivery and the postnatal care phase. A doula is described by Nolte, (2011:171) as supportive companion who provide physical and emotional support to a woman during pregnancy, labour, delivery and postnatal period. The findings reveal that registered midwives have inadequate cultural competency knowledge and skills because they were trained within a biomedical paradigm. In South Africa there is no training of family members and traditional birth attendants regarding the provision of postnatal care, therefore registered midwives suggested there be training of registered midwives, family members traditional birth attendants to ensure the provision of quality postnatal care. All the participants said that for successful incorporation of “indigenous” postnatal care practices into midwifery healthcare system the following people should be trained:

- **Registered midwives**

Registered midwives are expected to provide care to patients from diverse cultures, and to work as a team with the family members and traditional birth attendants to ensure the provision of quality patient care. This is evident in the following quotes:

Yes it is necessary to train the registered midwives on cultural congruent care in order to enhance acceptance by the midwives because currently the midwives view the “indigenous” postnatal care practices as anomalies, witchcraft and un-religious.

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The registered midwives, family members and traditional birth attendant must meet and discuss about how best they can work together when taking care of us and our new-born babies during the postnatal period.

These quotes reveal a need to train registered midwives on culturally congruent care to meet the cultural needs of diverse patients. This supports the findings of Rhode (2012:119), and Mofokeng (2009:10), that healthcare professionals trained only in Western methods cannot enhance or maintain that mutual and therapeutic relationships with clients. Rather, they tend to be ethnocentric and develop negative attitudes towards clients of diverse cultures.

Training is defined by the Livingstone (2008:702) as “an action of teaching a person a particular behaviour or skill to practice and exercise to become physically fit”. During data analysis and interpretation it has been found that registered midwives in South Africa require cultural competency skills in order to provide maternal care that would meet the cultural needs and demands of patients during the postnatal period (Tebid, Du Plessis, Beukes, Van Niekerk & Jooste 2011:968).

As stated in the Declaration of Human Rights, “... all citizens have the right to be treated with dignity and respect regardless of race, social status, religion, politics, personal characteristics, conscience, belief, culture, language, marital status, ethnic or social origin or the nature of health problems” (The Constitution, 1996:3). Furthermore, they recommended that the Western trained healthcare professionals should receive education regarding culture in general to enable them to provide cultural congruent care (De Villiers, 2011:133; Mofokeng, 2009:10).

According to Sri and Khana (2012:3) and UNIPFA (1996:1), training of family members, traditional birth attendants and registered midwives on culturally congruent care is a useful strategy in the reduction of maternal and perinatal mortality as the two groups function as a team. The family members and traditional birth attendants would possess knowledge and skills on how to take care of postnatal patients, including assessment, recognition of complications and immediate referral (Nagi, Ofili-Yebovi & Marsh, 2005:56; Wilson et al 2011:3).

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- **Family members, traditional birth attendants and doulas**

The family members, traditional birth attendants and doulas are expected to receive training on how to provide care during the postnatal phase to ensure continuity; however, the findings revealed that the family members and traditional birth attendants were not trained in postnatal care, and that there were no doulas in South Africa. Therefore, registered midwives recommended the training of family members, traditional birth attendants and the introduction of doulas to improve the quality of care during the postnatal period. This was evident in the following quotes:

... is too much necessary to train the grannies, the family members and traditional birth attendants because besides taking care of postnatal patient, some patients are having precipitated labour, you find that labour just starts when the lady is busy cooking in the kitchen, when she leave the kitchen and enter the room, the baby is already out...

Involving men during the postnatal period, men should be trained on the care of the woman during the postnatal period, so that they know the dangers and taboos of early sexual relations.

We can appreciate a lot if we can receive training on how to care for the postnatal patients, because currently we just us what we have learned from our elderly people, so we do not know how the registered midwives are taking care of the postnatal patients, as each and every one is doing his or her own things in isolation, even though we are taking care of one patient.

It can be easy for us as family members who are responsible for taking care of the women during the postnatal period, to get support from the registered midwives, because now we are struggling with the care of postnatal women and their new-born babies alone. They cannot give themselves a chance to come and see the woman and her new-born at home, just to give them moral support...

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... Some of the issues that should be included in the training program for the family members and traditional birth attendants is hygiene, because some patients are cared for in the environment that is really not conducive to health and safety and nowadays eighty per cent of postnatal patients are HIV positive and they are at risk of infections.

These quotes confirm a need for incorporation of “indigenous” postnatal care practices into the midwifery healthcare system in order to assist the government in recognition and training of family members and traditional birth attendants including men, on issues pertaining to postnatal care. The findings confirmed that it is crucial to train family members, traditional birth attendants and doulas on how to detect inverted uterus, any woman who is in shock, short of breath or appears very ill, and the importance of urgent seeking medical attention. It is clear that there is a need for training of doulas, to ensure provision of physical and moral support of patients during pregnancy, labour, delivery and postnatal care 3). (Fraser et al., 2010:46 This is supported by Kruskey and Barclays (2004:7), who had indicated that although training of family members and traditional birth attendants has been suggested long ago by the WHO as one of the strategies to reduce maternal mortality rate, it has not yet been implemented in South Africa. Even though 85% of the developing countries have successful training programmes in place for family members and traditional birth attendants (Sibely & Sipe 2006:475), in South Africa it remains a challenge.

Bulterys, Flower, Shaffer, Pius, Greenberg, Karita, Coovadia and De Cock (2002:2) found that for the previous decades in many regions of Sub-Saharan Africa, midwifery training of family members and traditional birth attendants was conducted as an initiative for safe motherhood. The main purpose was to reduce the maternal mortality rate based on the unavailability of high quality maternity care. In addition, they gave an example of rural Cameroon where the family members and traditional birth attendants received specialised training for six weeks after being identified and selected by the village committee. After training they received a certificate, instruction book and a kit used during delivery and

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postnatal care (Bulterys et al 2002:2). Similarly, Sibley and Sipe (2006:475), and Jokhio, Winter and Cheng (2005:2092) found that training of family members and traditional birth attendants. As regarding management of birth asphyxia, and pneumonia care has been effective in strengthening primary healthcare services and reducing maternal and child mortality rates.

The family members and traditional birth attendants in South Africa are untrained, but known by the chief, induna and other community members to be competent in conducting deliveries and care of women and infants during the postnatal period. According to Ngunyulu and Mulaudzi (2009:49), family members and traditional birth attendants are responsible for the care of postnatal patients at home after discharge from the hospitals and clinics. Since in South Africa patients are discharged home within six hour after delivery (*Guidelines for Maternity Care in South Africa* 2007:42), all the participants confirmed that the family members and traditional birth attendants should be trained regarding the Western care of postnatal patients, in order to gain knowledge, skills and confidence. It is also evident that without training of the family members it would not be possible to ensure quality patient care during the postnatal period.

In South Africa, currently, there is inadequate literature on training of family members, home-based care providers and men on the care of women during the postnatal period. The training is focused on the provision of care for patients with HIV and AIDS, meaning that future training of family members and home-based care providers should include care of women and new-born babies during the postnatal period.

Theme 4: Outcomes of incorporation

Postnatal care is expected to be provided by culturally competent registered midwives, knowledgeable and skilled family members and traditional birth attendants to ensure safety and security of patients during the postnatal period. The findings revealed inadequate culturally competent knowledge and skills

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amongst registered midwives, lack of confidence amongst family members and traditional birth attendants during the provision of postnatal care, and lack of teamwork between the registered midwives and the family members and traditional birth attendants. The registered midwives suggested that there should be incorporation of “indigenous” postnatal care practices into midwifery healthcare system, in order to achieve positive outcomes.

Category 4.1: Empowerment

South Africa, as a developing and increasingly multicultural country, requires healthcare providers who are fully empowered with knowledge and skills to ensure quality patients care. Currently there is lack of empowerment amongst registered midwives, family members, traditional birth attendants, doulas, postnatal patients, and registered midwives suggested there should be incorporation of “indigenous” postnatal care practices into midwifery healthcare system in order to empower all people that are involved in the provision of postnatal care. This is evident in the following quotes from an advanced midwife working at the clinic:

...We will not be threatened by the public and the media due to negligence, because we will be able to identify gaps during the care of the postnatal patients by the traditional birth attendants and the family members and attend to them before complications arises...

...The health educations and advices will be successful, there will be less problems and the work related stress because we will be able to work as a team with skilled traditional birth attendants, we will not appear in the front pages of newsletters due to negligence, in the department, we will not appear on the disciplinary hearings due to legal liabilities, South African Nurses will be retained because we will not leave the country , cross over, for greener pastures, thus brain drain will be avoided...

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Another midwife with 30 years of working in maternity unit said:

...For the postnatal patients it will be an eye-opener. It will enable them to make good decisions when they come across health related problems. If they are told to do things like this, they will now know what is right and wrong for their health...

These quotes reveal a need to equip registered midwives and community members, including family members and traditional birth attendants with the appropriate knowledge and skills. This supports the study of Knippenberg et al. (2005:1087), titled *Systematic scaling up of neonatal care in countries*, which indicated that the first step in reduction of neonatal deaths should be to empower the families and community with outreach services. In addition Lawn, Rohde, Rifkin, Were, Paul and Chopra (2008:2) pointed out that community members had the right to be empowered through active participation and involvement in planning and implementation of healthcare. The family members and traditional birth attendants, relatives and postnatal women should be involved in planning and implementation of postnatal care services to gain more knowledge and skills needed during postnatal care. Wallace, Law and Joshi (2011:3) has argued that in order to improve the health status of women and children in the community they should be empowered by increasing the female literacy level.

Category 4.2: Teamwork

Registered midwives and family members and traditional birth attendants are expected to work together as members of the multidisciplinary team in order to meet the “indigenous” and Western healthcare needs of postnatal patients. However, the findings revealed that there is no teamwork between the registered midwives, family members and traditional birth attendants, but the registered midwives suggested that there should be incorporation of “indigenous” postnatal care practices into midwifery. This is evident in the following quotes from a clinic midwife with ten years’ experience of working in a community health centre:

If we can work together as a team with the family members and traditional birth attendants, workload will be reduced because postnatal patients will be cared

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for by skilled and knowledgeable family members and traditional birth attendants...

...There will be less confusion amongst the postnatal patients because they will receive same health advice from midwives, family members and traditional birth attendants....

Another midwife with 13 years of working in the hospital maternity unit said:

Communication between the registered midwives, family members and traditional birth attendants improved, resulting in a therapeutic working relationship...

There will be no war between the family members, traditional birth attendants and the registered midwives; there will be no war between the registered midwives at the clinics and the registered midwives at the hospital.

These quotes reveal a need to establish teamwork between the registered midwives and the family members/ traditional birth attendants. Teamwork might ensure a safe working relationship with a positive impact on reduction of maternal and child mortality rates. Teamwork might also yield positive outcomes to registered midwives, family members, traditional birth attendants, postnatal patients, Midwifery lecturers and the maternal and child healthcare system in general. This supports Kruske and Barclay's (2004:9) holding up of Samoa and Malaysia as good examples of countries in which registered midwives are working successfully and in true partnership with family members and traditional birth attendants. Costello et al (2004:3) also stressed that collaboration between the family members, registered midwives have proven to be a useful strategy in the improvement of maternal health, resulting in reduction of maternal mortality rates. In addition, Van Wyk (2005:2) has indicated that teamwork can be achieved through integration of traditional and Western healthcare practices to ensure holistic patient care. Ojwang et al (2010:5) also argue that nurses, including registered midwives, who have cultural competency knowledge and skills appear to be open-minded, display positive attitudes towards patients of diverse cultures,

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are able to initiate and maintain mutual and trusting relationship with the patients, and meet the cultural demands of all patients, resulting in the provision of culturally congruent care. In support of the above, de Villiers (2011:118) has suggested that there be collaboration between the Western healthcare providers, family members and traditional birth attendants , to assist in the prevention of unnecessary pregnancy related complications.

Category 4.3: Improved job satisfaction

Job satisfaction is the backbone in the provision of quality patient care, with registered midwives expected to experience it in their working environment, especially during the provision of postnatal care. However, the findings revealed that registered midwives were working under stress, due to increasing workload, shortage of manpower and inadequate resources, leading to provision of sub-standard postnatal care and unnecessary complications, disabilities and/or even deaths. The registered midwives suggested that there be incorporation of “indigenous” postnatal care practices into midwifery healthcare system to improve job satisfaction through teamwork, as evident in the following quotes:

We will be relieved from shortage of manpower, because the patients will be taken care of by the family members and traditional birth attendants that are well trained, confident in what they are doing...

...the registered midwives will be relieved from legal liabilities and avoid writing of statements for maternal deaths every day.

These quotes reveal a need to improve the working environments for the registered midwives, family members and traditional birth attendants resulting in improve job satisfaction. This supports the claims of Ojwang (2010:3) and Tebid et al. (2011:969) that culturally congruent care knowledge amongst midwives will enhance open communication between the registered midwives, family members, traditional birth attendants and postnatal patients, so assisting in reduction of tension, anger and frustration and increasing levels of job satisfaction. In addition, Sibley and Sipe (2006:473) indicated that training of family members and

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traditional birth attendants in the care of postnatal patients can results in relieving workload from the registered midwives, leading to job satisfaction.

4.3.4 Midwifery lecturers

Table 4.10 (below) display the themes, categories and subcategories on the perceptions and experiences of Midwifery lecturers (fifth population group) regarding the incorporation of “indigenous” postnatal care practices into midwifery healthcare system

Table 4.10: Themes, categories and subcategories on the perceptions and experiences of Midwifery lecturers

THEME	CATEGORIES	SUB-CATEGORIES
1. Lack of information regarding” indigenous” postnatal care practices into Midwifery curriculum	1.1 Midwives trained within Western healthcare only	<ul style="list-style-type: none"> • Inadequate knowledge and skills amongst registered midwives regarding cultural congruent care
2. Incorporation strategies	2.1 Involvement of relevant stakeholders in planning	<ul style="list-style-type: none"> • Politicians, South African Nursing Council Department of Health, Midwifery training institutions, Nursing Education Association.
	2.2 Recognition of family members and traditional birth attendants by the government	<ul style="list-style-type: none"> • To improve their confidence during the provision of postnatal care.

Theme 1: Lack of information regarding “indigenous” practices within Midwifery curriculum

Theme one focused on exploration and description of lack of information regarding “indigenous” practices within the midwifery curriculum. Normally, the content is supposed to include information on “indigenous” practices in order to produce culturally competent midwives during midwifery training, but a lack of information regarding “indigenous” practices in the current one has resulted in inadequate culturally competent knowledge and skills amongst registered midwives. The

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Midwifery lecturers expressed concern on the issue of midwives being trained from a Western healthcare point of view only. During data analysis and interpretation of data from the Midwifery lecturers regarding lack of “indigenous” postnatal care practices the following category emerged:

Category 1.1: Midwives trained within Western healthcare point of view only

Midwifery training is expected to be conducted from a Western and “indigenous” point of view, in order to empower registered midwives with culturally competent knowledge and skills and ensure culturally competent postnatal care. However, the findings revealed that midwives in South Africa are trained from a Western point of view only, with “indigenous” postnatal care practices not included. Consequently, there is inadequate knowledge and skills amongst midwives regarding culturally congruent care, the following sub-category emerged:

- **Inadequate knowledge and skills amongst registered midwives regarding culturally congruent care**

Midwifery lecturers confirmed that registered midwives had inadequate knowledge and skills regarding the provision of cultural congruent care because current Midwifery curriculum did not include the “indigenous” postnatal care practices that are employed by the family members and traditional birth attendants during postnatal care. This is evident in the following quotes:

There is no information regarding cultural congruent care. The information that is there is so limited. Student midwives are not even assessed on it; hence they only follow the Western way when taking care of postnatal patients.

...Training of student midwives on “indigenous” postnatal care practices is a must because currently they are not taught about the type of “indigenous” practices. But once they have knowledge about these practices they will be able to identify the dangerous practices that are employed by the family members and traditional birth attendants during the care of postnatal patients...

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...According to my knowledge the information regarding “indigenous” postnatal care practices is not included in the Midwifery curriculum.

...Currently there is insufficient information within the Midwifery curriculum, midwifery books, Guidelines for Maternity Care in South Africa, scope of practice in midwifery and the South African Rules and Regulations on how to train student midwives on the provision of cultural congruent care...

...No, in the current Midwifery curriculum, there is no information regarding the “indigenous” postnatal care practices that are employed by the family members and traditional birth attendants when taking care of postnatal patients...

These quotes reveal a need for incorporation of “indigenous” postnatal care practices into the Midwifery curriculum, in order to ensure training of culturally competent midwives, resulting in provision of culturally congruent postnatal care. This supports the argument of Soderback and Chritensson (2007:7), that in order to empower the family and community members the registered midwives should be empowered with culturally competent knowledge and skills aimed at improving the health of women and children. In addition, Ottani (2006:33), in a study titled *Embracing Global Similarities: A Framework for Cross-Cultural Obstetric Care* pointed out that culturally competent knowledge and skills in healthcare provision are necessary in this era of consistent global migration in order to meet the cultural needs of diverse patients.

Theme 2: Incorporation strategies

Theme two explored and described the incorporation strategies suggested by Midwifery lecturers as suitable to assist during incorporation of “indigenous” postnatal care practices into midwifery healthcare system. Midwifery lecturers suggested that for successful incorporation, there should be involvement of relevant stakeholders, such as South African Nursing Council, Nursing Education Association, Department of Health, education institutions, community leaders and

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women and recognition of family members and traditional birth attendants. Two categories emerged.

Category 2.1: Involvement and participation of relevant stakeholders in planning

Stakeholders constitute a very important infrastructure, to be consulted during incorporation of “indigenous” postnatal care practices into a midwifery healthcare system. Relevant stakeholders involve South African Nursing Council, Nursing Education Association, the Department of Health, education institutions, community leaders and women. They play an important role in maintaining the health of South Africans and curriculum development. The study findings confirmed that active participation and involvement of relevant stakeholders can be an important strategy in the incorporation of “indigenous” postnatal care practices into midwifery healthcare system. Recognition of family members and traditional birth attendants was also identified as important strategy for successful incorporation, as evident in the following quotes:

...involve the top managers in Nursing Education, Nursing Education Association (NEA) top managers, the South African Nursing Council (SANC) and all the relevant stakeholders who are involved in curriculum development, make them aware about these problem [lack of incorporation of “indigenous” postnatal care practices into midwifery healthcare system and the consequences] and plan with them on how can we merge the two healthcare system to become one in order to ensure the production of culturally competent midwives.

...involve the politicians, the top managers in the Department of Health and Social Development, and other relevant stakeholders, consult them time and again, plan with them, and work hand in hand with them.

The mutual relationship can be enhanced by calling an “imbiso” meeting where the two groups can meet; including the counsellors, chiefs and “indunas”, religious leaders. Traditional healthcare providers and women both groups are made aware about the current situation and its consequences.

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These quotes reveal a need to consult relevant stakeholders, to ensure successful incorporation of “indigenous” postnatal care practices into the midwifery healthcare system. This supports the findings of Marley and Hepworth (2010:969) that involvement of other members of the team in the provision of healthcare has been an effective strategy in ensuring the quality of care in Australia. In addition, Schunemann and Fretheim (2006:8) have recommended involvement of relevant stakeholders in planning of healthcare for feasibility and efficiency of healthcare services. For successful incorporation of indigenous postnatal care practices there should be involvement of relevant stakeholders in planning and implementation.

Category 2.2: Recognition of Family members and traditional birth attendants by the government

Recognition has been described by the *Oxford South African Concise Dictionary* (2006:497) as to “know that something exists or is true and to accept something officially”. Family members and traditional birth attendants play a vital role in the care of postnatal period, despite the absence of support from registered midwives. They use their expertise to ensure physical and emotional wellbeing of the woman and the new-born (Ngunyulu & Mulaudzi 2009:50), ensuring that both are protected from evil spirits (infections), by isolating them in the grandmother’s hut throughout the postnatal period (Ngunyulu & Mulaudzi, 2009:50). One could argue that they deserve recognition, training and support from the government; however the study findings revealed that in South Africa there is no recognition, training or support of them. Midwifery lecturers suggested recognition of family members and traditional birth attendants as one of the effective strategies for successful incorporation of “indigenous” postnatal care practices into the midwifery healthcare system, as evident in the following quotes:

Encourage the government to recognise the family members and traditional birth attendants; this is the time to involve politicians, because if we can start incorporating without the politicians, if they discover someone has done things behind their back, that person will be in trouble.

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...Family members and traditional birth attendants should be recognised, involved in training for a certain period, receive certificates, so that they become responsible and are held accountable for their acts and omissions, as nurses do with the South African Nursing Council...

...Recognition of family members and traditional birth attendants should involve examination of the “indigenous” medications that they use during the postnatal period, to know its constituents, in order to protect patients from herbal intoxications...

These quotes show a need to facilitate the recognition of family members and traditional birth attendants as members of the multidisciplinary team, who are directly involved with provision of patient care during the postnatal period. This supports the claim of Wilson, Gallos, Piana, Lissauer, Khan, Zamora, MacArthur and Coomarasmy (2011:3), that recognition, training, support, participation and involvement of family members and traditional birth attendants regarding the care of postnatal patients and their new-born infants has significantly reduced the maternal and child mortality rates in developing countries. The Nigerian Government has already recognised and integrated family members and traditional birth attendants into the Primary Healthcare system and initiated a training programme for them (Nagi et al 2005:56). In addition the results of the study emphasised the issue of traditional birth attendants training because it was confirmed that their practices are unsafe if they are not trained or do not receive support from the registered midwives (Nagi et al 2005:56). In Gambia, researchers recommended that to ensure quality patient care during the postnatal period there should be recognition, training for six weeks, continuing education, regular updates, frequent supervision and support of family members and traditional birth attendants, because they provide care at local level, and are always available for patients (de Vaate, Coleman, Manneh & Walraven 2002:8).

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4.3.5 The maternal and child healthcare coordinators

Table 4.11 (below) display the themes, categories and sub-categories on the perceptions and experiences of the maternal and child healthcare coordinators (sixth population group) regarding the incorporation of “indigenous” postnatal care practices into midwifery healthcare system.

Table 4.11: Themes, categories and subcategories on the perceptions and experiences of the maternal and child healthcare coordinators

THEMES	CATEGORIES	SUB-CATEGORIES
1 Sub-standard postnatal care	1.1 Ineffective referral system	<ul style="list-style-type: none"> Increasing maternal and child mortality rates
	1.2 Inadequate resources	<ul style="list-style-type: none"> Shortage of manpower
2 Incorporation strategy	2.1 Team building	<ul style="list-style-type: none"> Between the registered midwives, family members and traditional birth attendants
3 Outcomes of incorporation	3.1 Improved standard of postnatal care	<ul style="list-style-type: none"> Feeling of safety and security during postnatal care
	3.2 Reduced maternal and child mortality rates	<ul style="list-style-type: none"> Achievement of Millennium Development Goals 4 & 5 by 2015 Reduced legal costs

Theme 1: Sub-standard postnatal care

Theme one relates to exploring and describing substandard postnatal care, which includes ineffective referral system and inadequate resources. Ethically, postnatal patients expect to receive care that meets their cultural needs from registered midwives, family members and traditional birth attendants. However, the findings have revealed that currently in South Africa, as a developing country, postnatal care is largely neglected. There is premature discharge of postnatal patients without follow-up support visits by registered midwives. Postnatal patients are placed directly under the care of unskilled family members and traditional birth attendants, hence substandard postnatal care was identified by maternal and

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child healthcare coordinators as the first theme. During data analysis of the data from the maternal and child healthcare coordinators regarding sub-standard postnatal care, two categories emerged.

Category 1.1: Ineffective referral system

The referral system involves discharging the patient from the hospital/clinic to the family members and traditional birth attendants at home or from the hospital to the nearest clinic. Patients should be handed over officially to the relatives, family members and traditional birth attendants who are responsible for the provision of care during the postnatal period. If the patient is referred to the nearest clinic for postnatal check-up, the midwife at the clinic should be made aware that there is a patient coming for a check up on this day so that he or she can prepare. In case the patient fails to go to postnatal for a check-up, the midwife at the clinic will be able to make a follow up. The findings revealed that postnatal patients are discharged home to the care of family members and traditional birth attendants who were not involved during health education on discharge. The postnatal patient is advised to attend the nearest clinic for postnatal check up on the third day after delivery, but the clinic midwife is not aware that there is a patient coming for a check-up. As a result, 50% of women do not visit the clinic for postnatal check-up and there is no follow-up visit by midwives to ensure continuity of care. This is evident in the following quotes:

... women on discharge are advised to go to the nearest clinic for postnatal check-up. But the registered midwives at the clinic are not aware that there is a patient who should come on this date for postnatal check-up.

Currently there is a problem in handing over of postnatal patients from the hospital/clinics to family members and traditional birth attendants, on discharge the patient is advised to do self-care at home in the absence of her relatives, no report is given to family members and traditional birth attendants on how to continue with the care of the woman and her new-born baby at home.

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These quotes indicate a need to strengthen the referral system from the hospital/clinic to the relatives, family members and traditional birth attendants. There should be clear communication between the registered midwives and the family members and traditional birth attendants. The registered midwives should involve the family members and traditional birth attendants when giving health advice on discharge, in order to give report on how to provide postnatal care to the woman and the new-born.

On the other hand, there should be clear communication between the hospital and the clinic midwives to ensure effective referral system. This is supported by Ngunyulu and Mulaudzi (2009:49), who indicated that midwives concentrate on in-patients, whilst the discharged patients are given health advice on how to take care of them and to visit the nearest clinic for postnatal check-up after three days. However, nothing is communicated to make the clinic midwives aware that there is a patient coming. Warren, Kornman, Cameron and Chinn (2011:58) have pointed out that communication, involvement of family members and proper handing over of patients on discharge during the postnatal period is of vital importance in ensuring quality and patient safety during the postnatal period.

Category 1.2: Inadequate resources

According to R2488 4(1) “a registered midwife shall keep clear and accurate records of the progress of pregnancy, labour and puerperium and of all acts, including emergency acts which she performs in connection with a mother and child”. Registered midwives are expected to record everything they do for the patients, regardless of the ratio of patients to registered midwives in the unit. However, the findings revealed that currently in South Africa there is a shortage of manpower in the maternity units. Despite rapid population growth in the country, which is increasing pressure on the healthcare delivery system, little is being done to increase the number of registered midwives. As a result, registered midwives are subjected to long working hours leading to job dissatisfaction and burn out syndrome. This is evident in the following quote:

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We deliver a lot of patients day and night, that are referred from the clinics, some come from home and we do not have enough manpower. According to, Maternity care guidelines we were supposed to discharge postnatal women six hours after delivery, but we are bound to discharge them before six hours elapses because we do not have enough beds to keep these patients for six hours.

This quote shows a need to reduce workload from registered midwives through training of family members and traditional birth attendants on postnatal care. It is evident that there is a need to increase the number of registered midwives in the hospitals and clinics, so that they are able to provide quality care and record everything they do for the patients, as required by SANC rules and regulations. This supports the findings of by Ojwang et al (2010:2), who indicated that work overload, long working hours, and disparity between the number of patients and the nurse's leads to burnout syndrome, poor attitudes of nurses towards patients, poor nurse-patient communication, and inadequate nurse-patient relationships, resulting in the provision of substandard care.

The WHO (2011:21), in the Philippines Health Review, also confirmed that low management capacity and lack of resources contribute to deterioration of quality of services. Tamang (2010:3) has argued that in order for Nepal to reduce maternal and child mortality there should be adequate resources that can meet the needs of the country. Similarly in Tanzania, registered midwives were failing to implement antenatal and postnatal care guidelines due to supply shortages, lack of trained staff and absenteeism (Gross, Shellenberg, Kessy, Pfeiffer, & Obrist 2011:36)

Theme 2: Incorporation strategy

Theme two of the maternal and child healthcare coordinators further explored and described the incorporation strategies that might assist in effective incorporation of "indigenous" postnatal care practices into midwifery healthcare system. During the

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discussion with the maternal and child healthcare coordinators, the following strategies emerged:

Category 2.1: Team building

The maternal and child healthcare coordinators indicated that it would be of utmost importance if the registered midwives, family members and traditional birth attendants could be motivated to work together as a team. They further suggested that a team building process can be commenced by educating the registered midwives, family members and traditional birth attendants on the importance of teamwork, as shown in the following quotes:

...The registered midwives, family members and traditional birth attendants must meet and discuss about how best they can work together when taking care of postnatal patients...

...We need to come with the effective strategy that will encourage them to gradually come together, recognise each other as co-workers, work together, plan together, share common goals until they reach a point where they get used to each other as healthcare providers...

These quotes highlight the need for incorporation of “indigenous” postnatal care practices into midwifery healthcare system to build a team of registered midwives, family members and traditional birth attendants in postnatal care. Registered midwives, family members and traditional birth attendants are expected to engage in the process of building a team. It is confirmed that lack of teamwork creates many challenges for the postnatal patients, family members, traditional birth attendants and registered midwives; therefore there is a need for teamwork between the registered midwives, family members and traditional birth attendants. This supports Hunt and de Mesquita (2012:3), who argued that in order to reduce maternal and child mortality in developing countries there should be strategies in place to break down political, economic, social and cultural barriers that face women trying to access intervention.

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Team building is described by Stone and Bailey (2007:259) as the process of teaching a group of participants so that they become effective team members in possession of the following: common purpose and clear goals; team skills; common approach to work; willingness to share information; trust and support to each other; ability to work through conflict; and willingness to take responsibility and hold themselves accountable for team output.

Similarly, De Dreu & Wiengart (2003:742) argued that effective collaboration requires regular meetings, planning together, setting goals together, and continuous relationships until the group acquire characteristics of effective team work that will lead to effective team performance and team member satisfaction.

Theme 3: Outcomes of incorporation

Theme three explored and described the outcomes of incorporation. The study findings revealed that currently there is substandard postnatal care, leading to high maternal and child mortality rates, increased legal liabilities and failure to achieve Millennium Development Goals 4 and 5. The maternal and child healthcare coordinators suggested that be incorporation of “indigenous” postnatal care practices into the midwifery healthcare system in order to achieve the following outcomes.

Category 3.1: Improved standard of postnatal care

Registered midwives are regarded as highly qualified practitioners, and are expected to provide care that will meet the cultural needs of patients from diverse cultures (culturally congruent care). It is confirmed that currently there is substandard care due to lack of communication and teamwork between the registered midwives and the family members and traditional birth attendants, and the maternal and child healthcare coordinators suggested that there should be incorporation of “indigenous” postnatal care practices into midwifery healthcare

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system in order to improve the standard of care during the postnatal care. This is evident in the following quotes:

...We will gain knowledge and skill regarding how to take care of patients from diverse cultures, because currently we are struggling to interact with these patients because we do not understand what they need from us.

I wish the process of incorporation can be facilitated quickly, so that they also start with the training programs on cultural competency skills, so that it becomes easier for us to provide nursing care that will meet the cultural needs of our patients.

These quotes reveal a need to empower registered midwives, family members and traditional birth attendants with culturally competent knowledge and skills. The provision of postnatal care by knowledgeable and skilled registered midwives, family members and traditional birth attendants might improve the standard of postnatal care. This is supported by the WHO (2011:21) in the Philippines Health System Review, confirming that adequate management skills and adequate resources contribute to adequate quality of patient care.

Leininger (2002: 76), Makhubele and Qalinga (2009:155), Ngunyulu and Mualudzi (2009:56); and Peu et al. (2001:54) write that for effective provision of culturally congruent care there should be integration of traditional and Western healthcare systems. The cultural difference between the registered midwives, family members and traditional birth attendants leads to the provision of substandard postnatal care (Tebid et al 2011:969). Currently, inadequate maternal care is evident because there is no partnership between the registered midwives, family members and traditional birth attendants resulting in lack of recognition of complications and delay in seeking medical assistance, leading to unnecessary deaths due to avoidable postnatal complications (Kruske & Barclay 2004:8).

Researchers revealed that the nurses, including midwives who have undergone training regarding cultural competency, are able to create a therapeutic environment for their patients by displaying a feeling of job satisfaction. This is evidenced by positive attitude towards patients of diverse cultures, enhancing

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mutual and trusting nurse-patient relationships and meeting the cultural needs of individual patients (Wray et al. 2010: 36; Cioffi 2002:302).

On the other hand, Bulterys et al (2002:5), Jokhio, et al (2005:2094), Sibley and Sipe (2006:476), de Vaate, Coleman, Manneh and Walraven (2002:8), Nagi, et al. (2005:59), Wilson, Gallos, Piana, Lassauer, Khan, Zamora, MacArthur and Coomaramasamy (2011:3) also argued that family members, traditional birth attendants and home-based care providers who have undergone midwifery training will be able to provide quality postnatal care because they should possess the necessary knowledge and skills for assessment, early recognition and referral of postnatal patients in case of complications.

Category 3.2: Reduced maternal and child mortality rates

During collection of the data from the maternal and child healthcare coordinators, the achievement of the Millennium Development Goals 4 and 5 by 2015 was also identified as an outcome for the incorporation of “indigenous” postnatal care practices into the midwifery healthcare system. The participants revealed that this would empower midwives with knowledge and skills regarding the provision of cultural congruent care. Once midwives become culturally aware they will understand the importance of different cultures. Cultural awareness amongst the midwives would proceed to cultural sensitivity and then gradual development of culturally competent knowledge and skills. As a result they would develop positive attitudes towards patients of diverse cultures. Patients would no longer be neglected based on cultural discrimination, as is happening currently. This would reduce complications during the postnatal period, and result in reduction of maternal mortality, hence the achievement of Millennium Development Goals 4 and 5. This argument is supported by the following quotes:

By incorporating “indigenous” postnatal care practices we can reduce maternal mortality, we can gain the cooperation of outsiders, family members and traditional birth attendants can relieve of workload from the registered midwives, because they will be properly trained on how to take care of postnatal patients, they will do so and give reports to the registered midwives on a monthly basis.

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Postnatal patients will be safe, there will be fewer complications, maternal deaths will be reduced....”

“Midwives can be relieved from shortage of man power, because family members traditional birth attendants will serve as an extra hand....

These quotes show a need to ensure patients safety at the hospital/clinic and at home during the postnatal period. This supports a claim by Tamang (2010:3), in a study titled: *Factors that persuade nurses to establish a maternity care centre in Nepal*, that the provision of postnatal care by skilled neighbours, family members and traditional birth attendants might be an effective strategy in reduction of maternal and child morbidity and mortality. Piane (2009:1), in a study titled *Evidence-based practices to reduce maternal mortality: a systematic review*, also argues that community-based interventions in sub-Saharan Africa, where postnatal care is provided by unskilled family members traditional birth traditional , could be and effective strategy in the reduction of maternal and child mortality.

During the discussion with the maternal and child healthcare coordinators regarding the outcomes of incorporation, achievement of Millennium Development Goals no 4 and 5 also emerged as follows:

- **Achievement of Millennium Development Goals 4 and 5 by 2015**

The Millennium Development Goals 4 is aimed at reducing child mortality by two thirds by 2015, whilst Millennium Development Goals 5 aims at reducing maternal mortality by two thirds by 2015. Postnatal care rendered by registered midwives, family members and traditional birth attendants is expected to focus on the achievement of both the Millennium Development Goals; however the findings confirm that they can be achieved only through teamwork between registered midwives, family members and traditional birth attendants during postnatal care. The maternal and child healthcare coordinators indicated that incorporation of “indigenous” postnatal care practices may empower registered midwives with cultural competency knowledge and skills. Culturally sensitive midwives may provide culturally congruent postnatal care. This is evident in the following quotes:

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...teamwork between registered midwives, family members and traditional birth attendants can ensure quality care during the postnatal period...

The Millennium Development Goal number four and five will be achieved.

These quotes reveal a need to initiate a multidisciplinary team approach which was suggested to be an effective strategy in reduction of maternal and child mortality rates. This supports by Tebid et al. (2011:967), who highlight a lack of knowledge regarding cultural values, beliefs and practices amongst registered midwives, which result in conflicts and negative attitudes, and thus substandard postnatal care and failure to achievement the Millenium Development Goals number 4 and 5. Kruske and Barclays (2004:9) pointed out that teamwork, mutual relationship and partnership between the registered midwives, family members and traditional birth attendants might lead to success in reduction of maternal mortality rate, whilst Costello, Osrin and Manandbar (2004:3) also revealed that collaboration between the family members, traditional birth attendants the registered midwives results in promotion of maternal health and hygiene, avoidance of delays in seeking medical attention and prevention of maternal mortality. They further revealed that current safe motherhood interventions are unsuccessful in attaining the Millennium Development Goals number 4 and 5 because they neglected and undervalued the contribution of family members and traditional birth attendants in the care of postnatal patients (Costello et al 2004:1). Sibley and Sipe (2006:474) reiterated that the success of the country in achieving the two Millennium Development Goals (4 and 5) lies between the community-based care and facility-based care.

- **Reduced legal costs**

The maternal and child healthcare coordinators confirmed that another benefit of incorporating “indigenous” postnatal care practices would be to reduce legal costs. This is based on a belief that the provision of culturally congruent care by the midwives might improve standard of postnatal care, resulting in increased patient

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satisfaction, fewer complaints from the relatives and reduced legal costs. This is evident in the following quote:

...there will be fewer complaints from the patient's relatives...

The government will save money for paying the legal suites because the standard of patient care at the clinics and the hospitals will be improved.

This quote shows a need to improve the standard of postnatal care, by empowering registered midwives with culturally competent knowledge and skills, training family members and traditional birth attendants introducing the use of doulas during postnatal care. An improved standard of postnatal care might prevent unnecessary complications and even deaths, supporting the claim by Costello, Osrin and Manandhar (2004:4) that active involvement of community members, including family members and traditional birth attendants during postnatal care, might be cost-effective, necessary and feasible in the reduction of maternal and child mortality. Once the “indigenous” postnatal care practices have been incorporated into the midwifery healthcare system, registered midwives will become culturally sensitive, work in collaboration with the family members and traditional birth attendants and improve midwife-patient relationships, thus resulting in provision of cultural congruent care and hence reduction of legal costs (Tebid et al. 2011: 968).

In support of the abovementioned findings, a therapeutic working environment leads to improved job satisfaction and in turn to attitudinal changes by the registered midwives, establishing a therapeutic environment for the patients. Culturally congruent care provision would result in reduction of legal costs for the Department of Health (Pacquiao, 2007:18).

4.4 SUMMARY

Quality patient care based on meeting the cultural needs of patients from diverse cultures can only be fully addressed by nurses who are culturally competent. South Africa, as a developing country with an increasing number of people coming from different backgrounds, requires culturally competent nurses to provide

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culturally congruent care. The findings of this study confirmed that the South African nurses are still trained from a Western point of view, and as a result have insufficient knowledge regarding culturally congruent care. The purpose of the study was to elicit the perceptions and experiences of different stakeholders in midwifery to obtain information assisted in developing and describing a model for incorporating “indigenous” postnatal care practices into the midwifery healthcare system.

The study findings described the perceptions and experiences of the postnatal patients, family members, traditional birth attendants, registered midwives, Midwifery lecturers and the maternal and child healthcare coordinators, according to four main categories that emerged during in-depth individual and focus group interviews. The themes, categories and subcategories for assisting in the process of incorporation were identified from concept and data analysis, and grouped according to different population groups. They have been analysed based on the identified perceptions and experiences of participants that emerged from the main categories. The strategies for incorporation of “indigenous” postnatal care practices into the midwifery healthcare system were also discussed under the themes and confirmed in the categories and sub-categories by the participants.

The conceptual framework of the concepts that emerged as the results for Phases One and Two will be presented in detail in Chapter Five.

CHAPTER 5

DEVELOPMENT AND DESCRIPTION OF A MODEL FOR INCORPORATING “INDIGENOUS” POSTNATAL CARE PRACTICES INTO MIDWIFERY HEALTHCARE SYSTEM

5.1 INTRODUCTION

Chapter Four presented the empirical perspective of the study, based on analysis and interpretation of the perceptions and experiences of postnatal patients, family members, traditional birth attendants, registered midwives, midwifery lecturers and the maternal and child healthcare coordinators, regarding the incorporation of “indigenous” postnatal care practices into a midwifery healthcare system. The findings supported or refuted relevant literature and 11 themes identified were related to the findings of concept analysis by Walker and Avant (2005:28). The similarities, matches and interactions between the themes, concept analysis findings and six aspects of Dickoff et al (1968:422) form the basis for development and description of a model for incorporating “indigenous” postnatal care practices into a midwifery healthcare system, presented in this chapter.

5.2 MODEL DEVELOPMENT

The model was developed in three phases.

- **Phase one**

Concept analysis as defined by Walker and Avant (2005:28) was used to clarify the concept ‘incorporation’ as it relates to “indigenous” postnatal care practices in a midwifery healthcare system. The findings revealed the antecedents that should occur before the incorporation, and its consequences or outcomes. Understanding the meaning of incorporation facilitated the process of data collection in phase two. The meaning of incorporation guided the research on the type of questions to be asked during the focus groups and in-depth individual interviews.

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- **Phase two**

The purpose for phase two was to explore and describe the perceptions and experiences of postnatal patients, family members, traditional birth attendants, registered midwives, midwifery lecturers and the maternal and child healthcare coordinators regarding the incorporation of “indigenous” postnatal care practices into a midwifery healthcare system. A qualitative, exploratory, descriptive and contextual approach was followed.

- **Phase three**

Phase three consists of the development and description of a model for incorporating “indigenous” postnatal care practices into a midwifery healthcare system, based on the findings for phases one and two as conceptualised following the six aspects of activity by Dickoff et al (1968:422):

Agency: Who or what performs the activity?

Patiency: Who or what is the recipient of the activity?

Context: In what context is the activity performed?

Procedure: What is the guiding procedure, technique or protocol of the activity?

Dynamics: What is the energy source for the activity?

Terminus: What is the endpoint of the activity?

Figure 5.1 (below) displays the three phases of the study which served as a guide during development and description of a model for incorporating “indigenous” postnatal care practices into midwifery healthcare system.

A model for incorporating indigenous postnatal care practices into midwifery healthcare system.

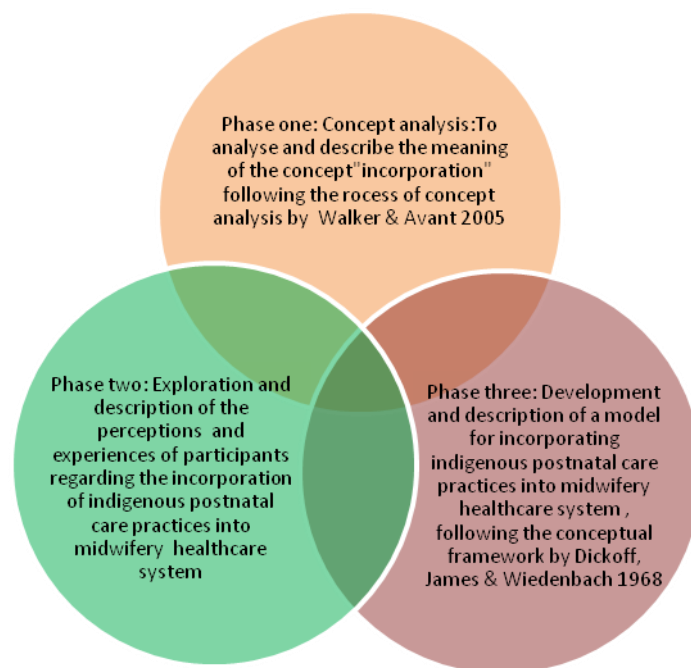


Figure 5.1: Guide to development and description of a model for incorporating “indigenous” postnatal care practices into midwifery healthcare system

5.2.1 Dickoff, James and Wiedenbach’s six aspects of activity

The first aspect, **Agency**; an **agent**, is described by Dickoff et al. (1968:425) as a person who performs an activity towards realisation of a goal. In this study, the agents are registered midwives, midwifery lecturers, family members traditional birth attendants and the maternal and child healthcare coordinators, as they are involved in provision, planning, organisation, management, monitoring and evaluation of postnatal care.

Patiency, as the second aspect, relates to those who receive from the activity of an agent. In this study the recipients are postnatal patients as they receive care from the registered midwives, family members, traditional birth attendants, midwifery lecturers and the maternal and child healthcare coordinators during the postnatal period.

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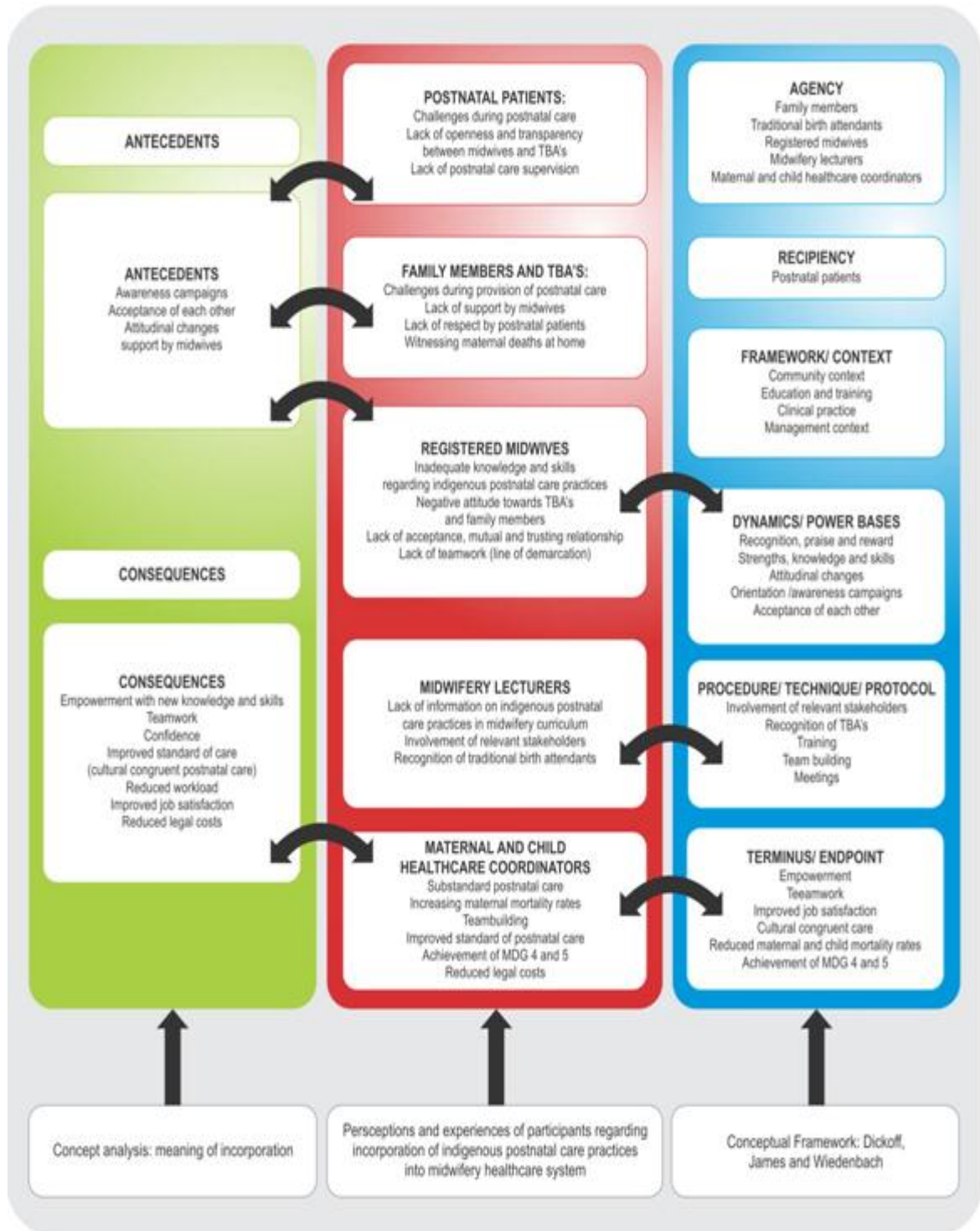


Figure 5.2: Relationships; merging and interaction of the findings for phases one to three.

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Figure 5.3: Agency and reciprocity of postnatal care

An activity is produced within the third aspect, the **context**, by the agent and received by the patient. In this study, the incorporation of “indigenous” postnatal care practices may be performed in different contexts, namely: community, hospital/clinic, midwifery training and midwifery management.

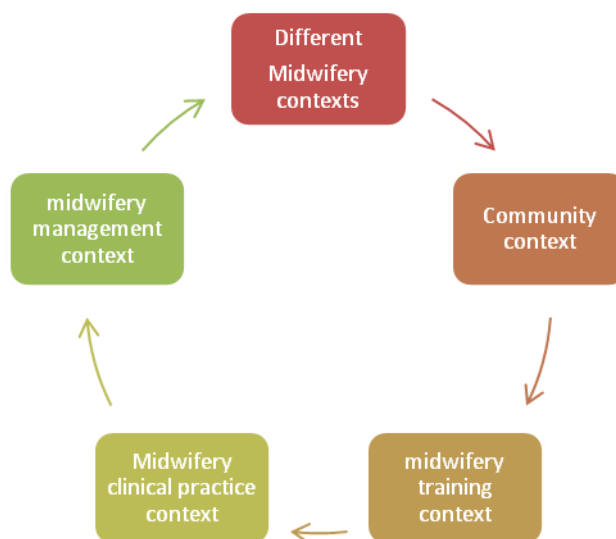


Figure 5.4: Framework/context of incorporation of “indigenous” postnatal care practices

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Dickoff, James and Wiedenbach (1968:431) described the fourth aspect, **dynamics**, as chemical, physical, biological or psychological power sources that can drive the activity towards the attainment of a goal. The dynamics for this study are displayed in figure 5.5 as follows:

- Recognition, praise and reward of positive performance towards the goal to ensure satisfaction to the agents and relevant stakeholders.
- Person's strength, knowledge and skills to perform the activity.
- Attitudinal changes towards acceptance of each other in a team.
- Orientation through awareness campaigns.
- Acceptance of each other.



Figure 5.5: Dynamics

The fifth aspect, the **guiding procedure, technique, or protocol** of the activity involves several steps, the first of which should be to involve the infrastructure (stakeholders) responsible for reviewing Midwifery curriculum. The infrastructure (stakeholders) will include: South African Nursing Council, Nursing Education Association, Department of Health, community leaders and women, educational institutions and managers in clinical practice. A plan should be drafted on the process to be followed during the incorporation of “indigenous” postnatal care practices into the midwifery healthcare system. The following factors will be included in the plan: recognition of family members and traditional birth attendants: awareness campaigns, training, team building, and meetings between the family members, traditional birth attendants and registered midwives to discuss their concerns, challenges and recommendations.

The procedure will encourage community participation and involvement in the care of postnatal patients to ensure protection and safety of patients during the postnatal period. Figure 5.6 (below) display the procedures and protocols that are followed during development of a model



Figure 5.6: Procedure to be followed during incorporation of “indigenous” postnatal care into midwifery healthcare system

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The final aspect of Dickoff, James and Wiedenbach, the *terminus*, is the end point or purpose of the activity. In this study, it is the incorporation of “indigenous” postnatal care practices into the midwifery healthcare system, and involves teamwork between the registered midwives and the family members and traditional birth attendants, empowerment of midwives, confidence of family members and traditional birth attendants, culturally congruent care, reduced workload, improved job satisfaction, reduced legal liabilities and achievement of Millennium Development Goals 4 and 5. Figure 5.7 (below) displays the terminus or endpoint of the activity.

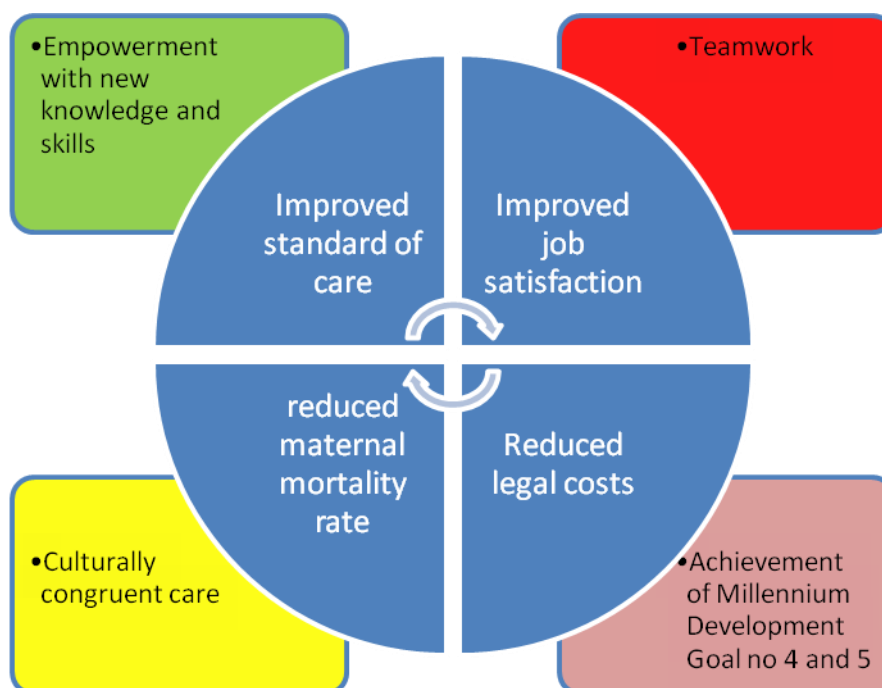


Figure 5.7: Display the terminus or the consequences of incorporation

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5.2.2 Schematic representation of the model

A model is defined by Walker and Avant (2005:28) as “any device used to represent something other than itself; it has been a graphic representation of a theory”. They further stated that a model can be drawn mathematically, as an equation, or schematically using symbols and arrows, as in Figure 5.8 (below).

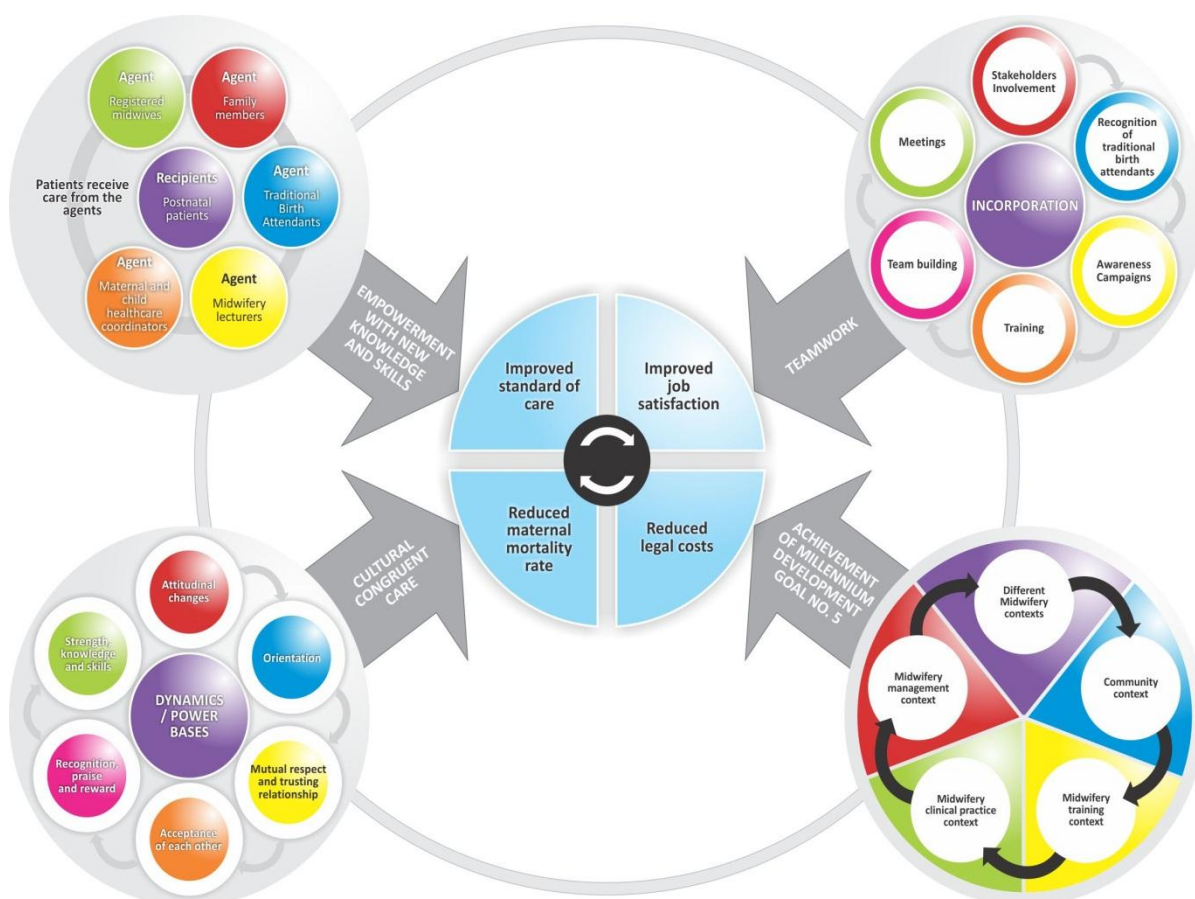


Figure 5.8: Model for incorporating “indigenous” postnatal care practices into midwifery healthcare system

5.3 MODEL DESCRIPTION

The purpose of the model is to incorporate the “indigenous” postnatal care practices into the midwifery healthcare system and improve standards through the

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provision of culturally congruent postnatal care, with development based on the themes identified during concept analysis in phase two. The components of the model are as follows:

- The infrastructures for regulating midwifery education and training
- The context in which the activity is taking place
- The agents responsible for performing the activity,
- The recipients of the activity
- The procedures to be followed during the incorporation of “indigenous” postnatal care practices into the midwifery healthcare system
- The dynamics/power bases
- The consequences of incorporation.

Several agents are responsible for performing the activity: (i) the family members and traditional birth attendants provide postnatal care at home; (ii) registered midwives provide care at the hospital and clinics; (iii) lecturers in Midwifery educate and train student midwives; and (iv) the maternal and child healthcare coordinators coordinate postnatal care activities (South African Nursing Council R2488 10c). The recipients of postnatal care from the agents are the postnatal patients.

The stakeholders who should be consulted and involved in planning the incorporation of “indigenous” postnatal care practices into the midwifery healthcare system include the South African Nursing Council, Nursing Education Association the Department of Health, education institutions, community leaders and women. They comprise one of the important power bases that need to be involved at the beginning of the incorporation process and are expected to participate throughout for successful realisation of the goals. The procedures to be followed during the process of incorporation are recognition of family members and traditional birth attendants by the registered midwives as team members in midwifery care and by the Department of Health as the members of the multidisciplinary team directly involved in the provision of postnatal care.

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Awareness campaigns are needed to orientate the following:

- Different stakeholders regarding the consequences of lack of incorporation of “indigenous” postnatal care practices into the midwifery healthcare system
- Registered midwives regarding the “indigenous” postnatal care practices that are employed by family members and traditional birth attendants during postnatal care
- Family members and traditional birth attendants regarding the professional postnatal care practices employed by registered midwives during postnatal care
- Training of registered midwives regarding the provision of culturally congruent care, traditional birth attendants, family members and community-based care providers on the provision of postnatal care
- Team building between the registered midwives and the traditional birth attendants to enhance and maintain team work during the provision of postnatal care
- Meeting between the registered midwives, family members and traditional birth attendants to discuss achievement and challenges experienced during the provision of postnatal care and to discuss the recommendations on how to overcome these challenges (Wilson et al., 2011:3)

The identified agents and stakeholders are functioning in different midwifery contexts, namely: family members and traditional birth attendants are functioning within the community context, because they are responsible for the provision of postnatal care at home after the discharge of patients from the hospitals or clinics. Registered midwives are functioning within the clinical practice context, because they are responsible for providing postnatal care at the hospital or clinics. Midwifery lecturers are functioning within the educational context because they are responsible for education and training of student midwives. Maternal and child healthcare coordinators are functioning within the midwifery management context because they are responsible for planning, organising, management,

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implementation, monitoring, evaluation and coordination of postnatal care activities (Dippenaar 2012:8)

The dynamics or power bases needed for the agents and relevant stakeholders to accomplish the goal of the activity are being goal directed or motivated, and having the capabilities, strength, knowledge and skills to perform the activity. There should be recognition, praise and rewards in order to encourage and motivate the agents during the provision of postnatal care, orientation in the form of awareness campaigns, attitudinal changes, mutual respect and trusting relationships.

The terminus, or consequences of incorporation, include empowerment of patients, family members, traditional birth attendants and registered midwives with new knowledge and skills, teamwork, improved job satisfaction, improved standard of care, culturally congruent care, reduced maternal and child mortality rate, reduced legal costs and achievement of the Millennium Development Goals 4 and 5 (Weiss 2006:117).

5.3.1 The components of the model

The components of the model are described here in greater detail.

5.3.1.1 Infrastructures for regulating midwifery education and training

A number of bodies make up the infrastructure for regulating midwifery education and training.

- **South African Nursing Council (SANC)**

The South African Nursing Council (SANC) was identified as one of the regulatory bodies required to participate in incorporation of “indigenous” postnatal care practice because it assists in the promotion of health standards of the country. The study findings confirmed that there is substandard postnatal care due to lack of teamwork, with patients placed under the care of family members and traditional birth attendants without the support of registered midwives. This situation places

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the patient's life at risk of complications and/or even death. The South African Nursing Council should be made aware of this situation so that it advises the Minister of Health on strategies to improve the standard of care during the postnatal period. The South African Nursing Council is responsible for controlling and exercising authority over all matters relating to midwifery education, training and practice. To ensure successful incorporation of "indigenous" postnatal care practices into the midwifery healthcare system the South African Nursing Council should be involved throughout the incorporation process (SANC R2488 1996:6)

- **Nursing Education Association (NEA)**

The Nursing Education Association (NEA) was identified as one of the regulatory bodies that should be involved because they are responsible for empowering nurses and nurse educators with knowledge and skills required for improving the standard of care during service delivery. South African nurses work in collaboration with the South African Nursing Council, Department of Health and other relevant stakeholders in reconstructing and revitalising the nursing profession for a long and healthy life for all South Africans.

The involvement of the Nursing Education Association during incorporation of "indigenous" postnatal care practices into the midwifery healthcare system might facilitate the process because it forms part of the reengineering of primary healthcare services by ensuring the registered midwives plays a critical role when working as a team with family members and traditional birth attendants (National Nursing Summit 2011).

- **Department of Health (DoH)**

The Department of Health (DoH) was identified as one of the regulatory bodies to be involved during the incorporation of "indigenous" postnatal care practices into midwifery healthcare system. It is currently working in collaboration with the South African Nursing Council, Nursing Education, Association education institutions, hospitals and other relevant stakeholder to ensure the achievement of Millennium Development Goals 4 and 5 by 2015, through re-engineering primary healthcare

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services. Reduction of the maternal and child mortality rate by 2015 is one of the Millennium Development Goals that should be achieved. Despite different strategies in place to reduce maternal and child mortality, the rates are still increasing every year (Kerber et al 2007:1368).

The involvement of the Department of Health during the incorporation of “indigenous” postnatal care practices into the midwifery healthcare system might create awareness in the department of the challenges faced by postnatal patients, family members, traditional birth attendants and registered midwives during postnatal care. Lack of teamwork and communication places postnatal patients under the care of unskilled family members and traditional birth attendants and so leads to serious postnatal complications and/or even death, hence the high maternal and child mortality rate in South Africa (Kerber et al 2007:1368).

- **Education institutions**

The education institutions were identified as amongst the regulatory bodies to be involved during the incorporation of “indigenous” postnatal care practices into the midwifery healthcare system. The reason for involving them is that they are responsible for education and training of midwives. Currently, midwives are trained from a Western healthcare point of view only, instead of combining this with an “indigenous” one in order to produce culturally competent registered midwives. Involving education institutions during the incorporation of “indigenous” postnatal care practices into the midwifery healthcare system might assist in adding culturally congruent information to the Midwifery curriculum and so empower registered midwives with diverse knowledge and skills (Mathibe-Neke, 2009:36

- **Community leaders and women**

Community leaders and women emerged as an important part of the infrastructure that should be involved during the incorporation of “indigenous” postnatal care practices into the midwifery healthcare system. The reason is that postnatal care is rendered at home within the community context by the family members who are often assisted by the traditional health practitioners (Ngunyulu & Mulaudzi

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2009:50). The community leaders, including chiefs, indunas, councillors, are the key stakeholders responsible for providing assistance, moral support and encouragement to family members and traditional birth attendants during the provision of postnatal care. During data collection the community leaders also assisted the researcher in identifying family members and traditional birth attendants that are responsible for taking care of women and new-born babies immediately after discharge from the hospital and clinics.

Women are actively involved in health promotion activities related to the health of their families members and the community. Culturally, in order to qualify to become a traditional birth attendant one has to be a woman, because of the natural caring attitude they are generally perceived as having. Hence, all the family members and traditional birth attendants who participated in this study were women. Involvement of community leaders and women might be an effective multi-disciplinary and community-based team approach during the incorporation of “indigenous” postnatal care practices into the midwifery healthcare system. It might enhance and maintain mutual respect and trusting relationships between the registered midwives, family members, traditional birth attendants, women and the community leaders. This was supported by one of the declarations in relation to reengineering of primary healthcare services declared during a National Nursing Summit held in Sandton from 5 to 7 April 2011, which stated that there should be “community ward-based multidisciplinary health teams with nurses playing a critical role” (National Nursing Summit 2011:1)

5.3.1.2 Framework and contexts for the incorporation

Various contexts constitute the framework for incorporation.

- **Community context**

A community is a group of people living together in the same geographical area, sharing the same interests, such as religion (*Oxford South African School Dictionary* 2010:120). Community members are characterised by mutual and

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trusting relationships, group cohesion, sharing of common interests and challenges, and mutual supporting in a crisis. It is an important and reliable context within which incorporation of “indigenous” postnatal care practices should take place through the provision of postnatal care by the family members and traditional birth attendants. Due to early discharge of postnatal women from the hospital or clinics, postnatal patients spent the postnatal period in the community under the care of family members and traditional birth attendants (Hodnet 2012:2).

The family members and traditional birth attendants, act as reliable healthcare providers for the patients during the postnatal period, because they are always available and share cultural values, beliefs, norms and practice during postnatal care. They take responsibility for caring for women and new-born infants throughout the postnatal period, despite the absence of support from the registered midwives. The incorporation of “indigenous” postnatal care practices into the midwifery healthcare system might empower the traditional birth attendants and family members with new knowledge and skills regarding the provision of postnatal care at the community level (Hodnet 2012:2).

- **Midwifery clinical practice context**

Clinical practice in midwifery is the context in which antenatal, intra-partum, labour, delivery and the initial postnatal care takes place before discharge from the hospital. Normally, this is the place in which official handing over of postnatal patients and their new-born infants from the registered midwives to the family members and traditional birth attendants should take place on discharge. However, the findings revealed that there is lack of communication between them (Mathibe-Neke 2009:36). Nor do the registered midwives give health advice to the postnatal patients on discharge without the involvement of family members and traditional birth attendants. As a result, postnatal patients receive clashing messages from them at home.

The incorporation of “indigenous” postnatal care practices into the midwifery healthcare system might empower registered midwives with culturally competent knowledge and skills. Culturally sensitive midwives understand cultural values,
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norms, beliefs and practices of postnatal patients and their relatives. It might assist in improvement of communication between family members, traditional birth attendants and registered midwives as it would enhance teamwork between the two groups. The provision of culturally congruent care by the midwives might prevent unnecessary complications which lead to maternal deaths during the postnatal period (Mathibe-Neke 2009:36).

- **Midwifery Education and Training context**

Midwifery education and training was identified as one of the contexts because it is where midwifery curriculum is implemented to train student midwives until they qualify as registered midwives. It includes nursing colleges and universities and other educational institutions involved in midwifery training. The findings confirmed that “indigenous” postnatal care practices are not included in the current midwifery curriculum; therefore midwives are trained from a Western healthcare point of view only. The registered midwives also confirmed that they did not have adequate knowledge or skills regarding the provision of culturally congruent care. Meanwhile, South Africa, as a developing country, requires culturally competent midwives who can provide a combination of Western and “indigenous” healthcare practices in order to meet the cultural needs of patients from diverse cultures.

The incorporation of “indigenous” postnatal care practices into the midwifery healthcare system might assist with the addition of culturally competent information into the Midwifery curriculum, and so empower registered midwives with appropriate knowledge and skills. Midwifery lecturers should be actively involved in the process (Pandi 2005:5).

- **Midwifery management context**

Midwifery management was also identified as a suitable context. In midwifery management the maternal and child healthcare coordinators are responsible for coordinating, assessing, planning, organising, managing, monitoring and evaluating all activities pertaining to pregnancy, labour, delivery and postnatal care. They operate at district, provincial and national levels to ensure the provision

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of quality care aimed at maintain the health and well-being of women and children. During data analysis and interpretation of their perceptions and experiences of the incorporation, it was confirmed that in South Africa there is a high rate of maternal and child mortality. They further indicated that increasing maternal and child mortality is due to sub-standard postnatal care, ineffective referral systems between the hospital or clinics and the community, hospitals and clinics, hospitals and referral hospitals, and inadequate resources. They suggested that there should be incorporation of “indigenous” postnatal care practices into the midwifery healthcare system to ensure the provision of culturally congruent postnatal care, teamwork and communication between the registered midwives and the traditional birth attendants, and to ensure cultural safety of patients during the postnatal care. (WHO, 2010:53).

5.3.1.3 Agents for performing the activity

A number of agents are involved in performing the activity.

- **Family members and traditional birth attendants**

The family members and traditional birth attendants were identified as agents in the study because they are responsible for providing postnatal care to women and their new-born infants immediately after discharge from the hospital or clinics and for the following six weeks. Despite the absence of formal recognition by the Department of Health, as members of the multidisciplinary health team directly involved in provision of patient care, follow-up visits, support from the registered midwives and challenges they experience during the care of postnatal period, the family members and traditional birth attendants continue to provide postnatal care employing “indigenous” postnatal care practices. They expressed their willingness to work as a team with registered midwives by suggesting that there should be incorporation of “indigenous” postnatal care practices into the midwifery healthcare system to enhance and maintain a mutual and trusting working relationship with the registered midwives (Yousuf et al 2010:8).

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- **Registered midwives**

Registered midwives were also identified as important agents in realisation of a goal for incorporating “indigenous” postnatal care practices into the midwifery healthcare system (Dickoff, et al. 1968:422), because they are responsible for providing postnatal care within the clinical practice context. Registered midwives acknowledged that they have inadequate cultural competent knowledge and skills, leading to provision of substandard postnatal care and avoidable postnatal complications, and even deaths. They suggested that there should be incorporation of “indigenous” postnatal care practices into the midwifery healthcare system so that they would gain culturally competent knowledge and skills and so improve the standard of postnatal care through the provision of culturally congruent care (Pandi 2005:5).

- **Midwifery lecturers**

Midwifery lecturers were identified as important agents because they have knowledge and skills regarding midwifery curriculum and are responsible for education and training of student midwives. Currently they confirmed that the “indigenous” postnatal care practices are not incorporated into the Midwifery curriculum, and that student midwives are still trained within the biomedical paradigm only. They recommended incorporation of “indigenous” postnatal care practices into midwifery healthcare system in order to add culturally congruent care information into the Midwifery curriculum (Gallagher et al 2007:2714).

- **Maternal and child healthcare coordinators**

Functioning within the midwifery management context the maternal and child healthcare coordinators are responsible for coordinating postnatal care activities and ensuring the provision of quality patient care by the midwives. Hence, they emerged as important agents in ensuring the success of incorporation. South Africa has a high rate of maternal and child mortality, due in part to provision of substandard postnatal care and ineffective referral system from the hospital to the

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family members and traditional birth attendants via the clinic. They suggested there be incorporation to improve the quality of care during the postnatal period (Tebid et al 2011:967).

5.3.1.4 The recipients of the activity

Postnatal patients are the recipients of postnatal care from the registered midwives, family members and traditional birth attendants. The postnatal patients reported that they were dissatisfied with the care they received during the postnatal period, with no teamwork between the registered midwives, family members and traditional birth attendants. The registered midwives concentrated on hospital or clinic postnatal care, rendered for six hours after delivery before the women are discharge with health advice. After discharge, registered midwives do not continue with care through follow-up visits or provide supervision to ensure the implementation of that advice (Jokhio, Winter & Cheng, 2005:2096).

Because the postnatal patients are placed directly under the care of family members and traditional birth attendants only, without supervision by registered midwives, they suggested that there should be incorporation to enhance teamwork. Forde and Aasland (2012:523) write that it is not possible for registered midwives, family members and traditional birth attendants to work together as a team without openness and transparency.

5.3.1.5 Procedure, protocol to serve as guide during incorporation

The following procedure was suggested to serve as a guide during the incorporation.

- **Involvement of relevant stakeholders**

To ensure successful incorporation, the involvement of relevant stakeholders was suggested as an initial step. The findings confirmed that active participation and involvement is an important strategy, with the infrastructure responsible for

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management of midwifery education and training, namely, the South African Nursing Council, Nursing Education Association, Department of Health, community leaders and education institutions (Schuneman, Fretheim & Oxman 2006:2).

- **Recognition of traditional birth attendants by the government**

In South Africa the family members and traditional birth attendants are not yet recognised as members of the multidisciplinary team directly involved in provision of postnatal care. It was argued that it can be of utmost importance for the government, including the Department of Health recognise and accept the existence of the family members, traditional birth attendants and their effort regarding postnatal care (Kerber et al .,2007:1368).

It is evident that the family members and traditional birth attendants are working in isolation when providing postnatal care, and that the registered midwives are not even aware of the “indigenous” practices employed during postnatal care. This places postnatal patients at risk of complications and even death. Recognition of family members and traditional birth attendants emerged as an important strategy in the incorporation (Kerber et al 2007:1368).

- **Awareness campaigns**

The findings confirmed that registered midwives are not aware of the “indigenous” postnatal care practices employed by the family members and traditional birth attendants during the provision of postnatal care. This is because the registered midwives are trained within the biomedical paradigm only. Conversely, the family members and traditional birth attendants are not aware of the Western healthcare practices that should be employed during postnatal care, because currently there is no communication between them. Awareness campaigns emerged as a prerequisite to incorporation (Haynes, et al 2009:3)

(Haynes et al 2009:3).write that awareness campaigns might assist registered midwives, family members and traditional birth attendants to market and advertise their practices, establish rapport, initiate mutual and trusting relationship and gain

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recognition of each other's practices. For successful incorporation, awareness campaigns should be run as an initial step.

- **Training**

Training was identified as one of the incorporation strategies during data analysis of the perceptions and experiences of registered midwives regarding incorporation. It also emerged as one of the procedures or protocols to be followed during incorporation within the six aspects of activity listed by Dickoff, et al. (1968:422). The following groups of people need to be trained in order to gain new knowledge and skills regarding the provision of postnatal care: registered midwives on culturally congruent care; family members, traditional birth attendants and community-based healthcare providers on Western healthcare practices. Training might improve the standard of postnatal care because it will be provided by culturally competent midwives, skilled family members, traditional birth attendants and community-based healthcare providers (Nagi et al 2005:56).

According to Nagi et al. (2005:56), training of traditional birth attendants and registered midwives on culturally congruent care proved to be an effective strategy in the reduction of maternal and child mortality, because the family members and traditional birth attendants possess knowledge and skills on assessment, early recognition of complications and early referral for medical assistance.

- **Team building**

Team building was identified as one of the incorporation strategies that can gradually motivate the registered midwives, family members and traditional birth attendants to work together as a team. It is evident that teamwork is an effective strategy in ensuring quality patient care, as the team will have common purpose, clear goals, develop team skills, share information, support each other and hold the team accountable for output (Stone & Bailey 2007:259).

- **Meetings**

It was suggested that for incorporation to be successful there should be regular meetings between the registered midwives, family members and traditional birth attendants. A model for incorporating indigenous postnatal care practices into midwifery healthcare system.

attendants Holding meetings on regular basis might assist both groups to establish rapport, get to know each other, develop mutual trust, maintain the initiated relationship, learn from each other, share common problems and discuss the achievements and challenges experienced during the provision of postnatal care (Sahlstedt 2012:93).

5.3.1.6 Dynamics and power bases

Consideration of a number of dynamics and power bases is important for the model of incorporation.

- **Recognition, praise and reward**

Recognition of family members and traditional birth attendants was identified in phase two as an effective strategy and as a power base/dynamic in the process of incorporation (Dickoff, et al. 1968:428). All the agents involved need to be recognised, praised and rewarded, thus motivating them to develop goal-directedness, ownership, active participation and involvement, and realisation of the goal and sustainability of the project (Kruske & Barclay, 2004:4).

- **Strength, knowledge and skills**

In order to successfully incorporate “indigenous” postnatal care practices into the midwifery healthcare system, all the agents involved in the process should be adequately motivated through recognition, praise and reward. They will then gain the strength needed to accomplish the goal. All should be orientated and trained so that they gain the requisite knowledge and skills (Fullerton & Thompson 2005:23).

- **Attitudinal changes**

Attitudinal changes were identified as amongst the antecedents during concept analysis of the concept ‘incorporation’. Some registered midwives display negative attitude towards the postnatal patients, family members and traditional birth

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attendant' "indigenous" practices, and so are failing to provide culturally congruent postnatal care. This was evidenced by ethnocentric practices, scolding, shouting, general rudeness, lack of respect in general, victim blaming approaches, and poor cultural competence (Wray, Weavers, Beake, Rose & Bick 2010:72). For successful incorporation to occur, registered midwives should be ready to change negative attitudes as these result in sub-standard care and place at risk the health of patients.

- **Acceptance of each other**

Mutual acceptance between registered midwives, family members and traditional birth attendants were identified as one of the expected antecedents to incorporation. The findings revealed that the family members and traditional birth attendants were willing to work together as a team with the registered midwives, and that they needed the support of registered midwives during the provision of postnatal care (Shah, Salim & Khan 2010:42).

The registered midwives are currently not accepting the family members and traditional birth attendants as co-workers directly involved in the provision of postnatal care. It was confirmed that for successful incorporation the registered midwives should be ready to accept the family members and traditional birth attendants and initiate mutual and trusting relationship so that they can work together as a team (Sibley & Sipe 2007:476).

5.3.6.7 Terminus or outcomes of incorporation

There are several factors relating to end of the process of incorporation.

- **Empowerment with new knowledge and skills**

Empowerment was identified as a prominent outcome of incorporation in all phases of the study. During concept analysis (Walker & Avant 2005:29) empowerment emerged as the consequence of incorporation, as it did during data analysis and interpretation of the perceptions and experiences of the registered

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midwives (Dickoff et al., 1968:422). Successful incorporation might result in empowerment of family members, traditional birth attendants, registered midwives, Midwifery lecturers, maternal and child healthcare coordinators, with appropriate new knowledge and skills. For postnatal patients it will be an eye-opener, as they will be able to make informed decisions when they experience health problems during the postnatal period. The feelings of fear and insecurity might be reduced as they will receive health advice from the registered midwives, family members, and traditional birth attendants. The standard of postnatal care might be improved because they will be cared for by the trained family members traditional birth attendants who work and traditional birth attendants might also gain knowledge and skills regarding the provision of Western postnatal care, resulting in feelings of confidence due to reduced stigma of labels such as witchcraft, illiteracy and non-religious and support from the registered midwives. There might be mutual respect for, and trusting relationships with the postnatal patients. The feelings of doubt expressed by the family members and traditional birth attendants. might be reduced because the maternal deaths would be reduced through the provision of culturally congruent postnatal care (Kruske & Barclay 2004:3).

Registered midwives might gain cultural competent knowledge and skills, leading to culturally sensitivity, cultural awareness resulting in the provision of cultural congruent postnatal care. Workload might be reduced as they will be working as a team with the traditional birth attendants and the family members, leading to improved job satisfaction and improved standard of care. The improved standard of care by the culturally sensitive midwives might results in prevention of avoidable postnatal care complications resulting in reduced maternal and child mortality rates, reduced legal costs and achievement of the Millennium Development Gaols (MDG,s) number four (4) and five(5) (Kruske & Barclay 2004:3).

Midwifery lecturers might also gain new knowledge and skills regarding the provision of culturally congruent care because the “indigenous” postnatal practices will be incorporated into the Midwifery curriculum. Midwifery training will no longer concentrate on Western healthcare practices only, but will be a combination of

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both. As a result, the newly registered midwives will have appropriate knowledge and skills (Maganda 2012: 23).

- **Teamwork**

Teamwork was identified as a consequence of incorporation, but it is evident that currently in South Africa there is none between the family members, traditional birth attendants and registered midwives; hence there is substandard care during the postnatal period. Samoa and Malaysia are good examples of countries in which registered midwives are working in collaboration and partnership with family members and traditional birth attendants (Kruske & Barclay 2004:9).

- **Improved job satisfaction**

Improved job satisfaction was identified as a consequence of incorporation during concept analysis (Walker & Avant 2005:29), and during data analysis of the perceptions and experiences of the maternal and child healthcare coordinators regarding the incorporation of “indigenous” postnatal care practices into midwifery healthcare system and as a terminus or endpoint in the six aspects of activity by Dickoff, et al. (1968:422).

- **Provision of culturally congruent care**

Improved standard of care (provision of culturally congruent care) was identified as a consequence of incorporation, and might lead to improved standard of care (Makhubele & Qualinga 2006:155). Culturally sensitive midwives would be able to create a therapeutic environment, showing positive attitudes towards patients of different cultures. The maternal and child healthcare coordinators suggested that there should be incorporation of “indigenous” postnatal care practices into the midwifery healthcare system in order to ensure cultural safety during the provision of postnatal care.

- **Reduced maternal and child mortality rates**

Reduced maternal and child mortality rates as a consequence of incorporation might empower registered midwives with culturally competent knowledge and

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skills, resulting in prevention of postnatal complications and reduction of maternal and child mortality rates.

- **Reduced legal costs**

Reduced legal costs were identified as a consequence of incorporation, reducing the legal liabilities facing midwives on a daily basis due to provision of substandard postnatal care. The Department of Health might save money spent currently on paying legal liabilities of registered midwives.

- **Achievement of the Millennium Development Goals 4 and 5**

Achievement of the MDGs 4 and 5 was identified as a consequence of incorporation, through the provision of culturally congruent postnatal care, improving the quality of care during the postnatal period, avoiding postnatal complications and reducing maternal and child mortality rates. Validation and operationalisation of the model will be conducted as a post-doctoral project.

5.4 SUMMARY

Chapter five focused on development and description of a model for incorporating “indigenous” postnatal care practices into midwifery healthcare system. Model development was based on the findings for phase one (concept analysis by Walker & Avant 2008:30), phase two (empirical perspective) and phase three (conceptual framework by Dickoff, et al. 1968:422). The model was described under the following aspects: introduction, purpose, scope, components, and meaning of components and detailed description of the components. Chapter six will concentrate on conclusions, limitations and recommendations for further research.

CHAPTER 6

OVERVIEW OF RESEARCH FINDINGS, RECOMMENDATIONS IMPLICATIONS, LIMITATIONS AND CONCLUSIONS

6.1 INTRODUCTION

Having explored the development and description of a model for incorporating “indigenous” postnatal care practices into midwifery healthcare, the aim of this chapter is to provide an overview of research findings, draw conclusions, list the limitations and outline implications for further research.

6.2 OVERVIEW AND SUMMARY OF FINDINGS

6.2.1 Phase One – Concept analysis

The purpose of **Phase One** was to analyse the concept ‘incorporation’, which helped the researcher understand the meaning of incorporating “indigenous” postnatal care practices into a midwifery healthcare system. To achieve this objective, concept analysis was carried out, following the process of Walker and Avant (2005:49), during which the following findings emerged: theoretical definition, antecedents and consequences of the concept ‘incorporation’.

Based on the identified uses, defining attributes and model cases of the concept, the theoretical definition of the concept might be the process of integrating, including, unifying, mixing, embracing, coalescing, assimilating, amalgamating combining and introducing the “indigenous” postnatal care practices into midwifery healthcare systems, with the aim of improving the standard of care during the postnatal period.

According to Chinn and Kramer (2008:195) and Walker and Avant (2005:73), antecedents are those events or incidents that should occur prior to the occurrence of the concept. In this study, before incorporation of “indigenous” postnatal care practices into the midwifery healthcare system, the following events

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should occur: awareness campaigns, acceptance of each other, attitudinal changes and support follow up postnatal care visits by registered midwives.

Consequences were described by Chinn and Kramer (2008:95) and Walker and Avant (2005:73) as those events or incidents that occur as a result of the concept. In this study the following events were perceived as the possible consequences of incorporation: empowerment, new knowledge and skills, teamwork, confidence, improved standard of care (provision of culturally congruent care), reduced workload, reduced legal costs and improved job satisfaction.

6.2.2 Phase Two – Empirical perspective

The purpose of **Phase Two** was to explore and describe the perceptions and experiences of postnatal patients, family members, traditional birth attendants registered midwives, Midwifery lecturers and the maternal and child healthcare coordinators regarding the incorporation of “indigenous” postnatal care practices into the midwifery healthcare system.

A qualitative, exploratory, descriptive and contextual approach was used to achieve this objective. Eleven themes were identified from different population groups, with categories and sub-categories identified to substantiate each theme and be compared to relevant literature.

Postnatal patients reported the challenges they experienced during the postnatal period as follows: lack of openness and transparency between the registered midwives, family members, traditional birth attendants, and a lack of postnatal supervision.

Family members and traditional birth attendants reported struggling alone during the provision of postnatal care, without support from the registered midwives. They also experienced lack of respect and mutual or trusting relationships with the postnatal patients. Sometimes they witnessed maternal deaths in the home.

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The registered midwives confirmed that they did not have adequate knowledge of the “indigenous” postnatal care practices employed by the family members and traditional birth attendants during the postnatal period. Inadequate knowledge results in display of negative attitude towards family members and traditional birth attendants. They expressed concern about the increasing maternal mortality rates and identified the following incorporation strategies: awareness campaigns and training of registered midwives and the traditional birth attendants. Empowerment with cultural competency knowledge and skills, teamwork and improved job satisfaction were identified as possible outcomes of incorporation.

The midwifery lecturers reported a lack of information regarding “indigenous” postnatal care practices into the midwifery healthcare system, resulting from training of midwives within the Western healthcare point of view only, and leading to lack of knowledge amongst midwives regarding culturally congruent care. The following incorporation strategies were also identified during the discussions: involvement of relevant stakeholders and recognition of traditional birth attendants.

The maternal and child healthcare coordinators reported sub-standard postnatal care due to ineffective referral system and inadequate resources, leading to increasing maternal and child mortality rates. Team building was identified as an effective incorporation strategy. The following benefits emerged during data analysis: improved standard of postnatal care, reduced maternal and child mortality rates, achievement of the Millennium Development Goals 4 and 5, and reduced legal costs.

6.2.3 Phase three – Model development

The purpose of this **Phase Three** was to develop and describe a model for incorporating “indigenous” postnatal care practices into Midwifery health system. Model development was based on the findings for Phase One, concept analysis in Chapter Three, Phase Two, empirical perspective in Chapter Four and Phase

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Three conceptual framework by Dickoff et al (1968:422) in Chapter Five. The following questions were used as a guide during the process of model development:

- Who or what performs the activity?
- Who or what is the recipient of the activity?
- In what context is the activity performed?
- What is the endpoint of the activity?
- What is the guiding procedure, technique or protocol of the activity?
- What is the energy source for the activity?

6.3 MODEL DESCRIPTION

6.3.1 Purpose of the model

During model description the purpose was to incorporate “indigenous” postnatal care practices into midwifery healthcare system.

6.3.2 Scope of the model

The model is made up of three phases, namely:

- Phase one: concept analysis
- Phase two: Empirical perspective
- Phase three: conceptual framework.

6.3.4 Components of the model

The components of the model are as follows.

- **Infrastructures which regulates midwifery education**

The infrastructures responsible for regulating midwifery education and training in South Africa are the South African Nursing Council (SANC) as the regulatory body which controls midwifery training and practice to ensure the promotion of health

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standards of the Republic; the Nursing Education Association (NEA), which is responsible for empowering nurses with knowledge and skills needed to improve the standards of care during service delivery; the Department of Health (DoH), which is responsible for formulation of policies and guidelines used during the provision of care by midwives; education institutions responsible for education and training of nurses including midwives; and community leaders and women, who are key stakeholders responsible for providing assistance, moral support and encouragement of family members and traditional birth attendants during the provision of postnatal care .

- **Context**

The context is where the activity should take place, in this study the incorporation of “indigenous” postnatal care practice into midwifery healthcare within the following midwifery contexts: i) the family members and traditional birth attendants will operate within the community context; ii) registered midwives within the midwifery clinical practice context; iii) midwifery lecturers within the midwifery education and training context; and iv) the maternal and child healthcare coordinators within the midwifery management context.

- **Agents**

The agents who provide care to the recipients in this study are the family members responsible for provision of care during the postnatal period, together with the family members and traditional birth attendants registered midwives are responsible for taking care of women during pregnancy, labour, delivery and puerperium. Midwifery lecturers are responsible for education and training of midwives whilst maternal and child healthcare coordinators are responsible for management, monitoring and evaluation of postnatal care.

- **Recipients**

The recipients should receive care from the agents. In this study the postnatal patients are the recipients of care from the registered midwives, family members and traditional birth attendants.

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- **Procedure**

The procedures are the techniques or protocols to be followed during the incorporation of “indigenous” postnatal care practices into midwifery healthcare system. They involve stakeholders in the first step in the process of incorporation, and recognition of family members and traditional birth attendants should follow in order to initiate training, team building and regular meetings.

- **Dynamics**

The dynamics are the power bases needed for successful incorporation of “indigenous” postnatal care practices, namely: recognition, praise and reward of registered midwives, family members and traditional birth attendants’ strength, knowledge and skills, attitudinal changes, orientation and mutual acceptance.

- **Terminus or endpoint**

The terminus or endpoints are the consequences or the outcomes of incorporation of the model. They were outlined as empowerment with new knowledge and skills, teamwork, reduced workload, improved job satisfaction, improved standard of care, reduced maternal mortality, reduced legal costs and achievement of the Millennium Development Goals 4 and 5.

6.4 RECOMMENDATIONS

Based on the purpose of the developed model, the incorporation of “indigenous” postnatal care practices into midwifery healthcare system, the following actions were recommended:

- The South African Nursing Council (SANC) should assist in implementation of the model to improve the standard of postnatal care. It should also recognise the importance of culture in the provision of healthcare and compile rules and regulations to guide and inform policies regarding the incorporation of “indigenous” practices into Western healthcare. It should work in collaboration with the Nursing Education Association to facilitate

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incorporation of “indigenous” postnatal care practices into midwifery curriculum to ensure production of culturally competent midwives.

- The Nursing Education Association, in collaboration with relevant stakeholders should orientate nurses and midwives on community-based and multidisciplinary team approaches from the first year of training.
- The Department of Health Nursing Education Association and relevant stakeholders should initiate training of family members and traditional birth attendants taking care of postnatal patients as part of re-engineering the primary healthcare services. They should also initiate in-service training for registered midwives regarding cultural competency.
- The Department of Health should develop the second phase following the promulgation of the Traditional Health Practitioners Act no 22 of 2007, because this is regarded as an initial step in incorporating “indigenous” practices into the Western healthcare system. It should also strengthen referral systems between district hospitals and referral hospitals to ensure prompt management of obstetric emergencies, and prevent unnecessary deaths caused by delays between hospitals to clinics and the community. It should initiate the use of doulas, who are responsible for providing physical and emotional support during pregnancy, labour and puerperium (Wray et al 2010: 71).
- Registered midwives should conduct follow-up postnatal care visits to provide support to family members and traditional birth attendants and to ensure continuity of care to women and infants during the postnatal period (Wray et al 2010: 71).

6.5 RECOMMENDATIONS FOR FURTHER RESEARCH

Based on the abovementioned recommendations, research should be conducted into the following areas:

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- Development of guidelines for implementation of the Traditional Health Practitioners Act 22 of 2007.
- Development of guidelines for training of traditional birth attendants and family members regarding provision of postnatal care.
- Validation and implementation of the model for incorporation of “indigenous” postnatal care practices into the midwifery healthcare system.
- Discovery of other strategies for incorporating “indigenous” postnatal care practices into midwifery healthcare systems.

6.6 IMPLICATIONS

“Indigenous” postnatal care practices are currently not incorporated into the midwifery curriculum, resulting in training of midwives from a Western healthcare point of view only, and midwives having inadequate culturally competent knowledge and skills. Culturally insensitive midwives are failing to provide culturally congruent postnatal care, resulting in substandard care, complications and/or even deaths. It is also evident that the postnatal patients are directly under the care of unskilled family members and traditional birth attendants without supervision, guidance or support from the registered midwives, putting the health of postnatal patients at risk of delayed recognition of complications and seeking of medical assistance, resulting in deaths and/or disabilities. There is a need for teamwork between the registered midwives, family members and traditional birth attendants to improve the standard of postnatal care. The research findings have implications for the following groups.

For the South African Nursing Council

South African Nursing Council rules and regulations should emphasise the importance of culture in nursing to create awareness of socio-cultural factors and to ensure that the cultural needs of the patients are met. They should facilitate the incorporation of “indigenous” practices in healthcare to promote the standard of education, training and practice.

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For Nursing Education

The Midwifery curriculum should incorporate the “indigenous” practices to empower midwives with culturally competent knowledge and skills. It should also emphasise the importance of multidisciplinary team approach in healthcare to orientate student midwives during training and make it easy for them to work with family members and traditional birth attendants in future. The Nursing Education Association, in collaboration with the Department of Health, should initiate the training of family members and traditional birth attendants responsible for taking care of women and infants during the postnatal period, and so improve the standard of postnatal care.

For the Department of Health

The health policies should accommodate the “indigenous” practices to ensure the provision of culturally congruent care to multicultural South Africans. Following the *Guidelines for Maternity Care in South Africa (2007:42)*, which states that women should be discharged six hours after delivery, the Department of Health should recognise, praise and reward the family members and traditional birth attendants for their work during the provision of postnatal care. It should also allocate adequate staff (midwives) to maternity wards and clinics to ensure the provision of quality care and enable the midwives to conduct follow-up visits during the postnatal period.

6.7 CONTRIBUTION TO THE BODY OF KNOWLEDGE

A model for incorporating “indigenous” postnatal care practices into the midwifery healthcare system might contribute to the body of knowledge in nursing, specifically in midwifery, because it might add the “indigenous” practices within the Midwifery curriculum. Midwifery training might be carried out from both “indigenous” and Western points of view, and as a result registered midwives might be empowered with culturally competent knowledge and skills, leading to improvement of midwifery practice through provision of culturally congruent care.

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6.8 LIMITATIONS

According to Marshall and Rossman (1999:42), limitations are those trades-offs that remind a researcher what the study was and was not, and how its boundaries and results may and may not contribute to understanding. The following were the limitations in this study.

Potential limitations might occur during the process of incorporation because it requires the active involvement and participation of different stakeholders. The most serious limitation is that some. Registered midwives might be reluctant to recognise the importance of culture in the provision of nursing care. In order to overcome this limitation the researcher should study and become more knowledgeable regarding culturally congruent care, in order to allow for sensitivity with the participants during the evaluation and implementation of the model for incorporating indigenous postnatal care practices into midwifery healthcare system.

The focus of overcoming identified limitations should be on the strategies to incorporate “indigenous” practices into midwifery healthcare system, because, despite having suggestions and recommendations from previous researchers who indicated the value of incorporating “indigenous” practices into western healthcare, reaching the milestones is slow. In conclusion, the above findings support the argument that without culturally competent knowledge and skills it is difficult for nurses, including midwives, to provide culturally congruent care.

6.9 FINAL CONCLUSIONS

The purpose of this study was to develop a model for incorporating “indigenous” postnatal care practices into midwifery healthcare system. The attainment of this purpose was guided three phases, and the meaning of the concept ‘incorporation’ was described following the process of concept analysis by Walker and Avant (2005:29). The theoretical and operational definitions, antecedents and consequences were identified. The findings for concept analysis guided the

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researcher during the exploration and description of the participant's perceptions and experiences regarding the incorporation of "indigenous" postnatal care practices into midwifery healthcare system. The findings for Phases One and Two were used to develop and describe a model following the conceptual framework by Dickoff et al (1968:422). The findings of the three phases assisted the researcher to answer the research questions and to attain the research objectives.

The model might be regarded as one of the milestones towards implementation of the Traditional Health Practitioners Act, 22 of 2007 in South Africa. The developed model might be significant to nursing and midwifery, including transcultural nursing, because there is high priority of increasing nurses' knowledge and skills through research. The model would assist in training midwives, through addition of cultural congruent care information in the current midwifery curriculum and production of culturally competent midwives. The provision of culturally congruent care might reduce health disparities because cultural safety will be enhanced and maintained, leading to reduction of maternal and child mortality rates. The Department of Health and Social Development in Limpopo Province might utilise the model to enhance a mutual working relationship between the family members and traditional birth attendants and registered midwives, thus ensuring a multidisciplinary team approach to postnatal care.

Validation and implementation of the model will be carried out during postdoctoral studies.

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ANNEXURES A-N

A model for incorporating indigenous postnatal care practices into midwifery healthcare system.



ANNEXURE A

APPROVAL OF TITLE THESIS

A model for incorporating indigenous postnatal care practices into midwifery healthcare system.



ANNEXURE B

**PERMISSION LETTER FROM THE UNIVERSITY OF PRETORIA ETHICS
COMMITTEE**

A model for incorporating indigenous postnatal care practices into midwifery healthcare system.



ANNEXURE C

PERMISSION LETTER FROM THE DEPARTMENT OF HEALTH AND SOCIAL DEVELOPMENT LIMPOPO PROVINCE

A model for incorporating indigenous postnatal care practices into midwifery healthcare system.



ANNEXURE D

CONSENT FORM FOR POSTNATAL PATIENTS

A model for incorporating indigenous postnatal care practices into midwifery healthcare system.



ANNEXURE E

CONSENT FORM FOR FAMILY MEMBERS AND TRADITIONAL BIRTH ATTENDANTS

A model for incorporating indigenous postnatal care practices into midwifery healthcare system.



ANNEXURE F

CONSENT FORM FOR REGISTERED MIDWIVES

A model for incorporating indigenous postnatal care practices into midwifery healthcare system.



ANNEXURE G

INTERVIEW GUIDE

A model for incorporating indigenous postnatal care practices into midwifery healthcare system.

ANNEXURE H

TRANSCRIPTS FOR FOCUS GROUP INTERVIEWS WITH POSTNATAL PATIENTS

R = Researcher

P = Postnatal patient

R: Good morning all of you

P: Good morning

R: How is the morning?

P: It is fine, and how are you sister?

R: I am fine.

R: Before we start with today's discussion, let me remind you about the purpose of the study. The study is aimed at developing a model for incorporating indigenous postnatal care practices into midwifery healthcare system. Incorporating indigenous postnatal care practices simply means fitting in of the practices that are used by the family members and traditional birth attendants when taking care of women and their new-born infants during the postnatal period, into western healthcare practices in midwifery context. You as people who are recipients of postnatal care are a very important source of information which is needed for incorporation of indigenous postnatal care practices into midwifery healthcare system.

R: What are your experiences regarding the care that you receive during the postnatal period?

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P: During this period we experience a lot of confusion, because on discharge from the hospital the nurses give us health advices on how to take care of myself and my baby. On arrival at home the relatives are giving us other instructions that we need to follow during the postnatal period, the instructions from the relatives differ from the health advices from the nurses, so a person becomes confused , you do not know which instructions to follow.

R: What confuses you now?

P: The nurses advised me to follow their advices and not agree to any advice from the grannies because they are not safe for me and my child ,on arrival my mother-in-law assign a granny who is responsible for taking care of me and my child. This granny also gives me advices to follow during the postnatal period, so I become confused, I do not know which advices to follow.

P: Yes, she is right, I also have the same problem, and I do not know which advices to follow, whether the ones that I received from the nurses or the ones from my mother-in-law.

R: You said you receive different advices from the nurses and the grannies at home, tell me more about this.

P: The registered midwives are giving health advices to us as patients only, they do not involve our relatives who are taking care of us during the postnatal period, as a result we find it difficult to follow the postnatal care advices from the nurses, because they differ from what we are told at home.

R: Tell me, is there any problem if the relatives are not involved by the registered midwives when giving health advices on discharge?

P: Yes, the problem is that as postnatal patients we do not have a say on what should be done or followed during the postnatal period, because the grannies are very strict, they want us to follow what they tell us to do during the

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postnatal period. Most of the time this practice clashes with what the nurses is saying on discharge from the clinics/hospitals.

R: I do not understand when you say the health advises clashes with what the nurses are saying, can you clarify more on that?

P: It is difficult for us to come back for postnatal check-up after three days because the grannies do not allow us to move out of the house, even if you try to tell them about the advises given on discharge, they do not understand because they were not involved by the nurses when giving health advise on discharge”.

R Mhhhh! And you please tell us more about this.

P: Yes sister, at the clinic they told me to do some exercises in order to ensure good muscle tone and to facilitate involution of the uterus, on arrival at home my grandmother advised me not to do any household activities such as cooking because I’m still very weak and the food will smell breast milk.

R: Anything else?

P: The nurses told me to come back to the clinic for check-up after 3 days, but when I arrive at home, my mother –in-law told me to stay in the hut for 6 weeks without coming into contact with the people who are sexually active in order to protect the new born baby from the evil spirits, so I do not know which advise to follow.

R: What else, could you explain a bit more on the advises?

P: I was told by the sister to feed the baby with breast milk only for six months without giving other things like soft porridge, purity, danone,etc, but at home my mother-in-law is preparing ‘xidlamutana” for me and very light soft porridge for the new-born every morning.

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R: Is that all?

P: No sister, there are many examples that we can give regarding this things.

R: Can you give me more examples?

P: For my first born the nurse told me that the foremilk is good for my baby because it contains all the nutrients that are needed for growth of the new-born, at home, my granny encouraged me to first squeeze the foremilk and throw it away every time before I breastfeed the baby because the foremilk if dirty and is not healthy for the new-born baby.

R: Ok, you gave many examples of clashing health advises, so tell me, what are your perceptions and experiences regarding the incorporation of indigenous postnatal care practices into midwifery healthcare system?

P: To me it is a good idea that can assist the nurses to know what the grannies and the traditional birth attendants are doing at home during the postnatal period.

R: Anything else?

P: Yes, maybe it can help to encourage nurses to communicate with the family members, because currently the two groups are not working together, each one is working alone in isolation, so we are in between, and we do not know what to do.

R: What do you mean when you say each group is working alone in isolation?

P: I think there should be truth and reconciliation between the registered midwives and the traditional birth attendants/family members because currently the two groups are not in good terms with each other, the registered midwives

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are advising us to be careful about what the traditional birth attendants will tell us to do during the postnatal period because they are dangerous to us and our new born babies.

R: What else?

P: It can be better if the indigenous practices can be incorporated into western healthcare, because currently when I arrive home I do not know where to start, my mother-in-law is so aggressive, I remember when I arrive home with my firstborn, when I try to explain what was said by the nurses on discharge, my mother-in-law does not even want to hear such stories, she just say “that will not happen to my grandchild, over my dead body. So it can be better if the nurses can invite her to be present when they give health advices, may be this problem can be solved.

R: Tell me more on why should we incorporate indigenous postnatal care practices into midwifery healthcare system?

P: Sister, I think it is better to incorporate the indigenous postnatal care practices into midwifery healthcare system, so that nurses become aware about these practices.

R: Why do you think it is necessary for nurses to know about these practices?

P: It is necessary because currently the nurses do not know about the advises that the family members are giving us at home, which differs from what they are telling us at the hospital, it can be better if they can know about them so that they come to a consensus with the family members and traditional birth attendants on which advises are safe for us to follow.

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R: What else?

P: Currently I do not feel safe to be cared for by a family member who is not even trained on how to care for a woman during the postnatal period, because anything can happen to me and my new-born baby, and it will take time for this family member to realize that there is a problem that needs urgent attention. So I think it can be better if these practices can be incorporated into midwifery healthcare system, so that the family members can work together with the nurses.

R: What do you mean when you say you do not feel safe to be cared for by a family member who is not even trained, tell us more about that?

P: I had a bad experience after delivering my first born child, so I do not want it to happen to me again.

R: How bad was the experience, can you tell us more about that?

P: Yoooh! I once bled with clots during the postnatal period, when I report to the granny who was allocated to take care of me, she said that it is normal to bleed during the postnatal period, the uterus is cleaning where the baby was situated, bleeding continued until I collapsed, is then that they called an ambulance to take me to the hospital.

R: Eeeh! That was really bad, is there anyone who had a similar experience?

P: Yes Sister, my first child nearly died due to bleeding from the umbilical cord, which was not tied properly by a traditional birth attendant at birth, she took time to allow me to take the baby to the clinic, on arrival at the clinic, and the sister referred the baby to the hospital urgently because the baby was paper white. So really it is not safe at home, unless if the nurses can sometimes come to visit us.

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R: Anything else?

P: Another thing is that there is no openness and transparency between the family members, the nurses give you advises on the date of discharge, on arrival at home, the grannies gives you other instructions, that are totally different from what the nurses told you at the hospital, so I find myself in a dilemma, because I do not know which instructions to follow.

R: What do you mean when you say there is no openness and transparency between the family members and the nurses; can you give example of that?

P: Yes, on discharge for my third baby, the sister gave me an injection for family planning on discharge to prevent accidental conception during the postnatal period, my mother-in-law advised me not to resume sexual intercourse until after the menstruations starts again after delivery.

R: You seem to be having something say, also, do you have something to add?

P: Yes sister, during health education on discharge for my second born, the nurse said: “do not allow the grannies to cut and put black stuff on the fontanel of the new-born baby, because your baby will die”, on arrival at home my granny invited the family’s traditional health practitioner to come and put the “muti” on the baby’s fontanel, when I tried to tell her what the nurses said, she said not on my grandchild.

R: Anything else?

P: I was once told to go to the nearest clinic for postnatal checking’s after 3 days, when I arrive at home my granny said, for you and your baby’s safety, you must not come closer to the people who are sexually active, which means that you are not allowed to go out of this hut until the end of the sixth week, so I did not manage to go to the clinic for postnatal checkup.

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R: I heard someone from this group saying that you do not feel safe unless if the nurses can come and visit you; can you tell us more about that?

P: Yes it is me, the nurses must go back to what they use to do before, where the nurse was moving around the villages on a bicycle, visiting the women and their babies at home after being discharged from the hospitals/clinics, now they are no longer coming, and it is a serious problem to us because now we just struggle alone and we are not sure whether we are doing the right thing or not.

R: Is there anyone with a similar idea?

P: Yes, if they can visit us at home, at least we can have someone to ask if we have some questions during the postnatal period.

R: Anything else?

P: I think they can also assist the family members, because they also struggle alone at home, they do not have any one to support them.

R: Anything else?

P: No

R: Ok, THANK YOU SO MUCH FOR YOUR TIME, YOUR ACTIVE PARTICIPATION DURING THE DISCUSSION, IF YOU NEED MORE INFORMATION REGARDING THIS, YOU ARE FREE TO CONTACT ME, AND I WILL ALSO CONTACT YOU IF I NEED SOME CLARITY ON THIS ISSUE. Thank you once more.

P: THANK YOU.

ANNEXURE I

TRANSCRIPTS FOR FOCUS GROUP INTERVIEW WITH FAMILY MEMBERS

R = Researcher

F = Family member

R: Good morning all of you

F: Good morning

R: How is the morning?

F: It is fine, and how are you?

R: I am fine.

R: Before we start with today's discussion, let me remind you about the purpose of the study. The study is aimed at developing a model for incorporating indigenous postnatal care practices into midwifery healthcare system. Incorporating indigenous postnatal care practices simply means fitting in of the practices that are you use at home when taking care of women and their new-born infants during the postnatal period, into western healthcare practices in midwifery context. You as people, who are responsible for taking care of postnatal patients immediately after discharge from the hospital/clinics, are a very important source of information which is needed for incorporation of indigenous postnatal care practices into midwifery healthcare system.

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R: What are your perceptions and experiences regarding the incorporation of indigenous postnatal care practices into midwifery healthcare system?

F: Do you think nurses will agree to include the indigenous postnatal care practices into midwifery healthcare? I do not think so, because currently they prefer working alone, and we are also working alone, it is not easy for us because they do not support us, it can be easy for us as family members who are responsible for taking care of the women during the postnatal period, to get support from the registered midwives, because now we are struggling with the care of postnatal women and their new-born babies alone, they cannot give themselves a chance to come and see the woman and her new-born at home, just to have them moral support.

R: Any other idea regarding the incorporation of indigenous postnatal care practices into midwifery healthcare system?

F: I suggest that the indigenous postnatal care practices, be incorporated into midwifery healthcare system, may be things can go back to normal, because previously we use to see a nurse riding on a bicycle, driving around the villages, visiting all the women and their new-born babies who were discharged from the hospitals/clinics. It was very good support for us as people who are taking care of the postnatal women because we were able to ask questions and discuss some challenges that we experience when taking care of postnatal patients.

R: What else?

F: We use to delay resumption of sexual relations, by staying in the hut of our mother-in-laws with our new-born; we were not allowed to come closer to our husbands, until we start to menstruate again after delivery, is then that you are allowed to go back to your hut. Nowadays young men and women are dying every day because they do not follow the taboos during the postnatal period such as delayed resumption of sexual relations.

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R: Tell me more about this, traditionally how do you take care of a postnatal woman and her new-born baby immediately after discharge from the hospital or clinic?

F: In my family, when I come back with the woman after discharge from the hospital, I keep her in my hut with the baby, not everybody is allowed to enter the hut except elderly women who has reached menopause and the girls who has not reached puberty. Women who are sexually active are not allowed to enter the hut where the baby and the mother are placed because they are too hot for the newborn baby.” The woman is kept there until the end of the postnatal period, characterized by the first menstruation after delivery, when that happen, she must start by washing all her clothes in the hut including the blankets. After washing she must clean the hut thoroughly using cow dung, when I saw her doing that, I know that obviously, she started with the menstruation, then I will call other elderly women, and explain the them officially, that the woman has followed all the procedures of the postnatal period, so now she is ready to go back to her own hut, so the elderly women will call her and tell her that now she can go back to her hut.

R: I don’t understand when you say the end of postnatal period is characterized by the first menstruation after delivery; can you clarify more on that?

F: The first menstruation after delivery means is the resumption of normal menstrual period after delivery, it usually occur between the sixth and the eight week during the postnatal period. Traditionally, once a woman starts with the normal menstruations after delivery, it shows that now the uterus has returned to its normal functioning, meaning that it is now safe for the woman to resume with sexual intercourse, so I allow her to go back to her husband. So currently the postnatal women do not want to follow our instructions, they just do as they wish.

R: What do you mean when you say they do as they wish?

F: Our daughters-in-law do not listen to us anymore, they no longer show the respect as before because we are not educated, they only listen to the nurses,

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when I request her to come to my hut with the new-born for isolation against evil spirits, she said that: sisters at the clinic told me not to take any other advises except the advises given at the clinic or hospital, may be it can be better if the indigenous postnatal care practices can be incorporated into western healthcare practices, so that we gain that mutual respect and trusting relationship from our daughter-in-laws by talking the same language with the nurses.

R: What else?

F: I think it can also help us to know what nurses are doing, because sometimes we realize that the nurses at the hospitals and clinics, even though they say they are educated, they do not do their work properly, because these week I came back from the hospital with a woman who delivered twins, on arrival at home she stayed for a day, the second day she started to be weak suddenly and she fainted, I tried to call the ambulance which came immediately to take her back to the hospital, unfortunately she passed away before she arrived at the hospital, so now she left her twins behind, which I am taking care of, I do not have an option.

R: Mhhhh! that is a very sad experience; I do not even know what to say as a registered midwife, I feel so touched about this. Anything else?

F: When I heard about this loss, I started to doubts the knowledge and skills of nurses, more especially when it comes to ensuring that all the products of conception are removed from the uterus immediately after delivery.

R: What do you do to ensure that all the products of conception are removed from the uterus immediately after delivery of a baby?

F: when the woman delivers at home and the placenta is retained, I use to give her “dinda” or “xireti” to drink and the placenta will be expelled immediately. Again if the placenta is retained, I use to take a “drie foot”, let the woman sit on the “drie foot”, this automatically allows the placenta to be expelled. After expelling the placenta, I express the abdomen so that the remaining products can also be expelled out from the uterus, because if they are not completely expelled, women can die because of that.” So after

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delivery of the baby, I keep the woman and her bay in my hut, I do not allow the woman to cook, clean or do other things at home, because she is still weak, and she is not allow to come nearer to her husband because the child is still young, she has to delay resumption of sexual relations until the end of postnatal period, when she menstruate for the first time after delivery.

R: Anything to add on these?

F: I advise her to coughing and blowing a bottle until all the products of conception are expelled, then I tie a cloth around the waist of a woman, let her lie down on her tummy, until the womb returns to its normal state and bleeding stops.

R: Granny, do you have something to add?

F: Me naturally I do not eat food that has been cooked by a woman who has just delivered, because she still having that heavy smell of breast milk and per vaginal bleeding, as a result I keep her away from the kitchen, assign someone older to take care of her and her newborn baby throughout the postnatal period. This older person will be doing everything for the woman that includes, cooking for her, making sure that she gets warm soft porridge in the morning to promote production of breast milk for feeding the baby. The woman should be kept in the hut until she is strong enough to do all the household duties on her own. It is then that she can go back to her hut to sleep with her husband.

R: At the beginning of the discussion I heard you saying that incorporation of indigenous postnatal care practices can assist you to gain mutual and trusting relationship with nurses, can you elaborate more on that?

F: We need support from the nurses, because currently they do not care about what is happening about the postnatal women and their babies during the postnatal period, they leave us to struggle alone, even when we come across problems when taking care of postnatal patients, we do not have anyone to ask, but if they can communicate with us on a regular basis, we can be able to ask if we have problems.

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R: Anything else?

F: The problem is that the nurses do not trust us and what we do during the postnatal period, because they always advise the postnatal patients not to take our advises when they are at home, so these creates conflicts between us and the postnatal patients, they no longer show that mutual respect, they undermine everything we say or do for them and their babies. This makes us to lose our interest and confidence in caring for the postnatal woman.

R: Do you have something to add?

F: No.

R: THANK YOU SO MUCH FOR YOUR TIME, YOUR IDEAS AND OPINIONS, I LEARNED A LOT FROM YOU, IF I NEED SOMETHING FROM YOU REGARDING THE STUDY, I WILL CONTACT YOU, AND IF YOU NEED SOMETHING FROM ME REGARDING THE STUDY YOU ARE FREE TO CONTACT ME.

F: Thank you sister.

ANNEXURE J

TRANSCRIPTS FOR FOCUS GROUP INTERVIEW WITH TRADITIONAL BIRTH ATTENDANTS

R = Researcher

T = Traditional birth attendant

R: Good morning all of you

T: Good morning

R: How is the morning?

T: It is fine, and how are you?

R: I am fine.

R: Before we start with today's discussion, let me remind you about the purpose of the study. The study is aimed at developing a model for incorporating indigenous postnatal care practices into midwifery healthcare system. Incorporating indigenous postnatal care practices simply means fitting in of the practices that are you use at home when taking care of women and their new-born infants during the postnatal period, into western healthcare practices in midwifery context. You as people, who are responsible for taking care of postnatal patients and supervision of family members who are taking care of postnatal patient immediately after discharge from the hospital/clinics, are a very important source of information which is needed for incorporation of indigenous postnatal care practices into midwifery healthcare system.

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R: What are your perceptions and experiences regarding the incorporation of indigenous postnatal care practices into midwifery healthcare system?

T: I do not think it will be possible for the indigenous postnatal care practices to be incorporated into midwifery healthcare system, because in the first place nurses also regard us as witches, unreligious and uneducated, that is why even on discharge of a woman after delivery, when we go to the hospital to collect the woman and her baby, they do not even talk to us, in order to tell us how to care for this woman and the baby at home instead” instead they just talk to the woman alone, saying that when the grannies tells you to do this you must refuse because if you agree, your baby is going to die’ as a result we just keep quiet and look without giving any comment, because even our own children, their husbands they no longer listen to us, they only listen to their wives, if the wife can tell him that the baby is sick just because I bewitched the child, he will come back from Jouburg to kill me, so to avoid being killed by the youngsters, it is better to keep quiet and save our lives..

R: Tell us more about your perceptions and experiences regarding the incorporation of indigenous postnatal care practices into midwifery healthcare system?

T: Unless the midwives change their attitude that they display now, it will not be easy to incorporate indigenous postnatal care practices into midwifery healthcare system, we are ready to work with them in the care of postnatal patients, but they do not seem to be ready to accept us as their fellow workers, as a result anything I do for the postnatal woman I remain with guilt feeling because I’m aware that as traditional birth attendants we are no longer allowed to do home deliveries because the nurses regard us as non-religious, witches and people who are illiterate.

R: What else feel free to tell us more about this?

T: Yes she is right, the nurses are not ready to support us, they leave us alone to work on our own, as a result nowadays I no longer have that confidence that I use

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to have previously because we are being undermined by nurses, that is why we always hide everything we do for the postnatal patients, but if we can receive support from the nurses, we can feel confident in everything we do for the patients, because we will know what is right and wrong.

R: What do you do traditionally to ensure that the woman and the new-born baby are safe during the postnatal period?

T: Previously I use to keep the woman and the new-born baby in my hut until the end of the second month, but now things have changed, when the woman and the baby are discharged from the hospital/clinic, the father is the one who is carrying the baby home, so I just keep quiet because even if I talk, they do not listen to me”

R: What else, tell us more about this?

T: The way of doing things differ from one family to another, with me in my family ,on coming back from the hospital or clinic with the discharged woman after delivery, I do not do anything, because I am aware that they regard me as a witch, so I’m afraid that if I keep this woman in my hut and something happen to the baby or the mother, they will conclude that I bewitched them, so I just keep quiet because I do not want to be killed by their husbands.

R: Granny do you have anything to add regarding this?

T: Yes, I have a daughter- in- law who has just delivered, she does not even allow me to come closer or to hold the new-born baby, and she keeps the baby away from me, my grandson, he will grow without knowing me as his grandmother, this seriously affects our relationship.

R: Anything else?

T: What surprise me is that, they do not allow us to conduct home deliveries because they say we are illiterate, but I have just witnessed death of my neighbour who was recently discharged from the hospital, leaving twins behind, I think they left some

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products of conception inside the uterus, they were expected to compress the abdomen until all the products are expelled, because the products of conception are dangerous to the life of a woman as they cause infection, but they pretend as if they are the only people who know everything.

R: Anything else?

T: The day she was discharged I saw her when she arrives home on discharge, she not well, and because she was very weak, I think she was not yet fit for discharge, you cannot understand why nurses discharge people in such conditions.

R: Any other thing to add?

T: Yes sister may be if the indigenous postnatal care practices can be incorporated into western healthcare system, we can be able to work together with nurses, so that we learn from each other on how to ensure safety of patients during the postnatal period.

R: What do you do immediately when you arrive home with a postnatal woman after discharge from the hospital or clinic?

T: I take her to stay into my hut, I delegate someone, a close family relative who is old enough and has reached menopausal stage, to take care of the woman and her baby, as from the first day of discharge from the hospital/clinic until the end of the six to eight weeks.

R: Granny tell us, what do you do immediately when you arrive home with a postnatal woman after discharge from the hospital or clinic?

T: Immediately when we arrive at home the postnatal woman and the newborn baby are placed in my hut, the reason for placing her in my hut is that, according to our culture, the woman who has just delivered and the newborn baby are not allowed to come into contact with people who are sexually active, because they can be too hot for the baby, so in order to protect the baby from hot people, they should be kept in

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my hut until the woman starts to menstruate again after delivery, once she menstruate, is a sign to indicate that the uterus has returned to its normal state, which means that it is the correct time for the woman to resume with the sexual relations.

R: What else, tell us more about this?

T: With me also the woman and the baby are kept in my hut, the woman is not allowed to do the household duties until the end of the postnatal period.”

R: What do you mean by the end of the postnatal period?

T: By the end of the postnatal period means that the woman stays in my hut for a period of two months, where she is kept away from the rest of the family members who are sexually active, including the husband, if the husband wants to see the baby, he must ask from the granny who is taking care of this woman, the granny will hold the baby for him to see, because he is not even allowed the touch or to hold the baby, as they believe that he might be having some extra marital relationships, and be sexually active.

R: Tell us more about what do you do when coming back with a postnatal woman and the new-born baby after discharge from the hospital/clinic?

T: Previously I use to keep the woman and the newborn baby in my hut until the end of the second month, but now things have changed, when the woman and the baby are discharged from the hospital/clinic, the father of the baby is the one who is carrying the baby home, so I just keep quiet because even if I talk, they do not listen to me, they say that , there is no danger even if the woman and the newborn baby can be kept in their room because the nurses at the hospital/clinic has cleaned everything from the womb.

R: What do you do traditionally to prevent the woman from falling pregnant soon (method of family planning).

T: “She is advised not to come into contact or closer to the husband, she must just stay in the granny’s hut, prepare food before the husband comes back home, put food

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in the husband's hut and water for washing hands so that when he comes back, he find the food, he eat and sleep.

R: What else?

T: Even at my house, when I arrive home with the woman and the baby after discharge from the hospital, I do not allow her to go to her hut, she must stay in my hut for the period of six to eight weeks, without having sexual relationships with the husband, until she restart menstruations again after delivery, it is then that she will report the matter to the granny who is taking care of her that now she started with the menstruations again, at the end of that first menstruation, is then that she will be allowed to go back to her hut, and now she can resume the sexual relations with the husband.

R: I heard you explaining different indigenous practices that you use when taking care of postnatal patients, to ensure safety of the woman and her newborn baby, so tell me, what are your perceptions and experiences regarding the incorporation of indigenous postnatal care practices into midwifery healthcare system?

T: The combination of indigenous postnatal care practices and western healthcare practices is necessary to start a working relationship between us and the nurses, because currently we do not have working relationship with the nurses, they are working alone on their side and we are working alone, we do not communicate with each other regarding the care of postnatal patients.

R: Anything else?

T: If nurses can agree to incorporate our practices into western healthcare practices, may be they will also start accepting us gradually.

R: What type of challenges do you sometimes experience when taking care of postnatal patients?

T: Sister it is not nice to be an elderly person like me because now I am struggling to raise a new-born baby whose mother passed away two weeks back after delivery ...his father is also in a critical condition at the hospital, I do not know whether he will come back home or not.

R: What do you think are the contributory factors of these deaths?

T: According to me, the main cause of death is “makhuma” because, after delivery, the postnatal woman and her husband do not wait until after the commencement of the first menstruation post-delivery, which is an indication that the reproductive system returned back to its normal functioning state.

R: What do you mean by “makhuma”?

T: “Makhuma” is the type of illness which occur as a result of having sex with a woman who has just delivered or aborted, before the uterus return back to its normal state, which is a sign that it is ready for sex again.

R: Anything else?

T: No.

R: Thank you so much for your time and your contribution during this study, I will communicated with you regarding the findings of this study, if I need something from you regarding the study I will contact you, and if you need something from me regarding the study ,you can contact me anytime. Thank you once more.

ANNEXURE K

INTERVIEW TRANSCRIPTS FOR IN-DEPTH INDIVIDUAL INTERVIEW WITH A CLINIC REGISTERED MIDWIFE

R = Researcher

RM = Registered midwives

R: Good afternoon

RM: Good afternoon

R: How are you?

RM: I am fine and how are you?

R: I am fine

R: Before we start with today's discussion, let me remind you about the purpose of the study. The study is aimed at developing a model for incorporating indigenous postnatal care practices into midwifery healthcare system. Incorporating indigenous postnatal care practices simply means fitting in of the indigenous postnatal care practices into western healthcare practices in midwifery context. You as people, who are responsible for taking care of postnatal patients as from pregnancy, labor, delivery and puerperium are a very important source of information which is needed for incorporation of indigenous postnatal care practices into midwifery healthcare system.

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R: What are your perceptions and experiences regarding the incorporation of indigenous postnatal care practices into midwifery healthcare system?

RM: Currently the community members are aware that things like deliveries are not theirs that is why they try by all means to arrange transport that will take the woman who is in labor to the clinic or to the hospital for delivery.

During the postnatal period they also try to follow the advises from the registered midwives on discharge, but the problem is that the postnatal patient do not have a say on what should be done or followed, people are being guided by their cultures, in that automatically the close relatives will come with the advises that should be followed culturally regarding the care of the woman during the postnatal period and the infant. Most of the times this practices clashes with the advises given by the registered midwives on discharge from the hospital or the clinic.

R: Is it necessary to incorporate indigenous postnatal care practices into midwifery healthcare system?

RM: Yes, it is necessary.

R: Why is it necessary to incorporate indigenous postnatal care practices into midwifery healthcare system?

RM: It is necessary because we need to know about these practices as we are taking care of patients from diverse cultures, in order to meet their need, we should have cultural competent knowledge and skills. Currently do not know what the family members and traditional birth attendants are doing when taking care of postnatal patients during the postnatal period, as a result it is not easy for us to accept the traditional birth attendants, when I see a traditional birth attendant, I just think of herbal intoxication and nothing else. But is I know exactly what they are doing and how they are doing it, it will be easy for me to accept them as co-workers in the provision of healthcare.

A model for incorporating indigenous postnatal care practices into midwifery healthcare system.

R: How can we incorporate indigenous postnatal care practices into midwifery health care systems?

RM: There should be awareness campaigns that will make us aware of the indigenous practices that are employed by the traditional birth attendants and the family members during the postnatal period.

The awareness campaigns should also be made to the traditional birth attendants and the family members so that they are aware to the western health care practices that are used by the registered midwives during the care of patients during the postnatal period.

After the campaigns for both groups each group should be given the chance to voice out all the problems and the perceptions that they have regarding the new practices that they were made aware of during the awareness campaigns.

Then we and the traditional birth attendants should agree on the way forward, in order to enhance the working relationship during the care of postnatal patients.

R: Apart from the awareness campaigns what other strategies can be used to incorporate indigenous postnatal care practices into midwifery health care system?

RM: Training for the registered midwives is a must, because currently we are not aware of the type of practices that are employed by the traditional birth attendants and the family members during the care of postnatal period”

But once we have knowledge of these practices, we will be able to identify the dangerous practices that are employed by the traditional birth attendants during the care of postnatal period.

After identifying the practices, we will be able to give health education to the traditional birth attendants and the family members on how to modify them and improve the dangerous practices.

A model for incorporating indigenous postnatal care practices into midwifery healthcare system.

R: As it is necessary to train the registered midwives on cultural congruent care, do you think is necessary to train the traditional birth attendants and the family members regarding the western/proper care of patients during the postnatal period?

RM: Of course yes, they need to be trained on the western/proper care of postnatal patients in order to empower them on the new trends in the care of postnatal patients.

Once they are up to date, they should be encouraged to form support groups in order to empower each other.

Currently as there are home-based care providers in all the communities, who are responsible for the care of the chronically ill patients such as HIV/AIDS, they should also be trained on how to care for the patients during the postnatal period so that they work hand in hand with the traditional birth attendants and the family members in taking care of postnatal patients.

Currently there is no person who is supporting them or controlling/supervising them during the care of postnatal patients, they work independently and in isolation, even if there are good things that they know, they are afraid to say it out because we still view them as witches/anomalies and non-religious.

As a result they need regular health educations; if possible they can even be motivated by the being given the educational tours like taking them to Kruger National park for an outing.

R: Currently the government has recognized the Traditional Health Practitioners by promulgating the Traditional Healers Practitioner's Act no 22 of 2007, but the implementation strategies are not highlighted, so tell me what are the strategies to implement the Traditional Health Practitioner's Act?

A model for incorporating indigenous postnatal care practices into midwifery healthcare system.

RM: In order to implement this Act, the traditional birth attendants should be called once a month to meet with the registered midwives and be given health education for an example: avoid using one razor blade for more than one client.

There should be regular meetings with the registered midwives and the traditional birth attendants in order to enhance and maintain the good working relationships more especially during the care of postnatal patients.

R: If we can manage to incorporate indigenous postnatal care practices into midwifery health care system, what are the benefits to the patients, family members and the traditional birth attendants, the registered midwives and the government?

RM: For the post natal patients it will be an eye opener, it will enable them to make good decisions when they come across health related problems. If they are just told to do things like this, they will say that they told me to do this, but if they can be trained, they will be empowered with knowledge and skills that will be able them to make informed decisions.

There will be fewer problems, the maternal mortality rate will be reduced, there will improvement in service delivery, and there will be good communication between the western health care providers and the indigenous health care providers.

R: How will the family members benefit from incorporation?

RM: The family members /traditional birth attendants or the elderly will gain knowledge to choose between the good and the bad, because they will be empowered with new knowledge and skills on how to take care of postnatal patients.

Good relationship between the family members and postnatal patients on the how practices, notion wise, growth in knowledge, community building.

A model for incorporating indigenous postnatal care practices into midwifery healthcare system.

R: How will you (midwives) benefit from incorporation?

RM: We will not be threatened by the public and the media due to negligence, because they will be able to identify gaps during the care of the postnatal patients by the traditional birth attendants and the family members and attend to the problems before complications arise. The health educations and the advices will be successful, there will be less problems and the work related stress, because we will be able to work as a team with skilled traditional birth attendants, we will not appear in the front pages of newsletters due to negligence, in the department, we will not appear on the disciplinary actions due to legal liabilities, South African nurses will be retained because we will not leave the country, crossover for greener pastures, thus brain drain will be avoided.

R: What type of challenges do you experience when taking care of postnatal patients?

RM: The most frustration challenge is the increasing maternal and child mortality rate, we are working so hard trying to provide quality patient care, but rate of maternal and child mortality remains too high.

R: What are the contributory factor towards the increasing rate of maternal and child mortality?

RM: Late booking, because many patients do not come to the antenatal clinic at their advanced state of labour, by then a midwife does not have a lot of things to do for the patient because the delivery is near, most of the times you find that people who come late for booking are also HIV positive, with all the complications like anemia, and that patients life is already in danger.

The negligence of nurses also is another challenge, because nurses are trained to manage different types of problems for a pregnant woman including those that are HIV positive, but you find that the midwife is just lazy to do things the right way, as a result the patient is deprived the care that she was supposed to receive related

A model for incorporating indigenous postnatal care practices into midwifery healthcare system.

to her condition, until the patients reaches the advanced stages of labor and she complicates and loose her life.

The majority of nurses are having negative attitude towards the patients, instead of giving the health advices to the patients they just shout them, and once the patient is shouted by the midwife, when she became pregnant will end up not coming for ante natal visits, she will only come to the clinic at an advanced stage of labor for delivery, and when asked she will indicate that she was afraid of being shouted by the nurses as they did during the previous pregnancy.

R: Anything else?

RM: No

R: Thank you so much for your time, and your contributions during the discussion, if I need something from you regarding the study I will contact you, and if you need something from me regarding the study you are free to contact me anytime. The results of this study will be communicated to you as soon as they are ready. Thank you once more.

RM: Thank you.

ANNEXURE L

TRANSCRIPT FOR AN IN-DEPTH INDIVIDUAL INTERVIEW WITH A HOSPITAL MIDWIFE

R = Researcher

RM = Registered midwife

R: Good evening

RM: Good evening

R: How are you?

RM: I am fine and how are you?

R: I am fine

R: Before we start with today's discussion, let me remind you about the purpose of the study. The study is aimed at developing a model for incorporating indigenous postnatal care practices into midwifery healthcare system. Incorporating indigenous postnatal care practices simply means fitting in of the indigenous postnatal care practices into western healthcare practices in midwifery context. You as people, who are responsible for taking care of postnatal patients as from pregnancy, labor, delivery and puerperium are a very important source of information which is needed for incorporation of indigenous postnatal care practices into midwifery healthcare system.

R: What are your experiences regarding the incorporation of indigenous postnatal care practices into midwifery health care systems?

A model for incorporating indigenous postnatal care practices into midwifery healthcare system.

RM: what I have realized is that there is a line of demarcation between the registered midwives and the traditional birth attendants/family members, each and every one is working alone in her corner, and there is no communication between the two groups. I think it is because the indigenous practices are not included into midwifery health care system, we do not even know these practices, and so we just work separately with the traditional birth attendants and family members.

R: Tell me what the current situation is regarding postnatal care?

RM: Six hours after delivery we discharge the woman and the new-born baby to the care by people that we do not even trust. We do our part at the hospital until the patient is discharged, and the traditional birth attendants and family members are working alone at home when providing postnatal care.

R: I heard you saying you do your part until the patient is discharged, do you give report to the relatives, family member, neighbors and traditional birth attendants who come to fetch the postnatal woman and the baby on discharge?

RM: I do not remember giving report to the relatives, family members and traditional birth attendants, about the condition of the woman and the baby, and how they should continue with the provision of care at home, we just give health advice to a woman on how to take care of herself and the newborn at home, without the involvement of her relatives.

What surprises me is that, we (registered midwives and traditional birth attendant/family members) are responsible for providing care to postnatal patients, but we do not communicate to each other about these patient, the only time that forces us to communicate is when the family members/traditional birth attendants bring the postnatal patients back to the hospital/clinic because she complicated at home, is the time for us as midwives to ask “what happened to the patient?”

A model for incorporating indigenous postnatal care practices into midwifery healthcare system.

R: How can we incorporate indigenous practices into midwifery health care systems?

RM: We have to teach them how to do things the right way, we have meetings with them and we talk about this things, they should tell us what they are doing and how are they doing it, so that we become aware of the indigenous practices that they employ during the postnatal period.

R: Do you think is necessary to train the registered, midwives regarding cultural sensitivity?

RM: It is very much necessary because currently concentrate only on the western health care practices, we do not have the knowledge of cultural beliefs for different cultures, that is why when we give health education they concentrate on the western view only, and impose our own beliefs to other people, as a result patients do not follow the instructions, when they arrive home they just continue using their indigenous practices and forget about the nurses health talk, But the problem is that when they come across a problem, they come to the clinic sometimes with serious complications. We (midwives) should be given in service training so that we gain knowledge regarding cultural congruent care in order to take care of their patients holistically.

R: Do you think is necessary to train the family members and the traditional birth attendants at home regarding the care of postnatal patients?

RM: It is very much necessary because currently these people are expected to take care of postnatal patients without proper knowledge that is why they are having the chance of using their indigenous practices because it is the only thing they know. If they can be trained it will be easy to manage the postnatal patients and to maintain the quality of care, patients will not have the chance to deviate from the health educations because the nurses and the family members plus traditional birth attendants will be talking the same language.

A model for incorporating indigenous postnatal care practices into midwifery healthcare system.

R: What are the contributory measures towards maternal mortality rate in South Africa?

RM: We have the big five causes of maternal and child mortality such as post-partum bleeding, pregnancy related hypertension, pre-eclampsia, eclampsia, puerperal sepsis due to infection, HIV and AIDS

R: If we can manage to incorporate indigenous postnatal care practices into midwifery health care system, how can we benefit looking at the patients, midwives, family members/traditional birth attendants and the Department?:

RM: Patients will benefit because they will not be confused about the different advises from the nurses and from family members, both will be talking the same language. Family members and the traditional birth attendants will be able to take care of postnatal patients with confidence because they will know that they are doing the right things to the postnatal patients.

We (midwives) will be relieved from the workload because they will know that the family members are doing the right things when providing for the postnatal care. They will be able to provide quality patient care or cultural congruent care with knowledge of different cultures; they will also attend to the patients with confidence, as they will be empowered with new knowledge which now is lacking. The Department of Health and Social development will benefit because the legal suites against the nurses will be reduced, currently the government is paying a lot of money for the legal suites against nurses including midwives. The government will also benefit because they will not spend a lot of money for patients who are staying for a long time at the hospitals due to complications”

R: Anything else?

RM: No

R: Thank you so much for your time and participation during this study, If I need some clarity regarding what we talked about today I will call you, and

A model for incorporating indigenous postnatal care practices into midwifery healthcare system.

**the results for this study will be communicated to you once they are ready,
thank you once more.**

RM: Thank you

ANNEXURE M

TRANSCRIPTS FOR IN-DEPTH INDIVIDUAL INTERVIEWS WITH MIDWIFERY LECTURERS

Key: R = Researcher

ML = Midwifery Lecturers

R = Researcher

ML: Good morning

R: How are you?

ML: I am fine and how are you?

R: I am fine

R: Before we start with today's discussion, let me remind you about the purpose of the study. The study is aimed at developing a model for incorporating indigenous postnatal care practices into midwifery healthcare system. Incorporating indigenous postnatal care practices simply means fitting in of the indigenous postnatal care practices into western healthcare practices in midwifery context. You as people, who are responsible for training of midwives are a very important source of information which is needed for incorporation of indigenous postnatal care practices into midwifery healthcare system.

R: What are your perceptions and experiences regarding the incorporation of indigenous postnatal care practices into midwifery healthcare system?

A model for incorporating indigenous postnatal care practices into midwifery healthcare system.

ML My opinion in this regard is that the indigenous postnatal care practices should be incorporated into midwifery healthcare system because currently there is no information regarding cultural congruent care. The information that is there is so limited. Student midwives are not even assessed on it; hence they only follow the Western way when taking care of postnatal patients.

R: How can we incorporate indigenous postnatal care practices into midwifery healthcare system?

ML: The incorporation of indigenous postnatal care practices into midwifery healthcare system can be done through training of student midwives on indigenous postnatal care practices, which according to me is a must because currently they are not taught about the type of indigenous practices, as a result. They do not have adequate knowledge and skills regarding indigenous practices. But once they have knowledge about these practices they will be able to identify the dangerous practices that are employed by the family members/TBAs during the care of postnatal patients.

R: Tell me, are the indigenous postnatal care practices included in midwifery curriculum?

ML: Currently there is insufficient information within the Midwifery curriculum, midwifery books, Guidelines for Maternity Care in South Africa, scope of practice in midwifery and the South African Rules and Regulations on how to train student midwives on the provision of cultural congruent care, so they receive training within the western healthcare point of view only.

R: How can we incorporate indigenous practices into midwifery health care systems?

ML: We should involve the top managers in Nursing Education, Nursing Education Association (NEA) top managers, the South African Nursing Council (SANC) and all the relevant stakeholders who are involved in curriculum development, make them aware about these problem lack of incorporation of indigenous postnatal

A model for incorporating indigenous postnatal care practices into midwifery healthcare system.

care practices into midwifery healthcare system and the consequences and plan with them on how can we merge the two healthcare system to become one in order to ensure the production of culturally competent midwives.

R: Do you think is necessary to train the traditional birth attendants and the grannies regarding the care of postnatal patients at home?

ML: " Yes, training of traditional birth attendants necessary because besides taking care of postnatal patients, some patients are having precipitated labor, you find that labour just starts when the lady is busy cooking in the kitchen, when she leave the kitchen and enter the room the baby is already out. So if the grannies and the Traditional Birth Attendants are well trained, they will be able to assist the woman with a precipitated labour to deliver normally without any complications.

R: Do you think is necessary for the registered midwives to be trained regarding the provision of culturally congruent care?

ML: Oh! Yes because currently the registered midwives are no having any form of training regarding cultural congruent care, that is why they do not show any respect when taking care of patients, whether the patient is young or old, they treat them the same way.

R: Based on the experience that you are having as an Advanced Midwife and a Midwifery Lecturer, How do you think can be the best way to incorporate the indigenous postnatal care practices into midwifery health care systems?

ML : "Encourage the government to recognize the Traditional Birth Attendants, this is the time to involve the politicians if we can start incorporating without the politicians, if they discover that someone has done this, you are in for it"

R: If we can manage to incorporate indigenous postnatal care practices into midwifery health care systems, what might be the benefits towards the patients, family members, midwives the Department of Health and Social Development?

A model for incorporating indigenous postnatal care practices into midwifery healthcare system.

ML: “Reduce maternal mortality, team work between the Traditional Birth Attendants and registered midwives, this can relieve of workload from the registered midwives, because when they are properly trained on how to take care of patients during the postnatal period, they will do so and give reports to the registered midwives on a monthly basis, as they will be called home midwives, automatically will be getting reports from the home midwives., allocate them in different sections of the location, move around caring for postnatal patients, look at the midwives, month end they write the reports and come together to discuss the different reports, because trained midwives can be allocated to different areas, like in other developed countries. But in South Africa, 80% of the well trained midwives are given higher positions in the offices, instead of working at the clinics and hospitals assisting with the care of postnatal patients. It can also enhancing teamwork, and mutual relationship between the registered midwives and the Traditional Birth Attendants.”

R: Anything else?

ML: No

R: Thank you so much for your time and your contribution during this interview, the results of the study will be communicated to you when they are ready. If I need something from you in relation to the study I will contact you. Thank you once more.

ML: Thank you

ANNEXURE N

INTERVIEW TRANSCRIPT FOR MATERNAL AND CHILD HEALTH CARE COORDINATOR

R = Researcher

MC = Maternal and Child healthcare coordinators.

R Good Day

MC Good Day

R How are you?

MC I am fine and how are you?

R I am fine

R: Before we start with today's discussion, let me remind you about the purpose of the study. The study is aimed at developing a model for incorporating indigenous postnatal care practices into midwifery healthcare system. Incorporating indigenous postnatal care practices simply means fitting in of the indigenous postnatal care practices into western healthcare practices in midwifery context. You as people, who are responsible for management, planning, monitoring and evaluation of postnatal care, are a very important source of information which is needed for incorporation of indigenous postnatal care practices into midwifery healthcare system.

R What is your perception and experience regarding the incorporation of indigenous postnatal care practices into midwifery healthcare system?

MC I think it is better to incorporate indigenous postnatal care practices into midwifery healthcare system, to improve the standard of postnatal care because, currently women on discharge are advised to go to the nearest clinic for postnatal check-up. But

A model for incorporating indigenous postnatal care practices into midwifery healthcare system.

the registered midwives at the clinic are not aware that there is a patient who should come on this date for postnatal check-up.

R: How can we integrate indigenous postnatal care practices into midwifery health care system? There is no communication between the hospital, clinic and the traditional health care providers.

MC First thing I appreciate this topics it is very much relevant because really we are facing a lot of challenges more especially during the care of postnatal patients.

Secondly we need to .go back to the issue of ubuntu , because culture is within a person, order to be able to meet the needs of diverse patients , midwives must know that they have to treat that person as a human being rather than treating a person as an object.

R: Can you tell me more about that?

MC Integrate every clinic within the community, currently clinics are functioning in an island within the community, because the community not aware of the services that are rendered at the clinics, including the head men and ward councillors.

R What can be done to ensure that that the community services are known to the community members?

MC We need to market the services, make sure that all community members know all the services that are available for them, so that they are able to utilize the services.

R What else?

MC Shortage of nurses at clinics, include home-based carers to take care of them, utilize the same people who are now taking care of tuberculosis and HIV and AIDS patients, prenatal, postnatal, introduce them through “tinduna”,every time there is a postnatal patient, they must report to the registered midwives. This will improve their follow up and continuity of care

A model for incorporating indigenous postnatal care practices into midwifery healthcare system.

R: How best can be done to improve the quality of care during the postnatal period?

MC: The registered midwives should be trained regarding the importance of understanding the background of the patients. There is no way to assist the person without understanding her background, then come with your western issues when giving health advices, many patients cannot follow the instructions, so it comes back to the issue of advocacy for this patient at clinic, to reduce to ensure the provision of quality care to prevent complications which leads to maternal and child mortality.

R: Tell me, what are the contributory factors of high maternal mortality rates?

MC some causes are patient related, other are administrative related such as, delayed due to lack of transport, not planned in time., apart from waiting for EMS, referral criteria has loopholes for an example a woman at level 1 hospital, who needs urgent referral to level 2 hospital, the doctor need to negotiate with another level and this process causes delay resulting in avoidable complications and even deaths.

R What can be done to incorporate indigenous postnatal care practices into midwifery healthcare system?

MC The Government should be urged to employ a number of registered nurse according to the needs of the community in order to relieve workload from the registered midwives, because currently they deliver a lot of patients day and night, that are referred from the clinics, some come from home and they do not have enough manpower. According to, Maternity care guidelines they were supposed to discharge postnatal women six hours after delivery, but they are bound to discharge them before six hours elapses because we do not have enough beds to keep these patients for six hours.

A model for incorporating indigenous postnatal care practices into midwifery healthcare system.

R What else can be done to incorporate indigenous postnatal care practices into midwifery healthcare system?

MC We need to come with the effective strategy that will encourage them to gradually come together, recognise each other as co-workers, work together, plan together, share common goals until they reach a point where they get used to each other as healthcare providers.

R What might be the benefits of incorporating indigenous postnatal care practices into midwifery healthcare system?

MC By incorporating indigenous postnatal care practices, we can reduce maternal mortality, we can gain the cooperation of outsiders, family members/TBAs can relieve of workload from the registered midwives, because they will be properly trained on how to take care of postnatal patients, they will do so and give reports to the registered midwives on a monthly basis.

Postnatal patients will be safe, there will be fewer complications, maternal deaths will be reduced. Midwives can be relieved from shortage of man power, because family members/TBAs will serve as an extra hand.

R Anything else?

MC No

R Thank you so much for your time, your active involvement and participation, experiences and opinions you contributed during the interview, the results of the study will be communicated to you when they are ready. If you need some clarity in relation to the study you can call me, and I will contact you if I need some information related to the study, Thank you once more.

MC Thank you