

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

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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

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

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.