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KNOWLEDGE OF MIDWIVES REGARDING TRADITIONAL PRACTICES USED DURING THE INTRAPARTUM PERIOD IN A SELECTED HOSPITAL IN GAUTENG

By

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Submitted in fulfilment of the requirements for the degree of

MCur – Full dissertation

IN THE FACULTY OF HEALTH SCIENCES

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DATE: 09 December 2022

DECLARATION

I, Silindile Marcia Sithole, declare that **Knowledge of midwives regarding traditional practices used during the intrapartum period in a selected hospital in Gauteng** is my original work and that it has not been submitted before to any other institution. All sources that have been used or cited have been acknowledged by means of a comprehensive referencing system. I declare that this full dissertation is submitted in partial fulfilment of the requirements for the MCur degree (full dissertation) in the Department of Nursing Science, Faculty of Health Sciences, at the University of Pretoria.

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Signature: SM Sithole (Signed)

DEDICATION

This dissertation is dedicated to my family and my siblings, for the support, encouragement, and motivation they have given me during this study.

ACKNOWLEDGEMENTS

- First, I would like to thank the Almighty God for giving me the strength and wisdom to conduct this study.
- I want to thank my supervisors, Prof. RN Ngunyulu and Dr Jiyane, for their guidance, supervision, motivation and understanding. I would never have accomplished my dissertation without your supervision support.
- I would like to thank my family, friends, and my colleagues for giving me support in my studies. I would like to thank the Ethics Committee structures, University of Pretoria and the selected hospital in Gauteng for allowing me to conduct the study. I pass my sincere gratitude to the research participants of this study – without you this study would have been impossible.
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KNOWLEDGE OF MIDWIVES REGARDING TRADITIONAL PRACTICES USED DURING THE INTRAPARTUM PERIOD IN A SELECTED HOSPITAL IN GAUTENG

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ABSTRACT

Background

Traditional practices plays a pivotal role for the majority of women globally, including in South Africa, especially in rural areas, where family involvement is important when it comes to pregnancy, childbirth and childcare. The need to acknowledge traditional practices during the provision of maternal and child healthcare is a global issue that requires serious consideration. Knowledge and understanding of different traditional practices used by women during the intrapartum period are crucial to ensure positive outcomes to the mother and the baby.

The aim

The aim was to explore and describe midwives' knowledge of traditional practices used during the intrapartum period in a selected hospital in Gauteng.

Method

The study used was an exploratory descriptive qualitative design to explore and describe midwives' knowledge of traditional practices used by their patients during the intrapartum period. The researcher used purposive sampling to select midwives working in the maternity department of a selected hospital in Gauteng to participate in this study. Data was collected through individual in-depth interviews. Analysis was carried out simultaneously with data collection using content analysis.

Findings

The study findings revealed eight themes in the knowledge of the midwives regarding traditional practices used during the intrapartum period. These themes were knowledge of: practices that facilitate or hasten labour; using traditional rope/band/wool/cloth/elastic; prolonging labour using a stone; eating different things in labour wearing different types of

clothing; protection/calmness/prevention of preterm labour and caesarean section, and safe delivery; praying; and the do's and don'ts when in labour.

Conclusion

The study findings indicated that midwives have some knowledge regarding the traditional practices used during intrapartum period. For example, it is evident from the findings that midwives are aware that some traditional practices are beneficial to the mother and the baby while others may have adverse effects on the mother and unborn child that are not known to the patients, their family elders and traditional healers. The knowledge gained from this study, from both primary and secondary literature research, may be used to empower midwives with skills to enable them to identify safe and harmful practices. Maternal and child healthcare may also be improved and become sensitive to traditional practices as the midwives are able to show understanding of different traditional practices when caring for patients with traditional and cultural diversity. The findings of the study could be communicated to relevant hospitals to increase their knowledge and skills and improve the quality of patient care rendered.

Key words: intrapartum, knowledge, midwife, traditional practices

LIST OF ABBREVIATIONS AND ACRONYMS

BBA	Born Before Arrival
BP	Blood Pressure
CEO	Chief Executive Officer
CNS	Central Nervous System
C-Section	Caesarean Section
ESMOE	Essential Steps of Managing Obstetric emergencies
GABA	Gamma Aminobutyric Acid
GdoH	Gauteng Department of Health
ICM	International Confederations of Midwives
LAP	Lower Abdominal Section
P	Participant
PEP	Perinatal Education Trust
SANC	South African Nursing Council
SOMSA	Society of Midwives of South Africa
TBA	Traditional Birth Attendant
TM	Traditional Medicine
TOP	Termination of Pregnancy
UP	University of Pretoria
WHO	World Health Organization

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TO WHOM IT MAY CONCERN

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CHAPTER 1: ORIENTATION TO THE STUDY

In this chapter the research topic is introduced and a background to the study is provided that incorporates a review of literature related to the topic. The problem statement, research question, aim and objectives of the study, and the study's significance are then presented. The sections that follow clarify the key concepts used in the study, and describe the research paradigm, ontology, and research methodology. Lastly, rigour and ethical considerations are attended to.

1.1 INTRODUCTION, BACKGROUND AND LITERATURE REVIEW

Traditional practices play a pivotal role in maternal- and childcare for most women globally, particularly in many low- and middle-income countries, possibly because of inadequate healthcare coverage. This is especially true in rural areas, where family involvement is important when it comes to pregnancy, childbirth, and childcare (Siveregi & Ngene 2019: 6). Lack of acknowledgement of traditional practices during the provision of maternal and childcare and the need for culturally appropriate maternity care services is core to the World Health Organization's (WHO) strategy for improving maternal and new-born health and ending preventable maternal mortality (Musie, Peu & Bhana-Pema 2022: 1 & 2).

In South Africa, despite the fact that pregnant women have access to conventional medicine, some still use traditional medicine (TM), for reasons that may include indications that they feel are inadequately or not at all covered by conventional healthcare (Siveregi & Ngene 2019: 6). These indications include protection from evil spirits during pregnancy, and preparation of the pelvis and uterus for labour (Siveregi & Ngene 2019: 6). Some women use both conventional medicine and TM where they believe conventional medicine to be inadequate. South Africa is a multicultural country with about 55 million people (Misachi 2018). Each ethnic group in the country has different traditions and customs that it follows as guided by the Constitution and every citizen has a right to practise their culture and have their culture respected and treated with dignity (Constitution of the Republic of South Africa, Act no 108 of 1996 as amended 2008). This means that traditions and customs related to maternal- and childcare should be considered by healthcare providers when treating the women who practise them.

In most African traditions when a woman falls pregnant, the whole family gets involved, with the man traditionally being the decision maker in the family. The elders make decisions in relation to pregnancy and childbirth according to their tradition and the woman must follow these traditional practices irrespective of their choices. This can lead to barriers to the use of maternal care services (Ezeome, Ezugworie & Udealor 2018: 427). Many women have enough knowledge regarding maintaining a healthy pregnancy and women's understanding of traditions and cultural beliefs influences pregnancy about diet, activity level and rest

(Lennox, Petrucka & Bassendowski 2017: 6). Lennox et al. (2017) find that Maasai cultures and traditions, for example, affect prenatal, intrapartum, and postnatal care, both positively and negatively, where these traditions involve consultation with the elders regarding pregnancy matters. Midwives must involve the women's families and their traditions in planning for intrapartum care. Seopa (2021: 75) confirm that when women traditional family beliefs, spiritual beliefs and religious beliefs are respected, it will lead to positive outcomes because their anxieties will be reduced because many patients turn to their beliefs when difficult healthcare decisions are made, healthcare professionals need to recognise and accommodate patient's religious and spiritual needs.

The World Health Organization (WHO) estimates that 60% of the world's population depends on TM, with up to 80% of the population in Africa using these medicines to meet their daily healthcare needs, including pregnancy and the intrapartum period (Mawoza, Nhachi & Magwali 2019: 1). The populations of most countries in Africa use TM along with traditional birth attendants (TBAs) because they are accessible, affordable, and available all the time instead of patients having to travel to healthcare institutions. In addition, people in these countries believe that TM has a longer history than western medicine and their ancestors have used it before without complications (Shewamene, Dune & Smith 2017: 13). The traditional practices used by pregnant women during intrapartum care are either learned from family elders or from TBAs, who also use herbal medicines.

Across the globe, the use of TBAs presents an issue for healthcare professionals such as midwives. TBAs use methods and practices based on their experience and what they have learned from their elders. Study that was conducted in South Africa says that Traditional TBAs can be portrayed in South Africa as a moderately aged or elderly woman with no formal preparing, who gained their skills through experience and takes care of women during the course of their pregnancy, labour and the postnatal period in various ways (Oyesomi, Onakoya, Onyenakeya & Busari 2020: 8). TBAs are considered illiterate people of low status, who are non-religious and know little about caring for patients. Their methods are considered to lead to foetal and maternal complication, including death during intrapartum care (James & Essien 2017: 185). TBAs assist women during the intrapartum period and either send them to a health institution after delivery or look after them until the postnatal period. Some TBAs have knowledge regarding complications related to intrapartum and do send women in labour to health institutions even when they are in the intrapartum period if they discover complications. Oyesomi, et al (2020: 5) agree that TBAs are traditionally and culturally sensitive as they provide source of comfort, trust and counsel for mothers and pregnant women. The women believe and have trust in them, respect them and they take their advice seriously and put them into use. This trust and respect is brewed by the facts that TBAs speak the local language,

are part of the community, live in their immediate surroundings and share mostly the same belief and culture and this has helped cement trust in the community towards TBAs. Most women place more trust in them and their methods than they do in the health institution, which does not understand or involve their traditions.

During the intrapartum period, these practices, traditional medicine are either used at home before the women comes to the hospital or are used on the hospital premises, with most of the women hiding the practices from the midwives who attend to them. Buser, et al (2020: 6), reporting on rural Zambians' views on maternal-newborn care, find that some women believe home delivery to be better because they are given lupusu (traditional herbs in Zambian language) to help them deliver faster. The women also take this medicine to comply with the elders' wishes; as one woman says: so, we take these herbs with us to the facility because we can't go against the elders, but we must hide them from the nurses because they will throw them away and scold us for using them" (Buser, et al 2020: 6).
Midwives' knowledge of the traditional practices used during the intrapartum period can contribute to the positive outcome and wellbeing of the mother and the baby by allowing the midwives to display understanding of and show sensitivity towards the patients. Armed with this knowledge, midwives could involve the patients in their own care when it comes to traditional practices used during the intrapartum period (Cao, Stone, Petrine & Turale 2017: 132).

Oyesomi, et al (2020: 7) find that rural women like to utilize the services of TBAs as contrasted and their urban partners because the choice of home delivery gives them that comfortability and relaxation, they are easily accessible, openness, modest work, and that they have high confidence in the viability of their services. Having an inspirational disposition toward TBA services and satisfaction with services they got from TBAs was likewise altogether connected. When traditional values are not part of the nursing care plan, a woman and her family may choose their family's beliefs and the care they receive from traditional healers because they are regarded as socially acceptable to communities, as they are of the same culture as the community members and they are usually the first health care providers to be consulted because their family beliefs and traditions are respected and included and their care (Seopa 2021: 72). In contrast, a positive perception displayed by midwives to women regarding traditional practices will provide a conducive environment that is non-judgemental and supportive of the women and their families and in which the women will not have to hide their practices.

Cao, et al (2017: 132) state that most patients believe in these practices, and it is important for midwives to understand a patient's beliefs when providing intrapartum care.

Midwives need to understand that there are safe and harmful traditional practices. Whithers, Kharazmi and Lim (2018: 167) suggest that not all traditional beliefs and practices are harmful to women and their babies; some have psychological and physical benefits to a woman and her family, such as the tradition that requires a man to cut the cord of the baby. Generally, in the tradition of western medicine, this is regarded as interference. In a study conducted by Ocho (2017) at public hospitals in Trinidad and Tobago, one midwife stated that women and their partners came to the health facility and wished to perform their traditions, which the midwife saw as unacceptable and as interference (Ocho 2017: 547).

Midwives should be culturally sensitive and respect every woman's culture and their beliefs when caring for them. When midwives are traditionally and culturally sensitive, especially during the antenatal period, it will promote high attendance of the antenatal clinic and women seeking help on time. Abubakar, Yohanna and Zubairu (2018: 833) agree that lack of belief in and poor attendance of the healthcare system impact on maternal health, leading to emergencies that lead to maternal mortality.

Midwives in South Africa are western trained and minimum information about traditional practices is included in their curriculum. In the current study, the knowledge of midwives regarding traditional practices used during the intrapartum period was explored and described and gaps were identified to create awareness for the midwives to enable them to provide traditionally competent care. Gaps were identified such as that midwives have inadequate knowledge regarding traditional practices used during the intrapartum period. Our midwives believe in evidence-based practice, and they are willing to learn more about traditional practices used in the intrapartum period if there is proof regarding the usefulness of these practices. And that is very important, as traditional practices are necessary for congruent maternal and childcare.

1.2 PROBLEM STATEMENT

South Africa is a diverse country with different customs and traditions where some people in society still believe in using traditional practices when they are pregnant and during childbirth. Over the past years of working in a public hospital's maternity section, the researcher has observed that midwives have inadequate knowledge of whether the traditional practices used by women during the intrapartum period are safe or unsafe. This leads to them rendering poor traditionally competent care. Midwives believe that any traditional practices used by women should be discouraged because these practices are unhygienic and outdated and hinder the improvement of maternal health (Ohaja, Murphy-Lawless & Dunlea 2018: 2). Midwives need to identify culturally relevant facts and understand a patient's practices to provide the required

quality patient care. Once midwives are empowered with knowledge, they will be able to discourage the harmful practices and encourage the practices that are safe because not all traditional and cultural practises are unsafe (Ombere, Haller, Nyambedha & Merten 2021: 160). When it comes to health beliefs, midwives develop their beliefs from their own experiences of using westernised care because that is what their curriculum and evidence-based education have involved; hence, they do not understand the value of certain traditional practices (Cao, et al 2017: 140). Cao, et al (2017) indicate that midwives may change their negative attitudes towards the use of traditional practices only if they are knowledgeable about them and if there is evidence that proves these practices to be safe.

In most traditional practices in South Africa and even globally, when women fall pregnant, the whole family gets involved, including the elders. Women are expected to follow what the elders decide regarding the traditional practices in relation to intrapartum and are obliged to use traditional treatments even if this is against their preference. If midwives do not involve the family and the women's traditional practice during the intrapartum period, the women will still follow their traditions irrespective of the midwives' disapproval.

In this context, midwives need to be empowered with knowledge and skills regarding the traditional practices used during the intrapartum period because every woman deserves to be treated with dignity and have their culture and tradition be considered and respected (Mthombeni, Maputle & Khoza 2018: 60). Midwives should assess women's traditional practices, identify safe and unsafe practices, encourage them to use safe practices and discourage unsafe practices (Zeyneloglu & Kisa 2018: 152).

This study explored and described the knowledge of midwives regarding traditional practices used during the intrapartum period so as to provide traditionally and culturally competent care. The WHO encourages development structures that support the integration of TM into countries' healthcare systems (Mawoza, et al 2019: 1).

1.3 RESEARCH QUESTION

What is the knowledge of midwives regarding the traditional practices used during the intrapartum period in a selected hospital in Gauteng Province (Gauteng), South Africa?

1.4 AIM OF THE STUDY

The aim of this study was to explore and describe the knowledge of midwives regarding traditional practices used during the intrapartum period in a selected hospital in Gauteng, South Africa.

1.5 SIGNIFICANCE OF THE STUDY

In this study, the knowledge of midwives regarding traditional practices used during the intrapartum period was explored and described. The knowledge gained from this study could be used to empower midwives with knowledge to enable them to identify safe and harmful practices. Maternal and child healthcare might be improved and become sensitive to traditional practices, because the midwives will be able to show an understanding of different traditional practices when caring for patients with traditional and cultural diversity. The findings of the study could be communicated to the hospital in which the study took place to increase its knowledge and improve the quality of patient care rendered.

1.6 DEFINITION OF KEY TERMS

The following key terms, with their meanings as described here, are used in this dissertation.

Community service midwife – is a registered nurse with the South African Nursing Council (SANC) in the category of community service who has just completed a diploma or a degree in nursing and needs to practise for one year in a public hospital or clinic to obtain clinical experience under supervision of an experienced professional nurse in line with the Nursing Act no 33 of 2005 (South African Nursing Council 2005). In this study a "community service midwife" refers to the above nurse who also possesses a midwifery qualification and is working in the maternity department of a hospital providing intrapartum care to women from diverse cultural backgrounds under the supervision of an experienced midwife.

Intrapartum – refers to the process of going through stages of labour, from the commencement of true labour throughout the first, second, third and the fourth stage of labour, which last from one to two hours after delivery of placenta (Malesela 2018: 4). In this study the researcher refers to one of the stages of labour where traditional practices are used that may influence the outcome of childbirth for the baby and the mother.

Knowledge – refers to the awareness or understanding of something such as information, skills and that can be acquired through traditions, authority, borrowing, trial and error, personal experience, role modelling and mentorship, intuition, reasoning, and research (Gray, Grove & Sutherland 2017: 1298). In this study, it is the information that is known by the midwives regarding traditional practices used during the intrapartum period that is explored and described. That knowledge has been acquired through experience, education, research and/or learning about it.

Midwife - a person(s) who has undergone a midwifery educational programme and successfully completed the course of studies in both theory and practical programme that is based on the ICM (international confederations of midwives) Essential Competencies for Basic midwifery practise and the framework of the ICM Global Standards for midwifery education and is recognised in the country where it is located and has acquired a qualification to be legally licenced to practise midwifery. A midwife who works with women to give them support, care, advice during pregnancy, childbirth and postpartum, conducts births and provides care for new-born and infant (Marshall & Raynor 2020: 7). In this study the midwives are the participants that provide care in the maternity department of a mother and child hospital.

Tradition – is defined as the body of customs, thought and practices belonging to a particular country, people, family, race, or institution over a relatively long period. It can be described as the handing down from generation to generation of the same customs and beliefs, especially by word of mouth (Hingston & Auselime 2019: 53). In this study the researcher refers to common traditional practices used by women during the intrapartum period.

Traditional practices – the practices, customs and activities that are being performed habitually or regularly to maintain a tradition. They embody an individual or group's heritage, which is anything that has been transmitted from the past or handed down by tradition (Hingston & Auselime 2019: 53). In this study, the term "traditional practices" refers to the performance of traditional actions, beliefs, or rituals by women during the intrapartum period.

1.7 DELINEATION

This study focused on knowledge of the traditional practices used during the intrapartum period as obtained from midwives and community service midwives working in the maternity department of a mother and child government hospital in Gauteng Province in South Africa.

1.8 PHILOSOPHICAL / PARADIGMATIC ASSUMPTIONS

Polit and Beck (2017: 738) describe a paradigm as a theoretical framework, standard or set of ideas and a method of looking at something from a worldview that is used by researchers to collect, analyse, and interpret data in a particular field of study.

Polit and Beck (2017: 720) describe assumptions as statements or principles that are taken or assumed to be true without proof or verification, that we accept based on faith. These principles require strong knowledge in the research area that is to be uncovered (Alharahsheh & Pius 2020: 40).

In this study a constructivist paradigm was adopted to explore and describe the knowledge of midwives regarding traditional practices used during the intrapartum period. The assumptions associated with this paradigm as well as the ontological, epistemological, and methodological assumptions embraced by the study are discussed below.

1.8.1 Constructivist paradigm

The constructivist paradigm assumes that knowledge is maximised when the distance between the researcher and those under study is minimised, that there are multiple interpretations of reality and that the goal of research is to understand how individuals construct reality within their context (Polit & Beck 2017: 11). This is often referred to as the use of naturalistic paradigms as it assumes that meaning is constructed by both participants and observers, meaning that there are multiple realities (Polit & Beck 2017: 11). Using this paradigm, the distance between the midwife and the researcher could be minimised as reality could be considered as not fixed or definite, but rather as fluctuating and varying. The participants in this study were midwives who shared their knowledge regarding traditional practices used during the intrapartum period. The knowledge of midwives regarding traditional practices used in the intrapartum period was a real situation that could change since the reality exists within a context.

1.8.2 Ontological assumptions

Alharahsheh and Pius (2020: 40) define ontology as the set of assumptions about reality, revolving around how we view the world and all that is or exists. Ontology deals with what kind of world we are investigating, with the nature of existence and with the structure of reality as such. The reality is that midwives in South Africa are western trained and do not believe in the use of traditional practices, while health institutions have patients from diverse cultural backgrounds. This means that misunderstandings may arise between the midwives, the patients, and their families. This study explored and described the knowledge of midwives regarding traditional practices used during the intrapartum period.

1.8.3 Epistemological assumptions

Alharahsheh and Pius (2020: 40) describe epistemological assumptions as the knowledge of reality and the relationship between the inquirer (researcher) and those being studied, how the researcher can distinguish between right and wrong, and how the researcher views the world around them. The epistemological assumption in this study was that the participants would have knowledge of that reality. Based on this assumption, the knowledge of midwives regarding traditional practices used during intrapartum was explored and was revealed in clearly articulated answers to the researcher's question.

1.8.4 Methodological assumptions

Alharahsheh and Pius (2020: 40) describe methodological assumptions as procedures and methods to be used in a study that are conducted in a systemic and logical way to discover or know the reality. The concern is how the researcher will obtain the knowledge. The researcher's methodological assumptions guide and influence their investigation.

The researcher selected an exploratory descriptive qualitative design to explore and describe the knowledge obtained from midwives' interpretations of circumstances. The methodology process used a qualitative research design, which is a specific procedure used to identify, select, process, and analyse information collected to solve a problem identified. The methodological process followed this research design in a selected hospital in Gauteng, with a study population of midwives and community service midwives, sampled from the selected hospital. Data collection was achieved with in-depth interviews, after which the data was analysed. Strategies were put in place to ensure trustworthiness (see 1.10 below).

1.9 RESEARCH METHODOLOGY

Gray, et al (2017: 1302) describe research methodology as the specific procedures or techniques used to identify, select, process, and analyse information about a topic. A general type of research methodology is selected to answer the research question that can be qualitative, quantitative, outcome or mixed method.

In this study a qualitative research design was selected that enabled an exploratory and descriptive design. The methodology process, which involves the research design, method, context or setting, preparation for the research process, study population, sampling method and sampling size, pilot test, data collection and organisation, and data analysis, is discussed in detail in Chapter 2.

1.10 RIGOUR

Qualitative researchers use trustworthiness as a degree of confidence in their work to prove it as honest and truthful. This is how researchers persuade their audience that their research findings are worth paying attention to (Nassaji 2020: 428). To ensure trustworthiness throughout the research process for this study, the researcher had to make sure that the study was rigorous. To achieve this, she adopted the strategies of credibility, dependability, confirmability, transferability, and authenticity. These strategies are described below.

1.10.1 Credibility

"Credibility" refers to confidence in the truth of the study data. Credibility is achieved by taking steps to show the believability of the data to external readers and carrying out the study in a way that enhances the believability of the findings (Nassaji 2020: 428). In this study, credibility was guaranteed by audio-recording of interviews with quality tapes. The researcher was also a midwife working in the mother and child hospital, which further ensured credibility. In addition, an assistant researcher who was also a midwife and who did not work in the same setting as the participants was used to collect data to ensure credibility and avoid bias. Using multiple data sources (in-depth interview, field notes and literature control) further enhanced the credibility of the study.

1.10.2 Dependability

This refers to the reliability and stability of data over time and over different conditions. A study is considered dependable if, should the study be repeated, similar results will be obtained, and the results are reported in a way that similar interpretations would be achieved if the data was to be reviewed by others (Nassaji 2020: 428). To ensure dependability in the current study, the researcher was supervised by two supervisors, who checked all research steps. Data was collected by the researcher. In the interviews used to collect data, questions were asked, followed by probing questions. The data was coded by the researcher. In this study, dependability was further achieved by auditing of data and auditing of the audio-recorder and all other supporting documents being scrutinised. This suggests that a study would produce the same results if the study were to be repeated with the same participants in the same context.

1.10.3 Confirmability

"Confirmability" refers to objectivity and the level of confidence that the researcher's findings are based on the participants' narratives and words rather than the researcher's potential biases (Nassaji 2020: 428). In this study the data truthfully represents the information that participants provided. The experienced assistant researcher, who was also a midwife, collected the data to prevent the researcher from influencing the data-collection process. The researcher, supervisor and co-supervisor checked verbatim transcripts to ascertain no influence by the researcher. The themes, categories and subcategories that emerged during the data-analysis process were supported by direct quotations from verbatim transcribed interviews to further ensure confirmability.

1.10.4 Transferability

"Transferability" refers to the generalisation of data, which means that the findings can be transferred to other settings or groups within a similar context (Nassaji 2020: 428). The

researcher provided sufficient descriptive data in the research report for readers to evaluate the applicability of the data to other contexts. To ensure sufficient descriptive data, the researcher provided a description of the study settings and findings. In addition, field notes were used in comparison with the verbatim transcripts and to enhance the verbal data recorded so that the applicability of the data to other contexts could be evaluated and considered to allow outside researchers to make transferability judgements themselves.

1.10.5 Authenticity

"Authenticity" refers to the reality of the study and that it is genuine (Kyngas, Mikkonen & Kaariainen 2020: 46). Authenticity involves shifting away from concerns about the reliability and validity of research to concerns about research that is worthwhile and concerns about its effect on members of the community being researched. In this study, authenticity was achieved through using direct quotations as evidence.

1.11 ETHICAL CONSIDERATIONS

Ethics is a system of moral values that is concerned with the degree to which the research procedures adhere to professional, legal, and social obligations to the study participants (Johnson, Adkins & Chauvin 2020: 142). The request for permission was sent to the institution selected as the research site and to the Gauteng Department of Health (GDoH) by the researcher, attached as Annexures B and C. The following ethical principles were adhered to beneficence, respect for human dignity and justice.

1.11.1 Beneficence

"Beneficence" refers to doing good and avoiding harm (Johnson, et al 2020: 142). The researcher had the duty to minimise harm and maximise the benefits of doing this research. The participants explored and described their knowledge. The research was conducted by a qualified and experienced advanced midwife, so harm and discomfort were avoided. Participants were not exploited in any form; interviews took 20–60 minutes. Participants were assured that their participation and the information that they provided would not be used against them in any way (cf. Polit & Beck 2017: 139). There was no anticipated harm as the data was shared without disclosure of the hospital name or the names of the participants.

1.11.2 Respect for human dignity

Respect for human dignity means that individuals should be valued and respected for who they are (Johnson, et al 2020: 142). In research, human dignity is an important consideration in obtaining informed consent from the participants as this involves self-determination, which is a process where a person controls their own life, and full disclosure, which concerns the

researcher's being honest and transparent about what the research is about. In the current study, full information was provided to participants. Participants were given an opportunity to decide voluntarily to participate, have their questions answered, withdraw from the study at any time and be free from coercion and threats. The researcher further described the nature of the study fully, the researcher's responsibilities, and the risks and benefits of the study. This information was also included in the participant's information leaflet along with the participant's right to decline participation or withdraw from the study (Pietila, Nurmi, Halkoaho & Kyngas 2020: 63). A participant information leaflet was given to each participant and an informed consent form signed by the participants who were willing to participate in the study. (See Annexure D.)

1.11.3 Justice

"Justice" refers to being treated fairly, with privacy provided (Pietila, et al 2020: 53). Beginning with the fair selection of study participants based on the problem to be investigated, the researcher employed the principle of justice by respecting the participants' beliefs, habits, and lifestyles from different backgrounds and by applying equity (cf. Pietila, et al 2020: 53). Participants' privacy was maintained all the time as a private boardroom in the selected hospital was used and participants' data provided was kept strictly confidential. The researcher respected the agreements made with the participants, such as the use of an audio-recorder; she did not change to other methods of recording the interviews.

1.12 CONCLUSION

In this first chapter of the research report the study topic was introduced, and the background was outlined, with a literature review employed to describe the study problem in detail. The problem statement, objectives and significance of the study were then outlined. The key concepts were clarified, and the research paradigm and assumptions regarding the ontology, epistemology and methodology of the study were described. The strategies used in the study to provide rigour as a way of ensuring the trustworthiness of the study were briefly addressed, following which the ethical principles adopted by the researcher were explained.

In Chapter 2 a detailed discussion of the study methodology is presented.

CHAPTER 2: RESEARCH METHODOLOGY

2.1 INTRODUCTION

This chapter presents and discusses the research methodology in detail. The research methodology is the type of research selected to answer the research question. It informs the reader of how the study was carried out and the techniques the researcher used to systematically structure a study to gather and analyse information (Gray, et al 2017: 1302) and answer the research question. In the current study a qualitative research design was followed that guided the researcher in thoroughly exploring and describing the knowledge of midwives regarding traditional practices used during the intrapartum period in a selected hospital in Gauteng. This allowed the researcher to obtain in-depth and detailed information on the study topic through discovering meaning by understanding the whole. And that enabled the researcher to explore the richness, depth, and complexity of the whole phenomenon under study.

The chapter begins by presenting the research design, the research setting, and the methods used. The data-collection methods and process are then outlined, followed by the data-analysis techniques.

2.2 RESEARCH DESIGN

The research design is the overall strategy that the researcher uses to integrate the different components of the study in a coherent and logical way, in this way ensuring that the research problem is effectively addressed (Polit & Beck 2018: 566).

The study used an exploratory and descriptive qualitative design. The researcher explored and described the knowledge of midwives regarding traditional practices used during intrapartum. Gray, et al (2017: 1288) describe an exploratory descriptive qualitative design as useful for research that is conducted to address a problem in need of understanding and in need of a solution using a systematic, interactive, and subjective approach to describe perceptions and give them meaning. This design also guides the researcher in planning and implementing the study in a way that is most likely to achieve the intended goal strategies for enhancing the study's integrity (Polit & Beck 2018: 566). Using this type of research design was appropriate for obtaining in-depth thorough and truthful data that reflected the knowledge of midwives regarding the traditional practices used during the intrapartum period as it is designed to shed light on the various ways in which a phenomenon manifests on the underlying process.

2.2.1 Qualitative design

A qualitative design is the plan for gathering data that is conducted in an in-depth and holistic manner. This design encompasses a variety of accepted methods and structures that yield data that is richer and more insightful regarding the reasons underlying and patterns within phenomena (Johnson, et al 2020: 138). The main reason for using this design in the study was to gain a richly detailed understanding of the study topic, based on first-hand experience. This was achieved by having a relatively small but focused sample base. A qualitative design is flexible, holistic, and understanding of the whole phenomenon and requires the researcher to be intensely involved and reflective. As such, it requires a lot of attention. It seeks to explore rather than explain and manipulate variables.

Advanced planning is required from the researcher to support flexibility about research tradition, study site, data-collection strategy and equipment needed on site. Qualitative researchers plan for a variety of circumstances but decisions about how to deal with them are resolved when the social context is better understood (Nassaji 2020: 427).

The researcher used a qualitative design for exploring and describing the knowledge of midwives regarding traditional practices used during the intrapartum period in a selected hospital in Gauteng to obtain in-depth information on the phenomenon.

2.2.2 Exploratory design

An exploratory research design is conducted to clarify the exact nature of the problem to be solved. This type of design is used in a multitude of fields. It is flexible and is used to address research questions of all types. This adds quality and insightful information to a study and allows the researcher to be creative to gain the most insight into a subject (Gray, et al 2017: 156). This design also allows for better understanding of what a researcher's objectives should be throughout the duration of a project. An exploratory design uses a systemic set of procedures to develop an inductively derived grounded theory about the phenomenon being studied (Polit & Beck 2018: 312) because of its attempt to unearth a theory from data itself rather than from a predisposed hypothesis. Exploratory studies are used to explore a relatively unknown field or when limited information or knowledge exists about a particular subject. For these reasons, the researcher chose to use this design as ideal for gaining insight into and acquiring a better understanding of the knowledge of midwives regarding traditional practices used during the intrapartum period in a selected hospital in Gauteng, since very little is known about this phenomenon.

2.2.3 Descriptive design

The main objective of a descriptive design is to portray the characteristics of a situation, people, or groups accurately. The design offers researchers a way to discover new meaning,

describe what exists, determine the frequency with which something occurs and categorise something (Gray, et al 2017: 79). This type of research is usually conducted when little information is known about a phenomenon. A descriptive design is a scientific method that involves observing and describing the behaviour of a subject, with no intention of establishing a cause-effect relationship. A descriptive design may be used to identify problems with current practice, justify a practice, make judgements, or identify what other professionals in similar situations are doing, or develop theories. It is more concerned about gathering information from a representative sample of a population (Polit & Beck 2018: 546). The emphasis in the collection of data with a descriptive design is on structured observation, questionnaires, and interviews.

In this study, the knowledge of midwives regarding traditional practices used during the intrapartum period in a selected hospital in Gauteng was identified, described, and documented. The findings revealed this knowledge as described by all participants who were midwives and were providing intrapartum care.

2.3 STUDY SETTING

Gray, et al (2017: 660) and Polit and Beck (2018: 569) describe the study setting as the exact area or location where the research takes place. The current study took place in the maternity department of a mother and child hospital in Gauteng, South Africa. Three departments where intrapartum care was provided, the labour ward admission, labour ward and maternity high care, served as the setting for the study. The labour ward admission had 12 examination beds. The labour ward had nine delivery cubicles and five postpartum beds, where patients were observed for an hour and then transferred to the postnatal ward, and high care had five beds. The patients came from different traditional, cultural, and racial backgrounds. The venue for data collection was identified and booked. The boardroom was used as a setting for data collection because it was a comfortable quiet place that provided the privacy required for conducting interviews. The setting was prepared by sending application letters to the chief executive officer (CEO) of the selected mother and child hospital. During the preparation of the setting at the beginning of each interview, the participants were made comfortable so that their anxiety would be relieved, and rapport developed (cf. McGrath, Palmgren & Liljedahl 2019: 1003).

2.4 RESEARCH METHOD

The specific way in which the researcher chooses to conduct the study within the chosen design is referred to as the “research method”. The research method is made up of the strategies, processes or techniques utilised in the collection of data or evidence for analysis to uncover new information or create a better understanding of the research topic (Gray, et al 2017: 1302). Different types of research methods use different tools for data collection in a systemic way. This research method includes how the population is identified, the sampling approach and technique, the study sample selected, the data-collection methods, and data processing and analysis. All these methods as they applied to the current study are discussed in the sections that follow.

2.5 STUDY POPULATION AND SAMPLE

2.5.1 Study population

Gray, et al (2017: 617) define the study population as a group of people with common characteristics that has been chosen by the researcher to take part in the study. In this study all individuals selected to be part of the population had to meet a set of standards to be included in the study (cf. Polit & Beck 2018: 561). The population of the study consisted of midwives working in a mother and child hospital in Gauteng who came from different traditional backgrounds and with experience of six months or more in providing intrapartum care. Eight midwives were selected from the labour ward admission (this unit consists of 24 midwives in total). Eight midwives were selected from the labour ward (this unit consists of 28 midwives in total). Lastly, four midwives were selected from the maternity high care area (this unit consists of 10 midwives in total). This made a total of 20 midwives as participants.

2.5.2 Sampling method

Gray, et al (2017: 617) explain the sampling method as the process used by the researcher to select a portion or a group of people to ensure that the participants are representative of the total population that is being studied. Polit and Beck (2018: 244) state that when selecting a sample, it is essential to select a representative sample of the population, one in which the same range of characteristics or attributes can be found in a similar proportion as well as in the population itself.

Purposive sampling was used to select the participants. Johnson, et al (2020: 141) explain that using the purposive sampling method results in the selection of a non-probability sample that is selected according to characteristics of a population that are intentionally selected by the researcher and in line with the objective of the study. The sample represents the same

range of characteristics or attributes in similar proportions to the whole population. This method allows the researcher to select a sample based on knowledge of the phenomena being studied (Johnson, et al 2020: 141).

For the current study, the purposive sampling method was considered convenient and economical (cf. Busetto, Wick & Gumbinger 2020: 7), as it allowed the researcher to gain an in-depth understanding of midwives' complex experiences without great expense. Sampling does not only depend on the candidates' availability and willingness to participate but also on the time and costs involved for both the researcher and the selected participants. The researcher ensured that the selected participants had the desired knowledge of the research question at hand. To achieve this, the researcher drew up inclusion and exclusion criteria for the selection of participants.

2.5.2.1 Inclusion criteria

Inclusion criteria are characteristics that participants must possess to be part of the target group population (Gray, et al 2017: 620). The inclusion criteria used in the selection of the sample for this study are noted below. Participants had to:

- Have a midwifery qualification, both midwives and community service midwives
- Be working in a maternity department that rendered intrapartum care
- Be working in the selected institution, which was a mother and child hospital, and have worked in maternity departments for six months or longer after completion of their studies

2.5.2.2 Exclusion criteria

These are the characteristics of the people that should be excluded from the study sample (Gray, et al 2017: 620).

Participants who worked in a mother and child hospital maternity department who did not meet the inclusion criteria were excluded. These exclusion criteria were:

- Participants who were working in departments that did not provide intrapartum care
- Participants who had less than six months of experience in providing intrapartum care
- Participants who were not working in the selected mother and child hospital

2.6 DATA-COLLECTION METHODS

The data-collection methods comprised in-depth interviews and field notes taken during these interviews and secondary data was collected in the form of literature review.

2.6.1 Individual in-depth interviews

Busetto, et al (2020: 3) define the in-depth interview as a method of data collection in which the researcher obtains information and responses from participants in a face-to-face encounter. Verbal and non-verbal communication skills are vital in face-to-face interviews. The in-depth unstructured interview was used to ensure flexibility of the interview process and enhance free interaction between researcher and participants in the current study. Gray, et al (2017: 403) define this type of interview as a technique used to conduct intensive individual interviews where the number of participants is low, which was the case in the current study. Unstructured interviews were used as they are free flowing, and the questions are open ended, with Barrett and Twycross (2018: 63) describing unstructured interviews as informal and conversational. In-depth interviews were also chosen as they allow the researcher to explore a greater depth of meaning than any other methods and the response rate is higher (Gray, et al 2017: 752).

A neutral place was selected for the interviews that was convenient to the participants and where privacy and confidentiality could be maintained. As the researcher worked in the same setting as the participants in the labour ward, an assistant researcher who was also a midwife and who was not working in the same setting collected the data by interviewing these participants. Those participants that were not working in the same setting as the researcher were interviewed by the researcher.

The researcher compiled an interview guide, which was handed over to the other interviewer (the assistant researcher) who posed a question, followed by probing questions during the interview (cf. McGrath, et al 2019: 1003). (Refer to Annexure G)

The researcher or interviewer posed the main question:

1. What do you regard as traditional birth practices?

The question was followed by probing questions that were formulated according to the responses of participants to the main question, only if a participant's responses did not cover the scope of the main question:

1. What's your first reaction when you hear that the woman is using/has used traditional practices during the intrapartum period?

2. Tell me more about your knowledge regarding the traditional practices used during the intrapartum period.

3. Is there anything else you would like to tell me regarding traditional practices used during the intrapartum period? Or are there any other questions that you think I should have asked regarding traditional practices used during the intrapartum period?

To allow participants the opportunity to explore freely, the following communication skills were used: listening, probing, paraphrasing, and seeking clarity (cf. Polit & Beck 2017: 516). The interviews took 20–60 minutes with each participant before data saturation was reached, at which point there was no new information discovered from the participants. Double-checking questions were also asked to confirm what the participants really wanted to say and to clarify meaning.

All the interviews were audio recorded with the permission of the participants to focus on the interaction and the relationship with the participants during the interview. The recordings were checked immediately after each interview to ensure that they were audible. The researcher and assistant researcher had to remain still, without moving and without making any sound when the participants were talking to avoid disturbances.

To cover all the work shifts of the participants, two days were allocated per department where interviews were conducted during both the day and the night. Participants were invited to come to the boardroom individually. A positive environment was established before each interview by making sure that the chairs were comfortable. At the end all participants were thanked with refreshments provided.

2.6.2 Field notes

In addition to the recording of the interviews, personal and observational field notes were made during the interviews by the interviewer in a reflective journal. These notes were then recorded by the researcher during the data-collection process as intended to be read by the researcher as evidence to produce meaning and an understanding of the phenomenon being studied.

Polit and Beck (2018: 549) define field notes as notes taken by the researcher to record the unstructured observations made in the field and the interpretation of those observations. They are broader and interpretive. The researcher was responsible for documenting the field notes that had been taken during each interview held in this study. Polit and Beck (2018: 301) divide field notes into descriptive and reflective notes, where descriptive notes are objective descriptions of events and conversations that were observed, whilst reflective notes document the researcher's personal experience, reflections, and progress in the field. All the dynamics that took place during each interview were recorded in the field notes, including what the researcher saw, heard, experienced, and thought while collecting or reflecting on the data.

Field notes were written to describe verbal and non-verbal behaviours such as eye contact and individual gestures of the participants as soon after each interview as possible.

2.7 DATA-COLLECTION PROCESS

Data collection is a systemic process of interrelated activities aimed at gathering and measuring information from selected participants to answer the stated research question (Gray, et al 2017: 927). A data-collection plan is developed specific to the study being conducted and relevant to the research objective or purpose of the study being conducted.

Data collection followed a systemic process, which commenced on 11 February 2021 and was completed on 25 March 2021. The in-depth interview was used for the collection of data as it was considered flexible and would allow the participants to talk freely. It was also expected to produce more in-depth information on the participants' beliefs and attitudes than could be obtained through any other means of data gathering. The interview guide was prepared by the researcher in advance of the interviews. Data was collected through these in-depth interviews by the researcher and with the help of the assistant researcher, who had the necessary experience in research. Both the researcher and the assistant researcher operated an audio-recorder during the interviews. Audio-recorders were used with the permission of the participants to ensure quality of data collected (cf. Busetto, et al 2020: 3). Field notes taken by the interviewers added to the richness and truthfulness of what transpired during each interview. The midwives that were on duty were called one at a time to the boardroom to avoid disrupting service delivery.

The researcher and the assistant researcher discussed the interview guide before the study process began. Each interview followed a specific process. In each case, the researcher welcomed the participant. The audio-recorder was tested before use during the interview.

Following the interview guide, a broad, open-ended question was asked, and participants were allowed to tell their story without interruptions. Follow-up probing questions were used to increase detailed exploration and give the researcher and as assistant researcher an opportunity to clarify and expand responses. They also enhanced rapport by indicating to the participants that the researcher was truly interested in understanding their experiences. The researcher responded to participants' responses non-verbally by nodding and keeping eye contact to show interest without being judgemental (cf. McGrath, et al 2019: 1003).

2.8 PREPARATIONS FOR THE DATA-COLLECTION PROCESS OF INDIVIDUAL IN-DEPTH INTERVIEWS

2.8.1 Preparatory phase

The preparatory phase involved preparing the venue and recruiting the participants, preparing the assistant interviewer, and setting up the audio-recorder. The audio-recorder was operated by the researcher and the assistant researcher respectively during the interviews.

2.8.1.1 Preparing the venue and setting up the audio-recorder

The researcher obtained written permission from the CEO of the selected hospital to conduct the study at the hospital (see Annexure F). The venue for the interviews was prepared in advance. A comfortable and relaxing environment was established beforehand as the environment has the potential to affect the data collection (McGrath, et al 2019: 1003). The participants were also made comfortable to relieve anxiety and develop rapport. Comfortable chairs and the boardroom table provided a surface on which the participants could sign the consent form.

The assistant researcher was also prepared as she was sent instructions by the researcher a week before the interviews on how to operate the audio-recorder. The audio-recorder was tested before use during the interview.

2.8.1.2 Recruiting the participants

The criteria for recruiting participants for a research study are developed from the research problem, purpose, review of literature and research design (Gray, et al 2017: 619). For the current study, the participants were selected from the accessible population within the target population using the criteria described in 2.5.2.1 and 2.5.2.2 above. Participants were recruited for interviewing from the maternity departments that provide intrapartum care. A total of 21 participants were recruited in case of withdrawals. The participants were physically selected by the researcher face to face. The researcher also answered any questions asked by participants regarding participating in the research face to face.

Prior to recruiting the participants, the researcher sent applications to request permission to conduct the research and for access to recruit the participants from the hospital CEO, the GDoH and the University of Pretoria's (UP) ethics committee. Once permission had been granted, the researcher met with the operational managers of the departments identified in the hospital and explained that she had received permission to conduct the research from the hospital management and from the UP-ethics committee. She then requested their assistance and support in conducting the research.

She described the purpose of the study, the process, and the expectations. Privacy and anonymity were emphasised. She explained the participation information leaflet that contained

all the necessary details about the study and the researcher's contact details. The information provided in the leaflet included the aspects of voluntary participation, the freedom to withdraw at any stage and that there would be no incentives for participation (cf. Pietila, et al 2020: 62). The dates that were selected for the interviews were suitable for both the researcher and the participants. After the dates were selected, times and venue were confirmed with the participants. The researcher thanked the operational managers for their time and assistance (cf. McGrath, et al 2019: 1003).

2.8.2 Preparing for the interview questions

Before the interviews were arranged, the script instructions for participants were properly planned and developed. A pilot study was conducted in the selected mother and child hospital to test the questions set out in the interview guide. The prepared unstructured questions that were planned to be used during the in-depth interviews were tested beforehand by the researcher and found to be effective (cf. Barrett & Twycross 2018: 63).

2.8.2.1 Pilot testing

A pilot test is a small-scale study conducted prior to the main study on a limited number of participants from the population at hand. It is used to investigate the feasibility, duration, cost, and potential adverse events of the proposed study and to detect possible flaws in the methodology of the proposed study so that the study design can be improved on prior to the performance of the full-scale study (Busetto, et al 2020: 7). It also provides an opportunity to assess the reliability and validity of the research instrument (Gray, et al 2017: 751).

For the current study, a pilot study was conducted at the selected hospital to establish the validity of the data-collection instrument. The same study venue, setting and instrument as planned for the main study were used. No new questions were added during the pilot study.

Six participants were chosen that met the inclusion criteria but did not form part of the sample. The information leaflet was read and explanations about the purpose of the study, duration of the interview, expectations during the interview and the right of withdrawal were included before the consent form for participating and allowing audiotaping was signed.

The purpose of the pilot study was met as the participants understood what the researcher needed, and no changes were made to the questions (cf. Busetto, et al 2020: 7). No question was added nor was one discarded except when the researcher and assistant researcher were probing. The interviews lasted between 20 and 60 minutes and the planned time was 45–60 minutes. The researcher thanked the participants for their time and their contributions to the study.

In analysing the data, no coding problems were detected. Data from the pilot interview was not included in the study.

2.8.3 Conducting the interviews

All the individual face-to-face interviews took place in an organised setting, were guided by prepared questions, and were conducted by the researcher or the assistant researcher, who had the required knowledge of research and conducting interviews. Both interviewers were fluent in English, the language in which the interviews were conducted as all participants were qualified midwives who were fluent in English.

The interviews began with the interviewers briefly summarising the reasons for the interview, introducing the topic, and explaining the frame of reference of the in-depth interview. Following the advice of McGrath et al (2019: 1003), rapport was created with each participant and a relaxed atmosphere was created. Respect was shown to each participant and confidentiality maintained regarding their identity and opinions expressed (Johnson, et al 2020: 142). Participants signed a form affirming their written consent before the interviews were conducted.

Time management was demonstrated well, as starting times and finishing times were controlled and maintained. During the interviews, field notes were taken, and the interviews were audio-recorded. Each interviewer employed the communication skills of listening, probing, paraphrasing, and seeking clarity during the individual interviews to collect as much rich data as possible. Listening more and talking less were identified as key to conducting a successful interview. The interviewers also tolerated silence when the participants were not talking because they seemed to be thinking more about the topic to give more information (cf. McGrath, et al 2019: 1004).

In-depth data was collected through in-depth interviews. Data saturation was reached when the sample size was achieved, no new information was discovered from the participants and the researcher was satisfied that there was now an understanding of the study phenomenon (cf. Johnson, et al 2020: 141).

The dates and times of the interviews were identified and confirmed with the participants, operational managers, and assistant managers to avoid interfering with the patient care (cf. McGrath, et al 2019: 1003). The participants were called one at the time to the boardroom to avoid interfering with the patient care.

Roles of the interviewers

The researcher acted as the facilitator for the interviews, organising the venue, recruiting the participants, and handling the environmental logistics and conditions. She made sure that the venue was prepared, and during interviews that everything was in order. All the interviews were private, held in a room behind closed doors, and a notice that private interviews were in progress was put up outside the door to avoid unexpected interruptions. Fortunately, all interviews took place without interruptions.

The assistant researcher conducted the interviews of the participants that were working in the labour ward. Both interviewers had good communication skills, both in writing and verbally, as they took quality field notes (cf. Barrett & Twycross 2018: 64).

Audio-recording

Audio-recording is one of the technical devices used in data collecting for capturing sounds and converting them into an audio file that can be conveniently transferred to another device. It makes categorisation of the data easier during data analysis. Non-verbal responses were clearly observed during the interviews as using an audio-recorder allowed the interviewers to concentrate on non-verbal responses and allowed for much fuller record keeping than notes taken during the interview would. One audio-recorder was used for the interviews, and it was tested for proper functioning before the commencement of each interview. When preparing for qualitative interviewing, it is important for the interviewer to be familiar with the data-recording equipment being used. Participants were informed about the audio-recorder and verbal permission was received from them to use it (cf. McGrath, et al 2019: 1003).

2.8.3.1 Communication skills

Communication skills are very important when it comes to data collection. Verbal and non-verbal communication such as spoken language, facial expressions, and body language, along with style of dress, age, race, gender, social status, culture, and the researcher's relationship with the participants may influence participants' responses (Johnson, et al 2020: 142). Communicating openly and clearly creates rapport with the participants and boosts their spirits. It also establishes transparency that generates trust, leading to an environment where participants can be honest and accountable. To allow participants to explore freely, the communication skills of listening, probing, and paraphrasing were used in the interviews (cf. Polit & Beck 2017: 516), as described below.

Listening

The interviewer needs to listen more and talk less and use good listening skills to obtain quality information from participants, gain a better understanding of what they are saying and encourage them to talk more. In this study, the interviewers used the appropriate listening

skills, which led to obtaining more in-depth quality information without interfering when participants were talking.

Other communication skills complemented the listening skills used. Good eye contact was maintained throughout the interviews, which gave participants confidence to talk more. The interviewers demonstrated interest in the discussion by nodding and leaning forward as participants were expressing their knowledge regarding the topic at hand. The interviewers adopted the appropriate tone of voice when they responded verbally, and questions were asked clearly and audibly. All these skills were employed following the advice of McGrath, et al (2019: 1004).

Probing

Probing is defined as prompting questions that encourage the participant to elaborate on the topic that is being discussed (McGrath, et al 2019: 1003). Probing questions are designed to deepen the knowledge and understanding of the information for the person asking the question as well as the person answering. The probing questions used in this study provoked depth and insight in the answers as they promoted critical thinking and encouraged the participants to explore their thoughts, knowledge, and feelings about the topic. Both interviewers used the probing technique in a respectful and dignified manner to gain more detailed information from participants. Prepared probing questions were asked to obtain more details and clarity regarding the participants' knowledge.

Paraphrasing

Paraphrasing refers to the researcher presenting somebody else's ideas and information in their own words to demonstrate their understanding and ability to convey this message and acknowledging where it comes from (Gray, et al 2017: 1309). Paraphrasing was used in this research report to prevent plagiarism.

In the interviews, the interviewers also paraphrased the participants' answers where necessary using their own words without changing the meaning to clarify what the participants had said and encourage them to elaborate on it.

2.8.4 Post-interview phase

The post-interview phase occurred immediately after each interview. In this phase, the researcher took the opportunity after each session to thank the participants for participating, to demonstrate cooperation and show respect for each other during the proceedings. The participants were reassured that they would be informed about the findings of the study and that anonymity and confidentiality would be maintained (cf. Pietila, et al 2020: 63). During this phase, refreshments were also offered.

2.8.4.1 Identifying data from the participants

Data was collected from the 21 participants employed at the selected mother and child hospital. Each participant was assigned a numerical code and any personal data that might identify participants was removed (cf. Pietila, et al 2020: 63). The participants were identified as P1, P2, etc. for the purpose of anonymity during data collection and data analysis.

2.9 DATA ANALYSIS

Data analysis is the process of organising and evaluating data systematically once it has been collected (Polit & Beck 2017: 725). It involves organising all the data and observations recorded and written down to give meaning to the data collected. Qualitative content analysis was conducted simultaneously with data collection as reflective comments were documented in field notes.

Erlingson and Brysiewicz (2017: 96) explain the process of qualitative content data analysis following the steps outlined below.

Becoming familiar with the data

This process began with the researcher reading and re-reading the transcribed data from each interview to get a sense of the whole interview. Collected data was transcribed verbatim from the audio recordings of the spoken word into text exactly as it was spoken. Field notes taken during data collection were also analysed. The whole text was broken down into smaller parts in terms of the different messages expressed by the participants. Accuracy of the transcribed data was checked by listening to the recorded interviews.

Dividing up texts into units of meaning and condensing these units

The transcribed texts were divided into smaller meaning units. Located meaning units were further condensed to summarise the words used by the participants while keeping the meaning intact. The meaning units were only condensed where necessary as some were already compact. This process avoided the fragmentation of the participants' ideas whilst doing so.

Formulating codes

The data was organised by developing a method to classify it. Descriptive labels called codes were developed and assigned to the condensed meaning units. The researcher used participants' phrases as the code labels. The researcher had to re-do codes, re-think, re-adjust the codes and re-code the meaning units until she reached the point where she was satisfied that the codes expressed the meaning units accurately. During the process of coding, she took notes of her impressions of and reaction to the text.

Developing categories and themes

The codes were then compared to determine which codes seemed to belong together as they dealt with the same issue, in this way forming a category. Similar codes were grouped into categories. The next step in the analysis was to identify themes that emerged from the categories. Themes were formulated by grouping two or more categories together. Sub-themes were also identified within themes.

2.10 CONCLUSION

This chapter described in detail the qualitative descriptive exploratory research design used in the study. It presented the study population and sample and provided a comprehensive view of the data-collection methods and process, discussing how the in-depth individual interviews were carried out in detail. The data-analysis process was also outlined.

The results of the analysis of the qualitative data and a literature control of the findings are presented and discussed in the next chapter.

CHAPTER 3: PRESENTATION OF THE RESULTS OF THE STUDY

3.1 INTRODUCTION

The research methodology and design, and the data-collection and data-analysis methods used in this study were described in the previous chapter. This chapter presents the findings of the analysis of the collected data, using direct quotations from participants to support the findings and discussion.

The findings reflect the knowledge of midwives regarding traditional practices used by patients during the intrapartum period in the hospital in Gauteng selected as the research site. As detailed in Chapter 2, data was collected through in-depth interviews conducted at the selected hospital in Gauteng by the researcher and assistant researcher. Qualitative content data analysis was undertaken, which involved coding meaning units discovered in the verbatim interview transcripts and identifying themes and sub-themes. Data analysis gave the researcher the opportunity to be immersed in the data and added to the study credibility.

This chapter begins by describing the demographic characteristics of the participants and then presents the interview findings regarding the traditional practices identified by the participants.

3.2 DEMOGRAPHICS

An overview of the demographic characteristics of the participants who participated in this study is presented in Table 3.2.1. The total number of participants interviewed was 21. All the participants worked in the maternity department of the selected hospital, i.e., the labour ward, labour ward admission and high care, where they provided intrapartum care.

Six participants were interviewed from the labour ward instead of the eight initially expected because one participant that had been chosen pulled out at the last minute and one audio-recording was erased by mistake by the assistant researcher. To compensate for these losses, three more participants were added from labour ward admission. All participants worked in the selected mother and child hospital in Gauteng, and all had more than six months' experience of providing intrapartum care.

Table 3.2.1 Summary of participants' demographic characteristics

Participant code	Department where participant currently working	Gender	Years of experience as a midwife
Participant 1	Labour ward	Female	7yrs
Participant 2	Labour ward	Female	8yrs
Participant 3	Labour ward admission	Female	8yrs
Participant 4	Labour ward admission	Female	38yrs
Participant 5	Labour ward admission	Female	11yrs
Participant 6	High care	Female	5yrs
Participant 7	Labour ward admission	Female	11yrs
Participant 8	High care	Female	3yrs
Participant 9	High care	Female	6yrs
Participant 10	Labour ward	Female	8yrs
Participant 11	Labour ward admission	Female	12yrs
Participant 12	Labour ward admission	Female	7yrs
Participant 13	High care	Female	13yrs
Participant 14	Labour ward admission	Female	37yrs
Participant 15	Labour ward admission	Female	8yrs
Participant 16	Labour ward admission	Female	2yrs
Participant 17	Labour ward admission	Female	3yrs
Participant 18	Labour ward admission	Female	9yrs
Participant 19	Labour ward	Female	11yrs
Participant 20	Labour ward	Female	3yrs
Participant 21	Labour ward	Female	2yrs

3.3 THE RESULTS

The aim of this study was to explore and describe midwives' knowledge regarding traditional practices used during the intrapartum period in a selected hospital in Gauteng. Data was collected from in-depth individual interviews and from field notes taken during these interviews. The data was coded, and themes and sub-themes formulated. Each theme was divided into sub-themes, as shown in Table 3.3.1. Data analysis revealed eight themes, which are:

- Knowledge of practices that facilitate or hasten labour;
- Knowledge of using traditional rope/band/wool/cloth/elastic band.
- Knowledge of prolonging labour using a stone;
- Knowledge of eating different things in labour;
- Knowledge of different types of clothing;

- Knowledge regarding protection/calmness/prevention of preterm labour and caesarean section, and safe delivery;
- Knowledge of praying; and
- Knowledge of the do's and don'ts when in labour.

Each theme is presented and discussed below.

Table 3.3.1 Themes and sub-themes

Themes	Sub-themes
1. Knowledge of practices that facilitate or hasten labour	1.1 Isihlambezo, imbita; 1.2 Umchamo wemfene;1.3 Ostrich egg; 1.4 Isivimbampunzi (snake onion) and ugobho; and 1.5 Enema/castor oil/laxatives
2. Knowledge of using traditional rope/band/wool/cloth/elastic band	2.1 Rope or cloth around abdomen or waist 2.2 Traditional or elastic band/wool/cloth/rope around the thigh 2.3 Cloth tied under the breast
3. Knowledge of prolonging labour using a stone	3.1 Abba the stone, stone around the waist, stone on top of your head and the stone tied in the corner of the dress 3.2 Carry a stone on the hand
4. Knowledge of eating different things in labour	4.1 Eating dates and Vaseline; 4.2 Drinking tea or soup; 4.3 Chewing a green stick or branch; and 4.4 You are not supposed to eat liver
5. Knowledge of different types of clothing	5.1 Babies' clothes to be hidden during pregnancy and taken out when in labour 5.2 Putting the cloth on the floor to deliver 5.3 Untying partner's shoes and belt 5.4 Wearing clothes of person who had quicker labour
6. Knowledge regarding protection/calmness/prevention of preterm labour and caesarean section, and safe delivery	6.1 Using holy water, prayed water, prophet water, church water and ichibi (water from Ushembe church) 6.2 Lying facing east, and inhaling impepho herb and uphunyuka bamphethe (herb)
7. Knowledge of praying	7.1 Praying during contractions; 7.2 Prayed bathtub; 7.3 Ukuphahla (speaking to ancestors)
8. Knowledge of the do's and don'ts when in labour	8.1 Women not to be assessed by male health practitioner 8.2. Don't tell people that you are pregnant and when in labour 8.3 Don't stand by the door 8.4 No crying when in labour 8.5 Men/partner not to be around during labour 8.6 No eating during labour 8.7 No shade of someone when drinking these traditional things 8.8 No plaiting/braiding hair

	8.9 The do's: Doulas, tshitanga (keeping room warm), squatting/kneeling birthing position

3.3.1 Theme 1: Knowledge of practices that facilitate or hasten labour

This theme emerged from most participants. Traditional practices that facilitate labour are commonly known by midwives and commonly practised during the intrapartum period by patients. The sub-themes that emerged from this theme were: 1.1 Isihlambezo, imbita; 1.2 Umchamo wemfene; 1.3 Ostrich egg; 1.4 Isivimbampunzi (snake onion) and ugobho; and 1.5 Enema/castor oil/laxatives. These sub-themes are explained further below and supported by direct quotations from participants. The sub-themes are interrelated as certain substances are the ingredients of other substances.

Sub-theme 1.1 Isihlambezo or imbita

Isihlambezo or imbita as the first sub-theme emerged from nearly all of the participants. The use of this TM was common knowledge for most participants. A total of 20 participants mentioned this substance, with only one participant, Participant 19, unsure about why it was used.

In support of this sub-theme, Participant 1 stated:

"They drink it as soon as they start having that small pains. Isn't maybe the pain is not increasing, then they worry why is the pain not increasing. And then they said as soon as the pain [stuttering] starts, that woman (traditional healer) tells them that you drink this then it will go faster and then it will be quick, and it won't be too much pain and then you deliver fast."

Participant 2 indicated the name of the medication:

"Imbita and isihlambezo they call it. And they usually give these patients this herbal medication from home to induce labour. They tell them they are going to deliver fast if they take that herbal medication."

Participant 3 agreed with the use of this medication:

"Isihlambezo, because it's just a medication just to enhance your delivery."

Participant 4 explained the tradition associated with it:

"For the Zulus is isihlambezo. So they go to a traditional healer, I don't [know] which type of medicine they give, and then they, they, the make the woman to drink that, it's in the bottle. And then, and then they, then the woman falls into labour and then before the woman comes to the hospital…"

Some of the participants speculated about what the mixture was made of:

"The isihlambezo that I know is for, is for the Zimbabweans…They won't, they won't tell you, but they have this cow dung, no, elephant dung and then they mix it with water and drink that is their isihlambezo. They have this cow dung, no, elephant dung and then they mix it with water and drink that is their isihlambezo. They say, it starts labour, to start labour and then it starts labour and then they'll progress" (Participant 4).

"Oh, the one that I know of is isihlambezo. Uhm, patients usually come with it from home in the transparent bottle or the Cocoa-Cola bottle, eh its transparent in colour but I don't know what is mixed in there, others they say it is uhm monkey's pee. Monkey's pee, others they say it is Monkey's pee mixed with elephant dung…So it helps them when they have uhm contractions, eh to dilate more" (Participant 6).

"The traditional healers they say when they mix isihlambezo. They take a snail; you remember that snail has got that. Ya so you see snail has got that ta, that lubricate itself where the snail walked. You'll see that lubricate, so when you, see when touching the snail, the bigger one, they just go inside. Yaa, so that they, they take that thing to mix so that during labour there'll be no complications of the head to come out so the head will just come out easily, so they use some animals" (Participant 14).

Participant 7 confirmed how patients consumed the medication:

"*So that uhm I remember one, uh one patient said, so that when the labour starts and then it's quicker and I'm used to this because it tastes horrible. Start drinking it, throughout, from 36, 37 a cup per day…Continue up until the labour, let's say maybe the labour pains become intense on that day. And she will leave home mos, and come to the hospital, obviously isihlambezo is left at home."*

Participant 8 also indicated what the medicine was used for:

"*So, there's this thing they call isihlambezo so that one is usually used by black patients like in the South African context [using hands]. So they come, like they, they have this formula there and somehow it causes you to have uterine contractions some patients are given that by their families and then, they drink that throughout their time in labour until they actually start having those strong contractions…It helps them to have strong pain and then they can like uh, well they don't use the word dilate but they, so that the baby can come out."*

Participant 9 confirmed that she did not know much about isihlambezo:

"I just heard about isihlambezo when you are in labour so that your labour didn't prolong you have to drink that isihlambezo I don't know how, which are, eish I don't know how much of that isihlambezo must be supposed to drink."

Participant 10 gave her understanding of the practice to induce labour:

"Isihlambezo according to culture which was a Zulu patient that she said that's her culture, when they are in labour according to them when I asked them what she means when she's in labour, she said no, when they tell her that it's now she's nine months pregnant, and then, between from 36 weeks until 40 weeks she can deliver any time so according to the culture then she starts drinking isihlambezo. Isihlambezo is something that the big people make a mixture they don't know what the mixture is in, but that mixture she must drink like 50mls or 100mls it depends on what they said she must drink. Then she drinks it, because she wants to get, uh, uh labour pains, so when she drinks it, and she gets labour pains she must go to the hospital…They want to have a normal vaginal delivery, so this is the things that will assist them not to be cut."

Participant 11 had taken isihlambezo in the past. She explained:

"I have taken isihlambezo and eh, eh after I've taken that or ugogo wami [grandmother] or my mum gave me this. This thing to drink and then after that I started having pain. And I believe maybe some of them they, they know about it some they're drinking it unknown. What is it that's going to do to them, some they'll tell you kuri [that] it'll make you shesha, it'll make you go fast?"

Participant 12 identified where isihlambezo was obtained and supported its effectiveness, saying:

"But with isihlambezo what I know that you get it from it's either a sangoma or a traditional healer or a nyanga, something like that…Because it's a mix of herbs, I don't know how they mix it but it's, you drink to induce, to induce labour, it also helps for dilatation, you dilate fast."

Participant 13 explained how the practice worked and even mentioned the practice to follow drinking it:

"You drink isihlambezo then you throw the cup behind you, and you go to the hospital…The intention to make sure that you have a simple and, uh, simple and short labour."

Participants 14, 15 and 16 identified speed of labour as the aim of taking isihlambezo:

"They drink isihlambezo that a, a Zulu herbal medication that will make things easier for them…Their labour will be quickly not like taking 16 hours" (Participant 14)

"When the contractions have started at home. Then they start giving them that so that they can progress quicker, and the baby can come quicker" (Participant 15).

"Monkey's urine is isihlambezo used for: *To speed up the progress, the progress of labour" (Participant 16).*

Participant 17 identified the problems associated with taking isihlambezo:

"With isihlambezo they saying that you can start drinking it when um, when you, when you are seven months so by the time you get into labour, your womb is already ready, ripen and ready for delivery, and in that way, you won't uh, you won't take long, your labour won't take long so that's why they, they, they drink it of which it's, it's a problem."

Participant 18 had not seen patients use it but had been told by people of its use:

"I've never seen it, but I've heard people say they're drink isihlambezo eh to make the, the contractions to be more severe so that you can deliver quicker."

Participant 20 described the purpose of this practice as:

"To enhance the labour, they drink um, isihlambezo".

Participant 21 discussed the popularity of isihlambezo:

"And then with us Africans, isihlambezo is number one I don't understand why…isihlambezo is just to, apparently, it's just to make the, the process of labour faster, that's what they say."

Sub-theme 2 Umchamo wemfene (Monkey's urine)

Umchamo wemfene also emerged as a sub-theme of the theme of knowledge of practices that hasten labour. This TM was also common knowledge to midwives and a common practice among their patients. In support of this sub-theme, eight participants had definite knowledge of this practice, with only Participants 18 and 19 unsure of why it was used. This practice was interrelated with the practice of using isihlambezo, as some midwives believed that umchamo wemfene was isihlambezo. Others believed that one medicine was used as an ingredient of the other one. These views are indicated in the quotations from participants provided below.

Participants 3 and 10 identified this sub-theme as a traditional cultural practice:

"*And then there's another thing they say (yoo) I'll say it in Tswana, moruto watswene [speaking another language] I don't know, but it's a black, it's a blackish, like a blackish herb, you also boil it and put it into water and drink it. So, it's fastening, it makes the whole period faster*" *(Participant 3).*

"*Then the other one it's the, the, the one patient that I had it, it's the culture of, it was a Tswana girl and she said that they drink monkey urine, they also said it's a mixture that the family makes but they don't know what the mixture entail" (Participant 10).*

Participant 11 spoke about isihlambezo and umchamo wemfene as one thing:

"Umchamo wemfene is the isihlambezo, the way they will explain it to you umchamo wemfene it is isihlambezo."

Several participants identified the purpose of umchamo wemfene:

"I think it's an herb, maybe they mix herbs or maybe they burn something then boil it before they, they do it then they drink it, they give you, it also helps the patients" (Participant 12).

"It helps you with dilatation" (Participant 12).

"The traditional part of it but the one that I know that it's being used a lot that people use a lot is moruto watswene…It is isihlambezo...To speed up the progress, the progress of labour" (Participant 16).

"They want to have a normal vaginal delivery, so this is the things that will assist them not to be cut" (Participant 10).

"The purpose of this is to make labour go faster and you finish fast" (Participant 11).

Participant 17 explained that the mixture was widely available:

"Umchamo wemfene it's something that they buy its written umchamo wemfene for short labour and whatever it's like, they say, say even in chemist you can get that."

Participant 19 suggested that the preparation of the mixture was not common knowledge:

"The monkey's urine ya if I put it that way yes, eh they usually drink that um still having to get um information from them as to how it's been prepared, how they take it, they don't usually dwell into those things because even with the ostrich egg."

Sub-theme 1.3 Ostrich egg

This sub-theme also emerged from the theme of knowledge of practices that hasten labour. Few participants had knowledge of this practice. In support of this sub-theme, three participants were aware of this traditional practice, but interrelated its use with the above sub-themes. The three participants with some knowledge of the practice were aware of its intended use and possible medicinal value. They also identified it as a cultural practice of groups.

Participant 2 stated:

"In the coloured cultures what I've noticed because our coloured people from Mpumalanga, they are mixed [laughing] half black, half coloured. So, they also practise these traditional practices from our black people there. They will tell you that they are drinking the ostrich

egg…They crush the inside where it's containing the Pitocin [quiet]. These are the ones that I know of."

"They say that after a while, they'll start feeling more pains, not knowing that it augments labour by giving the patient that."

Participant 3 stated:

"*Ok, I only know according to black cultures and Tswana cultures, eh we drink, there's this ostrich egg that they use, then they put it in water when you start having labour pains you drink it, you drink the whole cup, and you throw it at the back that will make the contractions stronger and faster.*"

Participant 11 supported this view by saying:

"*The ostrich egg I don't know I don't know somebody was saying that they take the ostrich egg and boil it something like that and they drink it, it's got oxytocin."*

"*When the person is starting to be labour, so that it'll progress."*

Sub-theme 1.4 Isivimbampunzi (snake onion) and Igobho

This also emerged under the theme of knowledge of practices that hasten labour. In support of this sub-theme only one participant (Participant 5) had any knowledge of this traditional practice, describing it as an herb mixed with water to be drunk to help with dilatation and for protection. This midwife identified this practice as used by the Xhosa nation. The mixture was given to women who were not having a child for the first time. It wasn't given to women who were experiencing childbirth for the first time because they could not predict what complications this person might have. Women giving birth to a child for the first time were given a stone to carry to prolong labour and then sent to hospital. All these practices were aimed at promoting a safe delivery and a healthy baby and mother at the end.

Participant 5 stated that for women who were given the mixture, they had to wait to rupture the membranes first and then told to take half a cup whenever they felt a contraction until the delivery. She explained:

"So, they take that, they put in water, the moment, you, you say you've got pains, they wait for you for the water to rupture. Then they give you to drink that. They believe that it's going to hasten the baby to come out."

Igobho (Gunnera perpensa)

Igobho is an herb with the scientific name Gunnera perpensa. This TM was also not common knowledge to midwives and not commonly used by their patients. This TM also emerged as part of sub-theme 1.4. In support of this sub-theme only one participant (Participant 12) had knowledge of this TM.

Participant 12 stated:

"It's an herb that you, you buy it, you buy it, it's been bought in those traditional stores."

"I've seen most of the patient they do drink it when the pains start because it helps empty the uterus...Even during labour."

Sub-theme 1.5 enema/castor oil/laxatives

This sub-theme was the fifth sub-theme to emerge under this first theme and was identified by participants as a commonly known practice used by all ethnic groups for different reasons. The substances identified in this sub-theme were used to facilitate labour, induce labour and as detoxification (cleaning the system) so that the women did not pass faeces during labour. This was supported by five participants.

Participant 2 described the purpose of this TM:

"So, I think by giving that natural enema, the head will descend if the rectum is empty and then labour will progress faster, that is what is happening there."

Participant 10 added a further purpose to the one above:

"The castor oil is also to help them to go also quickly into labour. Others say the castor oil is because they don't want to embarrass the nurses when they go and do number two so that's

the 2 different, the other ones are to clean, the other ones said it's because the want to go into labour and deliver."

Participant 12 identified both castor oil and enema as being used by the patients she encountered; she stated:

"The enema when you start, when you start feeling pains then they will give you an enema. Then you must go and empty your, your, not your bladder, your rectum. You empty your rectum they say, they have a belief that if their rectum's empty it will help for the baby's head to, to go down so the labour won't be prolonged it will go fast."

"The coloured and white people they drink castor oil…They said, it helps, it helps with dilatation, you dilate too, you dilate fast."

Participant 16 supported this view by saying:

"Most women they turn to castor oil because then it gives them uh, uh, it makes their…, it gives them a runny stomach so in that way the hyper stimulation of rectums then it stimulates labour then they have contractions."

Participant 17 identified the use of the enema but for a different reason. She said:

"It must be warm and then it will make, the, the colon will be clean, just go to toilet and then when, during the delivery time, you won't have, there will be no faeces around because they believe that once the baby comes, um with those faeces and then the baby it's like, the baby will have uh bad luck."

3.3.2 Theme 2: Knowledge of using traditional rope/band/wool/cloth/elastic band

This theme emerged from the study participants. It was discovered that the use of rope was common knowledge and commonly practised in different ways and for different reasons or beliefs by various ethnic groups. Rope was believed to be used for the protection of the mother and the baby; for safe delivery; to prevent evil spirits during pregnancy, labour, and delivery; and to make labour go quickly.

The sub-themes that emerged from this theme were: 2.1. Rope or cloth around abdomen or waist; 2.2 Traditional or elastic band/wool/cloth/rope around the thigh; and 2.3 Cloth tied under

the breast. These themes are explained further and supported by quotations of participants' views. Only one participant, Participant 2, while aware of the tradition of the rope, was unsure about why it was practised.

Sub-theme 2.1 Rope or cloth around abdomen or waist

Tying a rope around the waist was found to be the most known practice amongst the three sub-themes that were identified. This sub-theme was identified by 11 participants.

Participant 1 stated:

"they say they put it when the pain starts and they get it from family elders at home. When she's coming to the hospital because she's complaining of the pain, they put on that rope, possible she's in labour. So that the labour goes smooth and fast, and the baby comes out healthy."

Participant 2 stated:

"I always see them also coming with the rope tied under the tummy. Red rope."

"I don't know what that rope is for, but I always see them coming with that rope, but they've never told me."

Participant 3 explained:

"For delivery purposes when you start having contractions, ok they have it I think some throughout pregnancy but immediately when you are in hospital, when you about to deliver, then, they, they will tell you can you please cut it out…. Maybe to protect the baby I don't know."

Participant 6 pointed to it as a church practice:

"I think the Indians, the other ones they have the rope on their waist. Apparently that one is given by the pastor at church…It can be red. Others is green, others it white."

"It's for protection in pregnancy. You only cut it when you are in labour."

Participant 10 also suggested:

"According to their culture their thing is to protect her and protect the baby so because is to protect the baby."

Participant 11 explained:

"*It's, apparently, they're tying your pregnancy so you don't lose your pregnancy, it's to maintain the pregnancy and when you are in labour in order for you to, your labour to progress you need to be cut because some people they will tell you if you don't cut it off, I won't deliver."*

Participant 14 described the practice as one used by traditional healers:

"Others they put eh, what they put in, intambo [rope]."

"Yes, muti there, you see, you see what they believe, they traditional healers what they believe they talk to the muti. Ya that's what they think, they believe that they talk to the muti, do this, and this and this. And then it during labour vuma atete [allow her to deliver]."

Participant 16 stated:

"So, let's say we been having a lot of miscarriages. Other than going the western route, then they do it the traditional route, making you strong for pregnancy. Then when you are in labour you supposed to take it out, if you do not take it out then you become poor progress of labour."

Participant 17 explained:

"Then you put it on it protects you even if there's someone who has cursed you or someone maybe who like, who'll say no your things won't go right, and whatever. I think they believe that maybe with your pregnancy someone can do something and tie a rope so that it will go right. And then when you are in labour, you must put that thing on. Until you deliver and then you can take it off after delivery."

Participant 20 agreed:

"They usually have a traditional band with um, the black people usually have it on their waists."

"It's the same answer to protect the baby, the pregnancy, to protect the baby for the labour to be smooth as well so ya."

Participant 21 also agreed:

"*They tie around their abdomen apparently, and then its connected to, or its attached to a note, apparently that's a note of um, it's like a prayer or apparently it's supposed to keep the woman safe until they arrive at hospital and to enable like safe labour something of some sorts and then when they get to the hospital apparently they, like you take it off, you take it off or they take it off and then it enables labour, so apparently it's like, it's like a hold."*

Sub-theme 2.2 Traditional or elastic band/wool/cloth/rope around the thigh

This sub-theme was also common knowledge and a practice identified by many of the midwives under the theme of knowledge of using traditional rope/band/wool/cloth/elastic band. This sub-theme was identified and discussed by seven participants. Participant 5 was unsure about why it was used.

Participant 4 related her experience of the practice:

"Few day ago, this lady had this, she had tied something on the thigh. And then there was like it was a rope like, elastic band. White ones, these white ones you see them the broad ones…And then there was this thing that was tied inside, wrapped inside into, it was sewn and then I asked her what this is? And then it was medicine inside, I don't know what medicine? And then I, I asked her why? What is it for? She said it's for me to have safe delivery."

Participant 5 described the material used as:

"It's a, a sort of a velvet, velvet material. They make the very nice then they put it around their thigh...They don't say why."

Different cultures were identified by the participants as practising this tradition.

"*Yaa there's something, there's something there, that I don't know what's inside there, inside there, because they make a wool neh? It's a round thingy and then it's like, should I speak Zulu? You see what you put on the babies when they're teething? It's something like that…Yaa so it's something like that but they tie it on their thigh on one thigh…Fasten labour" (Participant 7).*

"Muslim woman. They put a band on the thigh, on the woman's thigh. Yaa, so some they will say it's their husband who removes it after the baby has come out. But some they will say hey, like they, there's one that we had last, said that no anybody can remove it. But there's some of them they say immediately the baby put out the, then the, the, the father must remove that rope on the thigh…Yes, that when the deliver, after the delivery they'll remove that rope and it sometimes have some something that is folded, you don't know what is inside" (Participant 11).

"I've seen Indians when they come during, eh labour. They have this thing, this material tied on their thigh, I've seen that when we deliver them in labour, it's like a, a thin cloth that's tied around their thigh, it looks like it has something inside I don't know what it is if there's something odd inside…I've asked one who said that its culture they never explained" (Participant 18).

Participant 17 explained its significance:

"The cloth doesn't have anything, it's just a cloth, but just because the great-grandmother or the grandmother has made it, I don't know what do, what do they use or what do they do to it? And then she must just put on until…They believe it's protecting them."

Participant 20 also explained its importance:

"When the husband came while she was pushing, she had a black cloth that she, he wanted to tie on the woman's thigh because she said it's for the protection of the baby and also it is to help her bear down because they do not want another c-section."

Sub-theme 2.3 Cloth tied under the breast

This sub-theme emerged under knowledge of using traditional rope/band/wool/cloth/elastic band. This sub-theme was not common knowledge to all the participants and was identified by one participant.

Participant 13 described the practice and speculated about its purpose:

"And the others they tie something, it's as they tie it here (demonstrating under the breast)". "They tie something somewhere as well you know so I don't know where…It's maybe to prevent her from delivering on the way."

3.3.3 Theme 3. Knowledge of prolonging labour using a stone

The tradition captured in this theme is practised by Africans, particularly the Zulu nation, and Indians. It was stated by the midwives that the practice of the stone is used in different ways and maybe for different reasons too. The objectives of the practice include to prolong labour and to give women strength and power to be able to endure it. The sub-themes that emerged from the participants during the interviews were 3.1 Abba the stone, stone around the waist, stone on top of your head and tie the stone in the corner of the dress, and 3.2 Carry a stone on the hand.

Sub-theme 3.1 Abba the stone, stone around the waist, stone on top of your head and the stone tied in the corner of the dress

Four different ways of using a stone were mentioned by the midwives. This sub-theme was supported by four participants, with each participant mentioning a different way of carrying the stone. This indicated that this practice was not common knowledge among the midwives.

Participant 1 spoke about abbaing [carrying something at back] the stone:

"Zulu people when they are pregnant and in labour they don't want to deliver at home. They postpone the delivery by abbaing the stone just above the bum on the lower back and then until they reach the hospital bed where they going to deliver, then they can take that thing off."

Participant 5 spoke about the stone around the waist:

"In the places where the hospital is very far, they give, eh woman the stone to put around the waist so that they mustn't deliver on the road. To delay the labour, until they get into the hospital."

Participant 9 spoke about the stone carried on top of the head:

"When you are, you went into labour let's say you are at home they're still trying to arrange the transport you must be carrying a big stone on top of your head so that you mustn't deliver before you reach the clinic."

Participant 14 spoke about the stone tied into the corner of the dress:

"You put the stone there on the, on the corner of the dress then you tie it the stone then the woman will travel along in the car until she'll reach hospital, without delivering on the way. Then when he, then when the woman comes to the, to hospital then she will take off that, uh, uh stone and throw, we throw it away that she now can deliver."

Sub-theme 3.2 Carry a stone on the hand

This sub-theme was common knowledge amongst the midwives and was supported by three participants, who identified two reasons for carrying the stone in the hand: to endure labour and to prolong labour.

Participant 7 discussed the meaning of carrying the stone as enduring labour rather than prolonging it:

"Ok they carry that stone in their hands. Ok uhm, throughout labour."

"Ok they'll carry that stone; they say the belief is that stone give them strength. And power to be able to, to endure the, the labour."

Participant 10 described the intention of the practice as prolonging labour:

"The patients come with a stone, so the stone is in the hand so as soon as she comes into the admission ward. Having pain, and then she throws the stone down and then we assess her and then when we assess her. She's in labour ya, so I also asked about why the stone, and they said this stone is to prevent her from not getting a delivery like a BBA [born before arrival]."

Participant 18 supported this meaning of the stone by saying:

"So like holding it in the their hand, on their hand they say, let's say they, they don't have transport at home and they ya, having a, a LAP [lower abdominal section] so they believe that if you carry that stone the baby won't come out until you throw it away when you reach the hospital, so they keep that stone with them, and then once they are in the labour ward. That's when they release it, they believe that now the baby, when they release that stone, the baby will come out, it stops them from delivering at home."

3.3.4 Theme 4. Knowledge of eating different things in labour

Knowledge of eating different things in labour was also identified as one of the themes, with different reasons for why this tradition was practised. The following sub-themes emerged during the interviews: 4.1 Eating dates and eating Vaseline; 4.2 Drinking tea or soup; 4.3 Chewing a green stick or branch; and 4.4 You are not supposed to eat liver. These practices were not common knowledge to midwives as they were mentioned by few participants.

Sub-theme 4.1 Eating dates and eating Vaseline

Eating dates and Vaseline was the sub-theme that emerged to help with contractions and delivery. This sub-theme was supported by two participants only.

Participant 13 mentioned eating of dates and the reasoning behind this practice:

"One thing again, that they believe kguri or it causes, causes contractions or smooth, it enhances actually the contractions, it's dates."

Participant 6 spoke about the eating of Vaseline:

"Vaseline. So eeeh she got it from the church, eeeh it was supposed to help her when she delivers that the baby will just come out, it's gonna be easy."

Sub-theme 4.2 Drinking tea or soup

This sub-theme emerged during the data analysis. This practice was identified as mostly practised by church goers, Muslims, Arabs, and Somalians to assist with labour and dilatation, to enhance labour and prevent complications during labour, and for protection from evil spirits. This sub-theme was supported by four participants.

Participant 2 described the use of tea as an herbal medication:

"Immediately when they tell me that they were given tea, then I know that one is herbal medication that was given by church people or the Gogo's [elderly] to help with the labour."

Participant 3 confirmed the idea of tea as a herbal medication:

"Will pray for them and they will drink that tea throughout labour so that they don't have complications throughout labour."

Participant 17 also mentioned the practice of drinking tea:

"They come with that tea, they tell you that, she must drink, she must keep on drinking this tea."

"They say it eh, eh it's going to help them with the pregnancy like eh they're protected and then also with the dilatation that the labour is going to be fast."

Participant 13 spoke about the practice of drinking soup:

"When I was in Saudi, they also do it, they talk about that specifically, yo, but I did not ask what is in it, sometimes it's like, it's like soup'ish."

"It's to allow them to deliver properly. You know it assists with the labour pains and the dilatations."

Sub-theme 4.3 Chewing a green stick or branch

This practice was not common knowledge to the midwives working in the selected hospital as it was identified by only one participant, Participant 6, who stated that:

"It's like a branch of a tree. It's green in colour. They chew it when they are in labour."

"They get it from the African countries, the Ethiopians they will tell you that they brought it from Ethiopia."

"It will help them to dilate."

Sub-theme 4.4 You are not supposed to eat liver

The sub-theme you are not supposed to eat liver was not well known to the midwives working in the selected hospital and was supported by one participant only. In fact, this participant was also unsure of why eating liver should be avoided.

Participant 18 stated that:

"I don't know if they associate it with the placenta or something, but they say you not supposed to eat liver or maybe it delays your labour. I don't know because liver eh, it has iron and it's important for pregnant women so."

3.3.5 Theme 5. Knowledge of different types of clothing

The theme of knowledge of different types of clothing emerged from the midwives. Different types of clothing are used mostly to ease and hasten labour. The following sub-themes emerged from the interviews: 5.1 Babies' clothes to be hidden during pregnancy and taken out when in labour; 5.2 Putting the cloth on the floor to deliver; 5.3 Untying partner's shoes and belt; and 5.4 Wearing clothes of person who had quicker labour. These sub-themes are presented below and supported by direct quotations from the participants.

Sub-theme 5.1 Babies' clothes to be hidden during pregnancy and taken out when in labour

This sub-theme was not well known to the midwives, and it was mentioned and described by one participant only.

Participant 9 stated:

"Those old people they don't believe in buying of cloth before baby comes, if you buy the clothes before time, they used to hide on top wardrobe so that you can't see it, but during intrapartum labour, they must take it out because if they leave it there on top which means they're going to prolong the labour, it's going to take long which means that person it's not going to get to delivery."

Sub-theme 5.2 Putting the cloth on the floor to deliver

This sub-theme also emerged from knowledge of the different types of cloth or clothing and was supported by two participants as a Malawian practice used to prepare for delivery. It was not common knowledge to the other midwives.

Participant 4 stated that:

"Where, where eh they deliver, they put something, the cloth on the floor and then they deliver and then eh I once heard another sister, she said something one of those they came from the bench, put the cloth and lay on there and then pushed in front of everyone."

"When we see them doing that, we, we know that it's either she's in advanced stage and/or she's fully dilated without saying anything."

Participant 18 spoke about Malawian women in particular:

"*I've seen my, with Malawian ladies once they feel that the baby, they're bearing down, the baby's coming down. They'll always like, they will lie on the floor wherever they are, especially the floor, I've never seen them going to the bed, they will take one of those cloths, those colourful cloths. That they always have and then they put, they put it on the floor and then they start bearing down on, on that cloth, so I don't know if it's the way, it's their culture or it's the way they've been socialised that if you feel that the baby is coming, you need to place something on the floor and then push the baby there I don't know."*

Sub-theme 5.3 Untying partner's shoes and belt

Untying the woman's partner's shoes and belt was identified as one of the sub-themes under the knowledge of different clothing for easy labour and to prevent a prolonged labour. This sub-theme was supported by two participants.

Participant 8 stated that:

"And then there's this one, I think this one is like old black people uhm your partner they must untie their shoes or untie their belt to help with the easy passage of the baby."

Participant 17 supported this view by saying:

"Then the others they, with that one also they say even if eh, it can also affect your labour, can be long if the husband also maybe is um, maybe there, eh he has a belt on, he must take the belt out."

"Yes, the belt out even the, the shoelaces they believe the shoelaces must also untie."

Sub-theme 5.4 Wearing clothes of person who had quicker labour

This sub-theme was also not common knowledge as it was supported by one participant only.

Participant 18 stated that:

"Other cultures they believe that if you want your labour to be quicker. Eh you must wear clothing of someone that had eh quicker eh, eh labour as well. Someone in the family who, who has told you that during her, her delivery. She was quick to deliver the baby, so they borrow you a, a piece of clothing and then you must wear it, and then they believe that your pregnancy, your labour as well will be quicker."

3.3.6 Theme 6. Knowledge regarding protection/calmness/prevention of preterm labour and caesarean section, and safe delivery

The participants revealed knowledge regarding protection/calmness/prevention of preterm labour and caesarean section, and safe delivery, where patients used different herbs and water in many ways to achieve these states. The use of water in different ways was especially common knowledge to the midwives. The following sub-themes emerged under this theme during the interviews: 6.1 Using holy water, prayed water, prophet water, church water and ichibi (water from Ushembe church), and 6.2 Lying facing east, and inhaling impepho (herb) and uphunyuka bamphethe (herb).

Sub-theme 6.1 Using holy water, prayed water, prophet water, church water and ichibi (water from Ushembe church)

The practice that emerged as this sub-theme was the most widely known by the participants, who identified different ways of using water. Using holy water, prayed water, prophet water and church water was supported by 11 participants.

Participant 1 spoke about prayed over clear water with a cut-off piece of white cloth in it and prayed over, holy water. She stated that:

"It's clear water, then there is some cut of the cloth, white cloth, they say it was prayed for by the prophet and then they said as soon as the labour starts, they must start by drinking that water so that the labour is fast."

"When or during labour when pain peaks like it's a peak, they drink that holy water, they said it's to reduce the pain and is to calm them."

Participant 4 spoke about prayed over water with ash and prayed over water with a newspaper that is bent. She explained that:

"Prayed water, they pray, its only clean tap water…And then, the pastor will pray for that. Ya and then others they take ash. And then they put ash in the, in the water."

"And then there's this other church where they bend a newspaper. Then they add on the prayed water also."

"It's just for protection during labour."

Participant 7 described the use of church water:

"Some of them will have water, they'll tell you it's holy water, that they drink, uhm they'll have their squeeze bottle with some things, with some things inside. You know when you ask them, they'll tell you no-no, this was given to me."

"So, they will tell you it was given to them by their grandmother, by the pastor you know to fasten. The action is the same. I drink this to make sure that labour goes quickly and faster, I don't feel pain."

Participant 9 agreed that holy water was used but was unsure about the reasoning behind it:

"I just heard about the holy water even the holy water I'm not sure about it, it's like isihlambezo I'm not sure."

Participant 10 spoke about church water, explaining that:

"*Then there's another one which they called um church water, the church water it's now um this new churches it's not normal churches that we attend, this new churches that uh came up where people, the pastor said she must drink it, it's a litre, it looks clear I don't know, does the pastor pray on it because they said the pastors just give it, they don't know what is it."*

"*Ya, they want to have a normal vaginal delivery, so this is the things that will assist them not to be cut."*

"*Even with the Muslims they also having the water to drink…So that nothing must happen she mustn't give birth before time."*

Participant 12 spoke about women being given warm water mixed with ashes to drink (as a Zulu tradition) and ichibi mixed with water to drink (from Ushembe Nazareth Church):

"They rub your tummy with the, those ashes and they also take warm water and put those ashes then you drink, it's, it's said to be it helps makes labour to go fast so that when you go to the hospital you can just deliver."

"Ichibi I don't know what's inside there but it's they believe that it's, it's, they use, you take water from the tap that, and they put this ichibi thing, I don't know what it is…I think it's a plant which is mixed, maybe they boil the water first because it's just clear water then they mix with the tap water then they give you'll drink that water, when your labour starts. Until you deliver."

Participant 14 spoke about consulting a prophet from the church to obtain prayed water:

"She's attending clinic, she's attending this prophet, the clinic will tell her OK do, the, they've done all the tests, the pregnant tests, urine, they take urine. And then immediately she knows that it's because I'm pregnant now she'll go to this woman maybe as early as three months until she delivers...The delivery will be easy."

Participant 16 spoke about prophet water, others with holy ash added:

"I know people that also use um prophet, prophet water…You start drinking it before labour, but they do give it to you whilst you are in labour…It's just plain water, others put holy ash, yes, it's it speeds up the process of labour then others use it for protection…they believe…"

Participant 18 suggested about holy water that:

"It's just prayed water, it's their religious practice that it will help you with your, your delivery so that everything goes well."

Participant 20 described an encounter she had had with a patient regarding holy water:

"She said no please wait I need to drink this water, that's when I asked what is that water? she said no its just holy water its prayed for I guarantee you they didn't add anything into it, so I just need to um drink the water so that my baby can be fine and I'm going to push nicely so she did push and she didn't even take time."

Participant 21 spoke about church water but did not provide a reason behind it.

Sub-theme 6.2 Lying facing east, inhaling impepho (herb) and uphunyuka bamphethe (herb)

The practices included in the second sub-theme of the theme of knowledge regarding protection/calmness/prevention of preterm labour and caesarean section and safe delivery were not well known to the midwives. Only four participants mentioned them.

Participant 1 mentioned about lying facing east that:

"They say she must face the east when she's in labour until she delivers…They say as long as they see the sun coming that way. To them it's the east, then there must look at the sun, they must face the sun…They say it's for [stuttering] the baby to survive if in labour. Because if they face away from the sun the baby is going to die."

Participant 4 spoke about burning impepho and inhaling the smoke (as a Zulu tradition). She stated that:

"Impepho, a traditional herb that is burned and you inhale it. Yes, most of them when they come, they'll tell you that they burnt impepho for them to inhale…It's, it's for, to take evil spirits away. And then, I think for me it's like they want the woman to have safe delivery."

Participant 12 spoke about uphunyuka bamphethe that:

"What else I've seen, I've seen also phunyuka bamphethe but ai, on one patient, that patient in labour ward…They said they, they were for protection in labour it helps with the dilation."

Participant 19 spoke about lying in a position to face the direction of the rising sun. She stated that:

"We usually ask they patient to lie on the left side when we are nursing them for transportation of the blood to the foetus, ya but that one um apparently she said that she would like to lie in a position where the sun is rising from…That was the first one that I've never heard of because she believes that um, it's like with sunrise, it opens up everything, brightens your days, so hopefully the labour itself would go well."

3.3.7 Theme 7. Knowledge of praying

Whether related to religion or cultural practice, this theme emerged as one of the traditional practices that the midwives had experienced and had knowledge about. While only three participants had experienced these practices and had knowledge of them, it was still one of the identified practices that patients believed in. Only three sub-themes emerged as part of this theme: 7.1 Praying during contraction; 7.2 Prayed bathtub; and 7.3 Ukuphahla (speaking to ancestors).

Sub-theme 7.1 Praying during contractions

This sub-theme was not common knowledge among the midwives and was supported by one participant.

Participant 14 mentioned this practice by saying:

"It's their prayer ya because I can't hear what they are saying. 'wara-wara' you see during contractions until she delivers…It's their belief that if they pray this prayer. It will, it will eh, eh, eh help this contractions aid and it will speed up this eh, eh, eh intrapartum thing. So that, the, the woman will deliver."

Sub-theme 7.2 Prayed bathtub

This sub-theme was not well known to the participants and was supported by one participant.

Participant 16 mentioned this practice by saying:

"Others bakufaka amabhavu, so when labour starts…They put your bathtub, pour you with water, pray for it, then it's supposed to speed up process of labour."

Sub-theme 7.3 Ukuphahla (speaking to ancestors)

This last sub-theme that emerged from the theme of knowledge of praying was also not common knowledge among the midwives and was supported by one participant.

Participant 16 described this practice, by saying:

"Others bayaphahla, they speak to their ancestors…They speak to the ancestors, they pray and speak to the ancestors so that they open the way for them."

3.3.8 Theme 8. Knowledge of the do's and don'ts when in labour

This theme was the least known to the midwives in the selected hospital, with most sub-themes identified being mentioned by one person only. One theme was mentioned by two participants (Sub-theme 8.2) and one by three (Sub-theme 8.8). Sub-theme 8.9 was identified by four participants. The sub-themes that emerged from the interviews are outlined below, supported by direct quotations from participants. The sub-themes that emerged as part of this theme were: 8.1 Women not to be assessed by male health practitioner; 8.2 Don't tell people that you are pregnant and when in labour; 8.3 Don't stand by the door; 8.4 No crying when in labour; 8.5 Men/partner not to be around during labour; 8.6 No eating during labour; 8.7 No shade of someone when drinking these things; 8.8 No plaiting/braiding hair; 8.9 The do's: Doulas, tshitanga (keeping room warm), squatting/kneeling birthing position.

Sub-theme 8.1 Women not to be assessed by male health practitioner

This sub-theme emerged as part of the theme of knowledge of the do's and don'ts when in labour. It was generally not common knowledge and was supported by one participant, Participant 17, who said:

"I don't know what the reasoning is, but with their culture they're not allowed to be seen by another male naked, except the husband."

Sub-theme 8.2 Don't tell people when you are pregnant and when in labour

This sub-theme was not common knowledge and was supported by two participants.

Participant 7 stated that:

"One of the commonest cultural belief is that once you become pregnant you don't, pregnant, you don't tell anybody that you're pregnant, so that the labour progresses smoothly, so that your pregnancy progresses smoothly, and your labour progresses smoothly."

Participant 8 also spoke about not telling people when in labour. She said:

"When you are in labour this is Tsonga people when you are in labour you shouldn't tell people, like you should keep it a secret cause if you tell too many people then they feel like those people give up like that energy then you won't be able to progress like it'll bring negative vibes."

Sub-theme 8.3 Don't stand by the door

This sub-theme emerged as part of the theme of knowledge of the do's and don'ts when in labour and was generally not common knowledge, being supported by one participant, Participant 8, who said:

"Yaa don't stand there by the door post, she must be inside. You won't progress if you are standing by the door post."

Sub-theme 8.4 No crying when in labour

The sub-theme of no crying when in labour was also supported by only one participant, Participant 17, who explained:

"And then the reason they are saying it, once you cry, with your, your first baby you'll always cry with all your other babies. That's a belief, when your first baby then thing that, the things that you will do with your first pregnancy, it's going to continue with all the other pregnancies."

Sub-theme 8.5 Men/partner not to be around during labour

This sub-theme was supported by one participant, Participant 13, who gave the reason for the practice as being:

"They feel that they don't want a husband to see them during labour and they, the husband, will not see them the same way as before, the same way they know them before labour, something like that."

Sub-theme 8.6 No eating during labour

This sub-theme emerged as part of the theme of knowledge of the do's and don'ts when in labour, although it was generally not well known and was discussed by one participant. While not eating during labour may be the result of a loss of appetite due to contractions or labour, Participant 3 had had encounters with patients who had specific beliefs connected to eating during labour. She stated:

"Oh, and then some people don't eat cause then they believe that. They believe that eh, when you deliver, you'll pass faeces and that will bring bad luck to the baby."

Sub-theme 8.7 No shade of someone when drinking these things (traditional medicine)

This sub-theme was relatively unknown among the participants and was described by one participant, Participant 17, who stated:

"There are things that you are told like the rules when you're drinking it, it's not, it doesn't have to, the mustn't be shade of someone before you drink it because that shape, like the spirit of that person, if it's someone that doesn't like you and then your things can go wrong during labour."

Sub-theme 8.8 No plaiting/braiding hair

Three mentioned sub-theme under the theme of knowledge of the do's and don'ts when in labour as it was supported by three participants. Midwives in the selected hospital strongly believed that the women really believed that if this practice was not followed it would obstruct and prolong labour.

Participant 6 mentioned that:

"Because uhm plaiting hair it makes you tight so I don't know the plaiting affects the cervix if you have plaited it means the baby won't come out so that is why sometimes you find others, they un-plait their hair when they are in labour."

That the hair must be unplaited was also supported by Participant 7:

"You must not plait your hair when you're in labour or when you, you about to start labour because that will make labour not to progress smoothly if your hair's plaited."

Participant 17 referred to the unplaiting of the hair:

"Yaa, you don't have to do such things you must, your hair must be just free and then they believe that if um you do your hair, it's like you are tightening your, your cervix you…it's going to take long. Hence that the ones that maybe at times they see that I'm in labour, but it's been too long I'm not, delivering you'll find them taking this things out."

Sub-theme 8.9 The do's: Doulas, tshitanga (keeping room warm), squatting/kneeling birthing position

This sub-theme emerged as part of the theme of knowledge of the do's and don'ts when in labour and was generally common knowledge as it was supported by four participants.

Participant 13 mentioned about the doulas:

"The only good thing is about doulas that's the one I can think of. They ease our job a lot. And they respect us, you know. Yes they know, this is a midwife, I'm just a doula. They're able to advise the, the patient according to what you've said or what you've taught them at that moment or educated them at that moment."

Participant 4 mentioned the tshitanga (keeping the room warm):

"Yaa, they make fire preparing for the baby. Yaa, so that when the baby comes eh, it's warm. And then they make noise so that people cannot you know here when the woman is screaming."

Participant 4 also spoke about the squatting/kneeling birthing position. She said:

"Yaa they, they, they do that and then, their, their tradition in fact most of the blacks they squat when they deliver. Squatting, even here you'll see them squatting. They were told they supposed to do that."

Participant 13 described the squatting position by saying:

"The ladies from Malawi will prefer to squat...That's one thing I've noted as well, it's a traditional practice from where they come from so, they're practising it here as well."

Participant 14 described her experience with women choosing the kneeling position by saying:

"The others they like, eh to say I will kneel down and give birth. And then now we here be using bed. You see. So, eh even if the women can kneel, but we, we, we want eh like here we are using when the women are in a lithotomy position."

Participant 20 had experienced patients who chose to use the squatting position. She recounted:

"They will give you a hard time getting into bed and push in a dorsal position, whatever position you would want them to push in, but um most of them really believe in just keeping quiet behind the curtains or just on the floor basically and just push while they are squatting, that's what I have seen. Um also…"

"And she said that's how we are doing it at ekhaya [home] and that's how they do it at home, wherever they come from, but she was from Mozambique, a Malawian I've never asked, cause most of our Malawian patients are actually language barriers, hence they always just keep quiet and do their own thing."

3.4 CONCLUSION

This chapter outlined the study findings. The findings were presented and discussed according to the themes and sub-themes that emerged from the data analysis and were supported by direct quotations from participants.

The next chapter presents a discussion of the results and their interpretation.

CHAPTER 4: DISCUSSION OF RESULTS, INTERPRETATION AND LITERATURE CONTROL

4.1 INTRODUCTION

The previous chapter presented the results of this study. In this chapter, the results are interpreted and discussed. The results of this study provided an opportunity to explore the knowledge of midwives regarding traditional practices used during the intrapartum period in a selected hospital in Gauteng. The eight themes and their sub-themes identified and presented in Chapter 3 are elaborated on in this chapter and relevant literature used to explore these themes. Section 4.2 presents this discussion and is divided into sub-sections according to the themes as follows: 4.2.1 Knowledge of practices that facilitate or hasten labour; 4.2.2 Knowledge of using traditional rope/band/wool/cloth/elastic band; 4.2.3 Knowledge of prolonging labour using a stone; 4.2.4 Knowledge of eating different things in labour; 4.2.5 Knowledge of different types of clothing; 4.2.6 Knowledge regarding protection/calmness/prevention of preterm labour and caesarean section, and safe delivery; 4.2.7 Knowledge of praying; and 4.2.8 Knowledge of the do's and don'ts in labour.

4.2 DISCUSSION ACCORDING TO THEMES

4.2.1 Knowledge of practices that facilitate or hasten labour

The first theme of this study concerned knowledge of practices that facilitate labour. This was the most common knowledge revealed by midwives as indicated by the direct quotations of their opinions expressed in the interviews. These results revealed that the midwives working in the selected mother and child hospital in Gauteng were aware of the traditional practices used during the intrapartum period to facilitate or hasten labour. However, most of them had no knowledge of the ingredients of the herbal medications that their patients drank during the intrapartum period.

Five sub-themes were identified as part of this theme: Isihlambezo or imbita; umchamo wemfene (monkey's urine); ostrich egg; isivimbampunzi (snake onion) and ugobho (Gunnera perpensa) and enema/castor oil/laxative. Most of the participants agreed that they discouraged the use of isihlambezo, umchamo wemfene, isivimbampunzi, ugobho and enema, castor oil or laxative owing to their unknown ingredients, unknown dosage and/or the potential side effects arising from the consumption of these concoctions. Hence, they described most patients hiding these herbal medications from them or taking them before

coming to the hospital. These results also revealed that the patients did not know the concoctions used in these traditional practices; they drank them because they had obtained them from sources that they trusted, which were their elders. These medications had been passed down from generation to generation via family members, traditional doctors and TBAs.

Isihlambezo or imbita

The first sub-theme related to the use of isihlambezo to facilitate or hasten labour. Isihlambezo is a TM that is generally used to hasten or facilitate labour and is one of the traditional concoctions passed down through generations. Even though most of the midwives did not know its exact ingredients, they believed it to be sold by traditional healers to the pregnant women themselves or to family elders. It was also believed that some family elders may have knowledge of its ingredients. The midwives considered that the ingredients used varied according to different ethnic groups in South Africa and different countries.

The midwives believed isihlambezo to be made in different ways and from different ingredients, ranging from standing water that results when a river overflows its banks, to umchamo wemfene, ostrich egg, ashes from fire, elephant dung, herbs, umhlonyane [African wormwood], and animals such as snails. They also pointed to differences in the ways that the pregnant women took this TM, with some taking it throughout the pregnancy to prepare for childbirth, until after delivery, and others taking it from the beginning of labour until childbirth. Even the dosage differed. Twenty participants out of the sample of 21 believed isihlambezo to be a dangerous concoction drunk by pregnant women based on their experiences and they strongly believed that it should be discouraged.

Maroyi (2021: 1182) states that isihlambezo is a herbal medication that is made from the roots of different types of herbs, such as G occidentalis and Agapanthus Africanus. The medication is used to augment labour, induce labour and as a postnatal medication to expel the afterbirth. Even though most midwives discourage the use of this concoction, there are some midwives who encourage the use of isihlambezo as they believe that if it is used correctly, it may have positive results, this came out during the interviews with the midwives

Kekana and Sebitloane (2020: 71, 74) also identify isihlambezo as a popular Zulu concoction made from various plants such as Clivia miniata, Agapanthus Africanus and Typha capensis to assist in the delivery of a healthy baby. In evaluating its safety, these authors point that in this study they found that patients who used isihlambezo had a higher prevalence of meconium-stained liquor, perinatal mortality and increased number of caesarean sections. However, the study showed that labour came early for the users with no need for induction of

labour and the duration of the first stage of labour and second stage of labour were reduced. Isihlambezo has more than 60 plants used as ingredients, with the Rhoicissus tridentate plant responsible for fatalities such as central nervous system (CNS) depression and respiratory failure (Siveregi & Ngene 2019: 6-7).

Ramulondi, De Wet and Ntuli (2022: 71) explain that the imbiza [Zulu word, same as in imbita which is SiSwati language] decoction (herbal mixture) was also reported to be used by patients in a study conducted at the Bertha Gxowa Hospital (Gauteng Province) for a quick and easy delivery by inducing labour and protecting the baby against witchcraft and evil, and to prevent complications, decrease swelling and drain water, decrease labour pains and clean the womb.

Umchamo wemfene / Monkey's urine / Moruto wamfene

The second sub-theme was the use of umchamo wemfene [in zulu language] / monkey's urine or moruto wamfene [in Sotho language] to facilitate or hasten labour. This is a herb that is dissolved in water and given to pregnant women to drink from as early as 28 weeks until childbirth. Pregnant women buy it from traditional healers or traditional shops or are given it by family elders. This sub-theme was mentioned by eight participants, some of whom associated it with isihlambezo while others believed that one might be an ingredient of the other one.

As with isihlambezo, most participants also did not know its ingredients and associated it with serious adverse effects such as foetal compromise and uterine hyper-stimulation. They therefore believed that it should be discouraged. Some participants believed that isihlambezo and umchamo wemfene were one thing and that they both had the same effects on the pregnant women, maybe because they were both used to speed up the progress of labour.

Siveregi and Ngene (2019: 6-7) address both isihlambezo and umchamo wemfene, stating that these TMs bear other names and may vary in method of preparation. These authors suggest that there is a paucity of data about their constituents, safety and efficacy. There is also concern that they may cause adverse pregnancy outcomes. They present a case of an 18-year-old who started drinking moruto wamfene from 28 weeks of pregnancy. She bought this mixture from a herbal pharmacy to protect her from evil spirits during pregnancy, prepare her for labour and promote foetal wellbeing, and it was administered by her mother. However, it resulted in adverse pregnancy outcomes such as uterine hyper-stimulation and foetal compromise. Ramulondi, et al (2022: 72) point to other ingredients in TMs, such as in the Xhosa culture where women consume horse womb during pregnancy to protect the mother and unborn baby and also drink baboon urine to help ease the delivery.

Ostrich egg

The third sub-theme under this theme was the use of ostrich egg to facilitate or hasten labour. Even though this sub-theme was mentioned by four participants, it was not common knowledge among participants. Some midwives have revealed that ostrich egg has been used as an ingredient in other concoctions that are used to facilitate, hasten, or induce labour.

The participants stated that the ostrich eggshell contained Pitocin and that patients crushed the inside of the shell, which contained the Pitocin, mixed it with water and drank it to facilitate or hasten labour. Some midwives believed the ostrich egg to be an ingredient of isihlambezo. Participants believed that the ostrich egg, isihlambezo and umchamo wemfene all had the same effects on pregnant women during childbirth and should all be discouraged. The results of this study do indicate that all three TMs are interrelated.

Participants also gave as a reason for women opting to use TMs such as isihlambezo, monkey's urine and ostrich egg that they intended to avoid a caesarean section. It is evident that TMs that contain Pitocin have the required effects, as Pitocin is given to augment labour in health institutions.

Shewamene, et al (2017: 8) discuss a concoction called kgaba that is mixed with ostrich eggshell, baboon urine, mud and ashes of burned herbs and is used during pregnancy and labour to protect against evil spirits and induce labour. Peters, Logan, Sneed and Pathak (2021: 5) state that some women prefer home delivery to avoid caesarean sections, owing to the cultural belief that a woman who delivers through caesarean section is weak, lazy and lacking faith and is regarded as a reproductive function failure.

Isivimbampunzi (snake onion) and Igobho

Regarding isivimbampunzi, the participant who identified this practice in her interview stated that this plant is mixed with water and given to a woman when she is about to give birth to hasten the arrival of the baby. The practice was identified as used mostly by the Xhosa nation and as given to women who had experienced childbirth before. Women expecting a child for the first time were given a stone to carry instead, as complications arising in a first delivery could not be predicted.

Isivimbampunzi is the Xhosa vernacular name for a plant that falls under the family of Alliaceae that is also used for different ailments such as an enema for stomach ailments and orally to

treat coughs or lower blood pressure (BP). It is also planted to keep snakes away. Zulu people of Kwa Nongoma eat both the flowers and the leaves as spinach (Mhlongo 2017: 292).

G. perpensa (igobho) has long been used in TM by different ethnic groups in southern Africa to initiate labour, ensure easy childbirth and reduce labour pains, and facilitate the expulsion of the placenta and clearing of the womb after birth in both women and animals. As such, G. perpensa is an important ingredient in at least three traditional concoctions in South Africa – imbiza ephuzwato, inembe and isihlambezo (Ramulondi, et al 2022: 72). Mhlongo (2017: 241) states that G. perpensa or igobho is used after birth to cleanse the abdominal area, with Ramulondi, et al (2022: 72) finding that G. perpensa (igobho) was also reported to be used to induce or augment labour and as an antenatal medication to tone the uterus.

The participant who identified this TM stated that this is a herb that is mostly used by Zulu people, who give it to women who have had a miscarriage to empty the uterus and to expel clots. In addition, some women use it for termination of pregnancy (TOP).

During the intrapartum period, some women drink the mixture when the pains start so that they can speed up labour, but this can lead to foetal distress, and can cause toxicity, increase BP, cause hyper-stimulation that may lead to uterine rupture, especially to multiparas, and can result in post-partum haemorrhage, one midwife stated. The participant explained that women normally buy the TM from traditional stores but that as it is harmful to the mother and the unborn child, these stores are also very strict when they must sell it, with potential buyers normally thoroughly interviewed to establish their reasons for buying it.

Several studies have been conducted about the use of herbs to hasten labour. Ramulondi, et al (2022: 69) further mention other herbs that are used to facilitate labour such as imbiza (herbal mixture) to speed up labour, umkhawulagazi (bridelia cathartica G. Bertol leaves) which is boiled and to be drank to clean blood, relief pain during pregnancy and stop blood flow after giving birth and umthombo (cissampelos torulosa E. Mey. ex Harv) which detaches the baby from uterine wall and reduces labour pains.

Enema / Castor oil / Laxatives

The last sub-theme mentioned under the first theme was the use of an enema to hasten or facilitate labour as one of the practices mentioned by the participants. Even though use of an enema has been discontinued in western medicine in the management of the intrapartum period, as part of tradition it is still used often during this period by the women themselves and sometimes at the advice of TBAs and family elders.

Five midwives mentioned the use of enema, castor oil and laxatives for facilitating childbirth. Different reasons were offered by the midwives for their use. They believed that patients used an enema to clean their rectums before childbirth to avoid passing faeces during childbirth as this was associated with bad luck for the child. The patients also believed that once the rectum was empty, this would help the baby's head to go down and then labour would not be prolonged. Using castor oil or a laxative they believed would stimulate the rectum and hence the labour process.

Aziato and Omenyo (2018: 8) report on the traditional practice of preparing an enema solution using herbs when a baby is due but delaying. The woman is given an enema and after five minutes the baby will come out. Pregnant women are also given herbal preparations believed to be diuretics if TBAs believe that there is more water around the child than there should be. These diuretics are aimed at making the woman urinate so that the child can turn. Shewamene, et al (2017: 4) also point to the traditional use of laxatives and castor oil by pregnant women to facilitate labour.

4.2.2 Knowledge of using traditional rope/band/wool/cloth/elastic band

The participants also revealed a knowledge of using traditional rope/band/wool/cloth/elastic band. They identified that rope could be used in many ways and put anywhere on the body but the reasoning behind it was always the same. Rope came in different forms and was sometimes wrapped in muti. In childbirth it was aimed at the protection of the mother and the baby, safe delivery, and quick labour, but rope was also used for the protection of children and adults generally. Three sub-themes were identified: rope or cloth around the abdomen or waist, traditional or elastic band/wool/cloth/rope around the thigh and cloth tied under the breast.

Rope or cloth around abdomen or waist

The first sub-theme under this theme was rope or cloth around the abdomen or waist. Use of a rope or cloth around the waist was identified as the most common practice out of all the ways that rope was used. This sub-theme was supported by 11 participants. The two ethnic groups identified as using the rope for different reasons were Africans and Indians. The rope was seen as being used throughout pregnancy, during childbirth and also immediately after birth as protection to the unborn child. Traditional bands were also identified as used all the time as a protection even outside of pregnancy.

The participants spoke of variations in the practice, with some stating that a rope was worn throughout the pregnancy until the woman delivered. Other participants explained that the rope was removed before childbirth because if it was not removed, it would lead to prolonged labour, while a further practice cited was that the rope would be removed after childbirth because if it was removed before childbirth, the protection of the mother and the baby would be lost.

The ropes took different forms and came in different colours – with some twisted together and others taking the form of a cloth – depending on the practices of the family elders, church leaders or traditional healers from whom they were obtained. The reasoning behind this practice is generally for the protection of the mother and the baby against evil spirits during pregnancy and labour, to prolong labour until they reach the health institution and to make sure that the labour goes quickly.

Honkavuo (2021: 381) states that as part of culture and belief for Zambian people, pregnant women are expected to meet with the traditional healer during the first three or four months of their pregnancy for the protection of the mother and the baby and the whole pregnancy from evil spirits, from premature labour and all other complications related to pregnancy and labour. The traditional healer performs a ritual that involves praying and then places a traditional waistband around the waist of the pregnant woman. Thereafter, the woman can face any pregnancy-related problems. During the ritual, the traditional healer uses chanting. Traditional bands are common, especially with Africans and Indians, and are mostly used for protection. When used in pregnancy and childbirth, they are used for the protection of the mother and the baby against evil spirits and to enable the mother to endure labour.

Cheboi, Kimeu and Rucha (2019: 9) also agree that pregnant woman wears special necklace, laced with charms for protection of the mother and the baby from evil spirits and that the necklace is removed during intrapartum as soon as the woman experiences labour pains to allow the woman to give birth. It was also reported that some women wear beads and head bands for protection throughout pregnancy.

A further study confirmed that these traditional bands are used not only in pregnancy. In their study in rural Zambia, Buser, et al (2020: 5) report that during childbirth one woman stated that they forced the mother to push or maybe tie a chitenge (traditional fabric) material around her waist and then pulled it so that she gave birth quickly.

Some women do not believe in TM but instead in religious practices. In their study, Thipanyane, Nomatshila, Oladimeji and Musarurwa (2022: 6) found that some women believed in prayers and holy water instead, with one woman stating that one could get a cord

that had been prayed for from St John's church, for pregnant women to tie around their waists. Other women in their study reported getting a cord made from wool from faith healers or herbalists, depending on what they believed.

Traditional or elastic band/wool/cloth/rope around the thigh

The second sub-theme was traditional or elastic band/wool/cloth/rope around the thigh. The results showed that the reasoning behind this practice was the same as for placing a rope around the waist.

The participants stated that their patients tied a rope around their thigh for labour to go smoothly and fast and so that the baby would come out healthy; to protect the mother and the baby; to have a safe delivery; to prevent evil spirits during pregnancy, labour, and delivery; and to make the labour go quickly. Different participants stated that the rope was to be cut or removed when in labour or after childbirth. Those who said it should be removed when in labour argued that if it was not cut, the baby would not come out, while those who said it should be cut after childbirth said that if it was cut before childbirth, the mother and the baby would lose the desired protection. This sub-theme was described by seven participants.

The research consulted revealed that a rope or band is commonly used during childbirth in different ways according to the cultural traditions of the people using it. In the Navajo culture, use of rope or sasha belt is thrown over tree limbs and placing this sheep wool allows the mother to pull on something as she is giving birth and bearing down (Peters, et al 2021: 4). In Gamlin's (2020: 6) study, a Nayeli woman describes how she was assisted by her husband when she gave birth; she crouched down holding on to a soga (rope tied from a beam in the ceiling) and her husband caught the baby and cut the umbilical cord.

Cloth tied under the breast

The last sub-theme is the practice of tying a cloth under the breast. This practice was the least known by the participants as it was mentioned by only one participant. She stated that it is used to protect the woman from delivering while travelling to the health institution. While ropes are tied around different body parts, they are generally used for the same reason. The practice of tying a cloth under the breast presents the only different use of the rope. As this practice is used to prolong the delivery until the woman is in a safe health institution, it means that when she arrives at the institution, the cloth should be removed because it is now safe for her to deliver. It has served its purpose.

Naanyu, et al (2018: 86) explain that many women choose to deliver in inadequately equipped clinics owing to health institutions, especially those that are well equipped, being too far away and their mode of transportation being inadequate. This increases health risks for the mothers and their newborn babies. The practice of prolonging labour by tying a cloth under the breast until they arrive at the health institution does not pose a risk to the mother and the baby; instead, it is beneficial to both.

Many studies has been conducted regarding women experiencing inaccessibility of health care centres when it comes to pregnancy and childbirth. Some women even loose their lives and babies due to inaccessibility especially in rural areas where transportation is the problem or healthcare centres are very far. So practises such as this to prolong labour until they reach healthcare institution should be encouraged to save lives of the women and their babies.

4.2.3 Knowledge of prolonging labour using a stone

The third theme of this study concerned knowledge of prolonging labour using a stone. This tradition was identified as being practised by Africans, particularly Zulu people, and Indians. It was stated by the participants that the practice of the stone was used in different ways and maybe for different reasons too. Two sub-themes were identified: abba (carry at the back) the stone, stone around the waist, stone on top of your head and the stone tied on the corner of the dress; and carry the stone in the hand. While the practices of using the stone are slightly different, they are all used to prolong the delivery. This is the safest traditional practice identified, as no herbs of unknown origin and amount are used, and no TM is orally consumed.

Abba the stone, stone around the waist, stone on top of your head and the stone tied in the corner of the dress

This was the first sub-theme identified and was mentioned by four participants. The participants stated that this practice was mostly used in rural areas where they experienced transport system problems, so they used this practice to prolong labour to avoid the woman delivering on her way to hospital before she reached the health institution. The results showed that all the practices regarding the stone, while they may be carried out in different ways, have the same purpose, which is to avoid delivering on the way to the health institution for childbirth. As soon as the women arrive at the institution, they throw away or release the stone because now that they have arrived, they can deliver. If the stone is not released when they arrive at the health institution, the labour may continue being prolonged.

Peters, et al (2021: 4) write that in South Africa to decrease the mortality rate, the healthcare system is free for pregnant women. Despite this, more than 80% of people from Sub-Saharan

countries still use TM rather than attending healthcare facilities. This disparity in healthcare facility attendance could be attributed to barriers such as distance or cost in the form of time. For this reason, the practice of using the stone to prolong labour is considered beneficial to prevent complications that may occur before the woman in labour reaches a health institution. Seopa (2021: 78) state that pregnant women protect themselves from evil deeds with several sayings, wearing a talisman, blackening the face, wearing amulets with prayers inside, and carrying various minerals, glass, stones, or seeds and grains, such as black sesame seeds. It is evident that the use of stone can be used in many ways to protect the pregnancy and child birth either than prolonging labour.

Carry a stone in the hand

The last sub-theme under this theme was to carry a stone in the hand. Three participants mentioned this sub-theme. Two of the participants that brought up this sub-theme provided the same reason as for the first sub-theme – to prolong labour. Only one participant gave a different reason. This midwife stated that a stone was carried in the hand throughout labour to endure labour and to give the women strength and power until childbirth. To give her strength until childbirth, the woman had to make sure that she kept the stone in her hand and did not lose it; otherwise, the purpose would be lost. This practice is safe as it does not put the woman and the unborn child at risk. Withers, Kharazmi and Lim (2018: 165) agree that women in labour need strength to endure childbirth. They refer to two studies from Nepal that describe women drinking cumin seed soup and glucose water to gain strength for birth, as well as using mustard oil or turmeric for childbirth.

4.2.4 Knowledge of eating different things in labour

The fourth theme of this study was knowledge of eating different things in labour. Four sub-themes were identified: eating dates and Vaseline, drinking tea or soup, chewing a green stick or branch and that you are not supposed to eat liver. The sub-themes under this theme were not common knowledge to the midwives as few participants mentioned them.

Eating dates and Vaseline

The first sub-theme identified was eating dates. Part of the palm family, dates are a natural fruit that is rich in iron, potassium, calcium, and magnesium, and they are a good source of fibre and calories. They are sweet in taste and a good source of energy, which makes them a good alternative to refined sugars. Eating dates and Vaseline were not common knowledge as they were mentioned by one participant each.

Eating dates during labour is mostly practised by Arab women, who believe that it assists labour by causing or enhancing contractions. The results showed that the consumption of date fruits during labour influences the outcomes of childbirth by augmenting labour. This is one of the safest TMs to be consumed by women in labour as it is natural fruit, not mixed with anything and has high nutritional value. Karimi, Elmi, Mirghafourvand and Navid (2020: 2) state that date fruit also contains necessary and unnecessary fatty acids that can produce prostaglandins, which play an important role in cervix ripening, acceleration of delivery progress, increase of uterine contractions and in inducing labour. Date fruit also contains hormones that prepare uterine stretching and childbirth and can accelerate the labour process, increase cervix dilatation, and reduce the need for induction. Gunawan, Aticeh and Hajrah (2020: 16 &19) write that date fruit contains saturated and unsaturated fatty acids that are responsible for prostaglandin production and oxytocin that causes contractions in the uterus. Hence, they prepare the uterus for stretching and childbirth. This suggests that eating dates can accelerate labour and increase cervical dilatation, thus reducing the duration of labour.

Regarding eating Vaseline, the participant who mentioned this practice stated that Vaseline was mixed with “black stuff” that the women obtained from church, and they were told to eat this mixture to help with the delivery. The midwife was not informed of what the black stuff was made of and believed it could have been herbs or muti. Her main concern was what the Vaseline was mixed with.

The findings showed that the use of traditional herbs is of concern. Herbs are used more often than any other practice when it comes to intrapartum care globally. The main concern is what ingredients are mixed into the TM, how much of it is used and the dosage that the woman is expected to take. Peters, et al (2021: 3) state that traditional herbs are used globally during childbirth for different reasons depending on the different traditions. These authors write that some herbs have adverse effects that may complicate pregnancy and childbirth and affect the foetus whilst others have a positive effect such as soothing abdominal pains. Chakona and Shackleton (2019: 15) support the use of medicinal plants, claiming that in Africa this is a well-established practice used to ensure good development of pregnancy and facilitate labour, with some women consuming these plants to strengthen pregnancy, promote foetal growth and make delivery easier.

Drinking tea or soup during labour

The second sub-theme was drinking tea or soup during the intrapartum period. This sub-theme was supported by four participants. The midwives were not sure what was mixed into the tea or the soup because the patients brought it already prepared and in a flask. Hydration is very important during the intrapartum period because dehydration may lead to complications such

as obstructed labour, but it becomes a concern when it is not known what is mixed into what the clients are drinking, and whether it is safe or unsafe to the mother and the baby. WHO (2018: 125) encourages offering oral fluids for low-risk women in labour as the restriction of oral fluid has no beneficial effects on the progress of labour?

Some participants believed that the tea or soup was mixed with some herbal medication that the women got from church or were given by family elders to assist with contractions during labour, for protection from evil spirits and to prevent complications throughout the pregnancy. Throughout labour, the women constantly took sips of the liquid until they delivered. The participants had no knowledge of whether this soup or tea had any positive or negative effects. Midwives believed that there might be something mixed into the tea or soup, as tea and soup on their own were not expected to influence the facilitation and induction of labour, leading to patients delivering fast.

Illamola, et al (2020: 3) state that rooibos tea has been used for labour preparation, facilitation during labour and induction of labour, with Del Mastro, et al (2021: 6&11) writing that women are given hot beverages such as tea to drink to speed up delivery. Authors further stated that, in accordance with this study's findings, Avellaneda, Rivas, Otto, and Leon have also reported they use traditional infusions and hot beverages to induce labour such as cotton leaf tea and malva or mallow, ginger, coffee, hot milk, tea, and hot water among Kukama-Kukamiria people.

Where midwives are unsure of the effects of herbal medicine, they may prevent patients from using it. A study by Musie, et al (2022: 5) found that one midwife who dealt with women from East Africa who used traditional herbs mixed in a bottle would not allow the mixture to be used as she did not know its ingredients.

Chewing a green stick or branch

The third sub-theme was chewing a green stick, which is mostly practised by Ethiopians when in labour to assist with contractions. The participant who identified it described it as looking like a branch of a tree and as green in colour. Most participants had no knowledge of this traditional practice during the intrapartum period as this was only supported by one participant. This participant explained that patients believed that it assisted with dilatation during labour. It is evident that the stick has herbal properties that influence labour.

Aziato and Omenyo (2018: 6) report that in cases of difficult or prolonged labour TBA's take a leaf, wash it, and sprinkle salt on it and then give it to the woman in labour to chew on it and swallow it, with the result that the baby will come out immediately.

You are not supposed to eat liver when you are in labour

The fourth and last sub-theme was the belief that you are not supposed to eat liver when you are in labour. The results showed that this practice was not common knowledge to midwives as it was mentioned by only one participant and that participant was unsure of why this tradition was being practised, speculating that it might be associated with the placenta or with the belief that it delays labour.

While much research has been produced about taboos associated with eating habits in pregnancy and labour, there is nothing specific regarding eating liver during labour (such as study that was conducted by Karahan, et al 2017). Some traditional practices warn against eating meat in general while others believe that it will affect the child once it is born. As mentioned by the participant, eating liver (or meat) during pregnancy and labour is beneficial to pregnant women because it has high nutritional value, especially iron, which is highly needed during pregnancy and labour.

A previous study provided some explanation regarding this practice but not related to childbirth. Karahan, et al (2017: 193) identify the belief that pregnant women should not eat liver or even touch it because the child will be born with a mark on its skin. However, Rianga, Broerse and Nangula (2017: 5&6) discuss a Kenyan belief that women are not allowed to eat any meat apart from the liver because it is believed that if that animal has ever encountered any pregnancy-related complications such as stillbirths the woman will also encounter them. Eating meat is also expected to bring misfortune to the baby and the mother.

4.2.5 Knowledge of different types of clothing

The fifth theme concerned knowledge of different types of clothing. Under this theme five sub-themes were identified: baby clothes to be hidden during pregnancy and taken out when in labour, putting the cloth on the floor to deliver, untying partner's shoes and belt, and wearing clothes of person who had quicker labour.

Baby clothes to be hidden during pregnancy and taken out when in labour

The first sub-theme was that any baby clothes that were bought before childbirth should be hidden during pregnancy and taken out when the woman was in labour. The reason for doing this is that most African traditions hold that purchasing a baby's clothes before the baby is born is associated with bad luck.

Only one participant reported this sub-theme. This participant believed that, according to old people, the baby's clothes were not supposed to be bought before childbirth. If baby clothes were bought, they should be hidden away and only taken out when the woman was in labour

otherwise the labour would be prolonged. Tradition suggests that buying an infant's clothes before delivery is a bad omen and will bring bad luck, such as miscarriage or stillbirth. The baby's clothes should only be bought once the mother has delivered.

Honkavuo (2021: 10) also identifies the cultural belief that the baby's clothes are not to be bought before childbirth because the child may die or be stillborn if clothes are bought before time. Hlatshwayo (2017: 142) agrees that the act of buying baby clothes before the child is born was traditionally regarded as taboo due to understanding that pregnancy was a delicate issue that could either result in life or death, the clothes are to be bought once the child has been born. Hlatshwayo (2017: 143) further stated that there was a study that was done in Northern Thailand, which revealed similar beliefs of not preparing baby clothes before birth because they believed that advance preparation was believed to result in the death of the unborn child. The Chiang Mai people would buy clothes for an expecting female relative, but they would only give them after the baby was born and were sure that the child was alive. In addition to protection of the baby until childbirth, Ombere, et al (2021: 155) write that the Giriama people from Kenya belief that a pregnant woman is considered vulnerable both physically and socially, and that there are norms and practices that are traditionally and culturally intended to offer protection to both the woman and the unborn baby, but only if she adheres to specific cultural beliefs during pregnancy until childbirth.

Putting the cloth on the floor to deliver

The second sub-theme involved putting a cloth on the floor to deliver. This is mostly practised by Malawians and people from Somalia. This type of traditional practice seemed to the participants to be a way of preparing for delivery, with only two participants discussing this practice.

The participants believed that putting the cloth of the floor indicated that some women believed in home deliveries more than institutional births. Home births and institutional births are not so different when it comes to some practices in relation to childbirth. Both institutions believe in preparation for childbirth that includes preparing the delivery area, creating a support system for the woman, managing the childbirth process, and providing immediate care for the neonate. Putting a cloth on the floor is a way of preparing a delivery area. Peters, et al (2021: 4) state that at home the women prepare the place for delivery by placing a cloth on the floor, with some traditions involving women in labour preparing a shelter for themselves with mats and coverings to prepare for childbirth. Withers, et al (2018: 164) describe some South Asian cultures where women have traditionally given birth in a cowshed, or a special hut constructed for birthing and that has been especially prepared for this beforehand.

Untying partner's shoes and belt

The second sub-theme involved untying the partner's shoes and belt during labour. This practice is carried out whether the woman's partner is with her during labour or not; wherever he is he should keep his shoes and belt untied for her labour to progress smoothly. This tradition was described by only two midwives, who identified it as practised mostly by black people.

The participants stated that this practice aimed to ensure easy labour because if the partner's shoes or belt were not untied it could prolong labour. The belief is that anything that tightens either on the woman in labour or her partner affects the labour. Hence, the partner's belt and shoes are untied, and the woman makes sure that she does not have anything that is tightening such as hair braids or plaiting.

It is believed that the woman in labour should untie or remove anything that is tight, as it leads to obstructed labour. Roy, et al (2021: 322), discussing homebirth practices in resource-scarce regions in India, write that the dias or midwives open and loosen any threads, buttons, clothes and jewellery of the woman and everything that is believed to help her relax. At the same time, they help with monitoring of progress of labour, support the women, help the mothers gain their confidence in their bodies and labour, and facilitate their mental and physical preparation for childbirth. In response, the women can tolerate pain, loosen, and warm up, and ease into the final stages of labour and delivery.

Wearing clothes of person who had quicker labour

The fourth and last sub-theme under this theme concerned wearing clothes of a person who had experienced a quick labour. This was supported by only one participant.

The participant stated that to have a quick labour, the woman must wear clothing belonging to someone in her family who had had a quick labour. This would symbolise receiving blessings from that family member and would mean that having blessings from this person, such as by wearing their clothes, would bring luck to the woman, leading to her having a quicker labour.

Previous studies have focused on other ways of receiving blessings from a person who has had a quick, easy delivery. Karahan, et al (2017: 193) mention these ways: if a woman who experienced easy labour rubs the pregnant woman's back, unlocks a door or opens a window; if a woman in labour drinks water from the hand of a woman who experienced easy labour; and the pregnant woman feeds the birds from her skirt. All of these are ways of receiving the

blessing of a woman who has experienced easy labour. The belief is that these practices will result in the woman having a smooth labour and delivery.

The converse of this is that if the pregnant woman associates herself with a person whose labour did not go smoothly and quickly, she will also experience the same thing. So, women are encouraged to associate with a person who has had a smooth, easy labour.

4.2.6 Knowledge regarding protection/calmness/prevention of preterm labour and caesarean section, and safe delivery

The sixth theme was knowledge regarding protection/calmness/prevention of preterm labour and caesarean section, and safe delivery. Two sub-themes identified under this theme were: using holy water, prayed water, prophet water, church water and ichibi (water from Ushembe church mixed with the plant); and lying facing east, and inhaling impepho (herb used for incense) and uphunyuka bamphethe (herb).

Holy water, prayed water, prophet water, church water, ichibi

The first sub-theme identified was using holy water, prayed water, prophet water, church water and ichibi (type of water from Ushembe church). This was the most common knowledge held by midwives, as the practice was identified by 11 participants.

The results showed that all the practices involving water that is received from church, prayed over and sometimes mixed with something are called by different names. There can be a cloth inside the water; the water can be mixed with ashes or mixed with a newspaper; or the water can be just plain tap water that is prayed for by the pastor. This water is used for protection, calmness, quick labour and prevention of preterm labour and caesarean section – all in all for everything to go well with childbirth. One participant mentioned that it was like isihlambezo when it came to speeding up the labour.

It is evident that, as with all traditional practices used during the intrapartum period, the aim is to have a quick, smooth childbirth and for the mother and the baby to be in good health at the end. However, sometimes practices are abandoned if they are found not to work. Drigo (2018: 67), in his study on attitudes of pregnant women to antenatal services in a municipality in Mpumalanga Province, found that one participant had stopped taking holy water from church because it was causing her abdominal pains and her sister-in-law had delivered before time at eight months because the church prophet induced her labour.

This water is either drunk throughout the pregnancy until the baby is born or during the intrapartum period until childbirth. Mawoza et al. (2019: 12), discussing this tradition in rural Zimbabwe, state that the woman drinks water from the apostolic church from the first trimester until the baby is born for the protection of the child and to ensure safe pregnancy and childbirth.

Aziato and Omenyo (2018: 6), in their study regarding TBA practices, state that TBAs pray over water and give it to pregnant women to drink when the baby is not coming out owing to malposition. After that the baby will turn or position well and the mother will kneel and deliver easily. Withers, et al (2018: 165) report that in Laos, one of the roles of TBAs is to administer TMs and “magic water” that has been prayed over by a healer or by lay people. This water is believed to relieve pain and energise the mother for a smooth birth.

Lying facing east, inhaling impepho (incense) and uphunyuka bamphethe (herb)

With the second sub-theme about lying facing east, inhaling impepho (incense) herb and uphunyuka bamphethe (herb), four participants identified these practices.

Concerning lying facing east during labour, the participants stated that during labour, even if they put the woman in labour in a different position, if she practised this tradition, she would turn. Her reason would be that she had been informed by the family elders to keep that position throughout labour until the baby was ready to be delivered.

It is believed that this position will bring luck to the pregnancy and childbirth and ensure that everything will go well. It is believed that as sunrise opens everything up and brightens the day, so hopefully by facing the sunrise the labour itself will go well. It is considered a lucky position.

Kruekaew and Kritcharoen (2018: 106), writing about Thai traditional midwifery care, write that traditionally Thai women in labour are expected to face in an easterly direction since Thai people believe that the east symbolises dawn, life, and birth whilst the west represents death. Facing east is therefore expected to brighten the labour and bring a healthy baby, meaning everything will go well with childbirth without complications.

Inhaling impepho, which means incense in Zulu, is practised mostly by African people to provide calmness, and take away evil spirits. Regarding pregnancy and childbirth, the midwife who described this practice stated that the belief is that it takes away evil spirits and provides calmness so that the woman will have a safe delivery. Burning incense and inhaling its smoke are associated with healing properties in other areas, not only with pregnancy and childbirth. This type of herb is also used to speak to the ancestors. It is believed that it connects the living with their ancestors, where during this process, people can request anything from their ancestors. It is used mostly by Zulu people.

It seems that not only Zulu people use incense. Llopis (2020: 138), in her study on culture and childbirth in Spain and Morocco, discovered that cultural beliefs during childbirth include ritual cleaning of the house, and burning oleander leaves, incense or alum stone to purify the air

and as preventative remedies in Arab traditions for both mother and baby. Roy, et al (2021: 221) discuss the use of incense for treatment of various pregnancy and labour-related problems in India. Incense is used to help heal minor tears or infections, and to purify both the mother and the baby. These processes restore the mother and integrate the newborn into everyday life and social relations. They are given dhuna sek (dry smoke from burning incense) to inhale.

One participant identified the practice of using uphunyuka bamphethe (the Zulu name for a particular herb). The participant stated that this herb was made into a TM that was drunk by pregnant women, who drank it three times a day as protection against bad spirits. The participant stated that she noticed that after women had drunk this TM, it increased their contractions. The belief was that it would help with dilatation and offer protection throughout the pregnancy and childbirth to the mother and the baby.

Withers, et al (2018: 162) confirm that plants and herbs are used for a range of conditions during pregnancy, childbirth and postpartum for the benefit of the mother and the baby in Asian countries. Thipanyane, et al (2022: 7), in their study on rural South Africa, confirm the use of herbs for protection against evil spirits, with some of their study respondents stating that when women are pregnant, they are vulnerable to evil spirits, so they use traditional concoctions that they drink until the delivery of the baby for protection against evil spirits and for help with obstructed labour to avoid caesarean sections.

4.2.7 Knowledge of praying

The seventh theme of this study was knowledge of praying. The results showed three sub-themes that were identified from the knowledge of the midwives regarding traditional practices used during the intrapartum period. These were praying during contraction, prayed bathtub and ukuphahla (speaking to ancestors).

Praying during contractions

Praying during contractions was the first sub-theme identified from a participant's knowledge. This was not commonly known to be practised during childbirth, as only one participant mentioned this, even though most women who came to the hospital for childbirth were Christians and prayed daily. While praying was a regular practice among patients, the reason it was mentioned by only one participant was probably because most people regard praying as a religious practice rather than a traditional practice.

The participant who described this practice stated that it was the belief of the women that if they prayed during a contraction it would aid with the contraction and speed up the process of the intrapartum period so that they could deliver quicker. This traditional practice is one of the safest practices for the mother and the baby; hence, the midwife can allow it to be performed freely by the woman. It is a spiritual belief.

Aziato and Omenyo (2018: 6), in their study regarding the practices of TBAs, stated that TBAs believed that prolonged labour was an indication that the baby was spiritually locked up in the womb. They would pray for it and believed that after praying, everything would be cleared, and the child would come out quickly. Karahan, et al (2017: 193), in their study set in a public hospital in Istanbul, identified the practice of praying, stating that as part of traditional practices related to delivery, praying was encouraged so that the delivery would be smooth, easy, and quick. Desmawati, Kongsuwan and Chatawet (2019: 224) suggest that Muslim women when praying by focusing and concentrating on Allah produce changes in neural regulation in pituitary hormone secretion by enhancing the endorphins hypothalamic and inhibiting GABA in the CNS, which can increase serotonin to increase the production of the neuro hormone melatonin. Melatonin has been shown to depress the CNS; modulate autonomic, metabolic, endocrine, and immune functions; and, thus, mediate global regulatory changes in various behavioural states, including producing a state of calm to reduce labour pain.

Prayed bathtub

The second sub-theme that was identified with this theme was the prayed bathtub. This was also one of the lesser-known practices as it was mentioned by one participant only.

The participant stated that when the labour began, the prophet put the woman into a bathtub, poured water over her and prayed for it. This was supposed to speed up the process of labour and was practised before she came to the hospital. Before going into labour, the women consulted a prophet who gave them this prayed over or prophet water, which they said was plain, not mixed with anything, but only prayed over and sometimes mixed with holy ash. This was believed to provide protection to the mother and baby to endure childbirth and to speed up the process of labour.

Other studies point to different practices used to protect the mother and child and relax the mother. Aziato and Omenyo (2018: 6), in their study on TBAs, found that when women are in labour and visit the TBA, they prepare a special soap that they have prayed over, and they give them this soap to bath with to prevent any challenges or complications they may face with delivery. Along this line, Desmawati, et al (2019: 224) suggest ways of alleviating labour pain other than pharmacological that involve massage, position, comforting, encouraging,

reassuring and relaxation. These authors suggest that these practices employed for 30 minutes strongly bring about alleviation of pain. This finding proves that breathing, massage, mindfulness, position and involving significant partners lower labour pain and reduce feelings of unpleasantness.

Ukuphahla (speaking to ancestors)

The last sub-theme identified under this theme was ukuphahla (speaking to ancestors), where traditionally people light candles, pray and speak to their ancestors to open the way for them. With ukuphahla, incense is burnt as part of the ritual when they communicate with the ancestors. Ukuphahla is undertaken when performing rituals in general and with matters related to childbirth.

This practice was identified by one participant, who stated that the women pray and speak to the ancestors to open the way for them during labour and childbirth. They ask for everything to go smoothly and for them to have an easy labour without complications. The belief is that in every challenge that they face in life, including childbirth, they have to speak to the ancestors to ask for them to bring luck, for everything to go smoothly and for the ancestors to protect them against any evil that may occur. They believe that if someone has planned to do evil during childbirth, to the baby or the mother, if they carry out this practice it will take away the evil that was planned. After delivery when the mother and the baby are healthy, they may also thank the ancestors for their protection and that everything went according to plan. During this process, they only burn incense, inhale, and talk to the ancestors. A belief associated with ukuphahla is that talking to ancestors is like talking to God because they are a link to God.

Thipanyane, et al (2022: 10) identify traditional medicinal products that are provided through divination with cowry shells; through the throwing of bones, shells, money, seeds, dice, and flat pieces of wood to diagnose and treat illness; or through spiritualism using prayers. In this case, faith-based providers consult God even about issues related to pregnancy and childbirth through prayer to guide and give direction about the conditions presented to them. Aziato and Omenyo (2018: 5) give the example of a woman who said that her father used ada salt [coarse salt that is sourced from Ghana] to perform a ritual that enhances delivery and before her father had finished the ritual, the baby was born. Hlatshwayo (2017: 146) agrees that the parents of the pregnant woman performed their family rituals to inform their ancestors of their daughter's pregnancy thereby requesting the ancestors for guidance throughout the entire phase of pregnancy until she safely delivers her baby.

Cheboi, et al (2019: 9) also state that the community of Marakwet in Kenya do a cleansing called barbarisho prior to delivery. The pregnant women are cleansed in the last trimester to

appease the ancestors and more importantly psyche the woman for delivery because they've exposed to evil spirits throughout pregnancy.

4.2.8 Knowledge of the do's and don'ts in labour

The results from the midwives indicated knowledge of many do's and don'ts in labour, with some having no clear explanation for why they were done. None of the sub-themes identified under this theme were common knowledge among the midwives. Nine sub-themes were identified: women not to be assessed by male health practitioner, don't tell people when in labour, don't stand by the door, no crying when in labour, men/partner not to be around during labour, no eating during labour, no shade of someone when drinking these things (TM), no plaiting/braiding hair, and the do's: doulas, tshitanga (keeping room warm) and squatting/kneeling birthing position.

Women not to be assessed by male health practitioner

The first sub-theme that was identified was that women should not be assessed by a male practitioner. Only one participant identified this practice.

The participant stated that she was not sure why this practice was followed, except that it was a tradition and part of their culture in certain tribes that the women should not be seen naked by any male apart from their husbands. This is a challenge in South African health institutions where there are a lot of male health practitioners. It is regarded as taboo in most traditions to have a male attend to a woman in labour; not even the woman's partner is allowed to be around. Only females are allowed to be present and to assist the woman.

Del Mastro, et al (2021: 8), in their study regarding the reasons why some women in the rural Peruvian Amazon prefer home deliveries to institutions, found that owing to cultural norms and personal preferences, they feel ashamed of and embarrassed about showing their bodies to male health practitioners. When these women deliver at home they are in the comfort of their home, where they know that they will be assisted by females. Buser, et al (2020: 6) state that in rural Zambia, women believe that no man outside of the home should see a woman without clothes on. This leads mothers to hesitate to deliver at a facility where they risk being seen naked by male nurses in the maternity ward.

Cheboi, et al (2019: 4) cite that according to Marakwet community, it is distasteful to be supported or assisted by a male especially if he's of the same age as husband to a woman. Being assessed by male practitioners makes these women feel uncomfortable, ashamed,

and distressed and an uncompromising attitude by health facilities is likely to lead to their avoidance of these facilities.

Don't tell people that you are pregnant and when in labour

The second sub-theme that a woman should not tell people that she is pregnant and when in labour was identified by two midwives.

One participant stated that women held the belief that they should not tell people when they were pregnant because that might bring bad luck when they were in labour. Also, they should not tell people when the labour began. The belief is this: the people that the woman talks about her pregnancy may bring negative spirits and bad luck and these may lead to prolonged labour. Pregnancy may not be kept as a secret forever because the woman will start showing but when it comes to labour and childbirth, these should be strictly kept private, and the woman is also not allowed to leave the house for a certain period after delivery to protect her and the newborn from evildoers due to most African cultures.

Honkavuo (2021: 8) states that as part of cultural practice during childbirth, the woman does not tell people when her due date is, including the date of delivery, as protection against evil and bad luck regarding the approaching delivery. Peters, et al (2021: 5) explain that most women prefer home delivery, to keep the delivery private and away from the public, because they believe that if people know about the delivery, their enemies may use the mother's blood from the delivery to carry out evil deeds such as making the woman become barren and bringing about the new-borns' death. Hlatshwayo (2017: 141) stresses that pregnant woman was not allowed to reveal the onset of her labour pains but was allowed to notify a closest relative, it is believed that if other people became aware of the onset of labour, they would bewitch the pregnant woman resulting in complications during delivery.

Don't stand by the door

The third sub-theme identified was that pregnant women and women in labour should not stand by the door. Only one participant described this practice, which was unknown to the other participants. This is understandable as there are so many beliefs related to childbirth that some things are not mentioned.

The belief that a pregnant or labouring woman should not stand by the door is supported by the Tsonga people, who say that a woman should not stand by the door post when she is in labour but should get inside. As the participant stated, the belief is that the woman's labour will not progress, and the baby will not come out. This practice refers to both pregnant women

and women in labour, predicting that if she is still pregnant, she will have complications during childbirth and even if she is already in labour, it will complicate things for her.

There's various norms and values that women are supposed to follow during pregnancy and childbirth. Cheboi, et al (2019: 5) identify that with the Marakwet women discovers that they are pregnant, they consult with the midwife who begins with the indigenous antenatal care. This entails inculcating pregnancy and childbirth norms, values, taboos and practices. Basically, the pregnant woman behaviour and way of life is a customized. Pregnant women are guided by values and norms on do's and don'ts. The values and norms are aimed at deterring disaster during pregnancy and childbirth.

In addition, Ombere, et al (2021: 160) point to this, a Giriama community in Kenya believe that pregnancy, childbirth, and postpartum practices are culturally prescribed and form a delicate journey that every childbearing woman must undertake. Every expectant mothers are expected to adhere to certain cultural norms to have a successful pregnancy and delivery such as abstinence from sex after the first trimester, food taboos, not viewing dead bodies, and following the orders of their husbands and elders.

No crying when in labour

The fourth sub-theme identified was no crying when in labour. Only one participant mentioned this. Regarding this belief, the participant confirmed that the things that the woman does in her first pregnancy are expected to continue with all the other pregnancies. The family elders guide and advise the woman at home before labour of the things to do and not do, including this one. This is one practice that does not put the baby and the mother at risk. The only way to prevent a woman in labour from crying is to offer pain relief and support during labour until delivery. This is one of the means to ensure quality patient care and comfort to women in labour.

Spencer, du Preez and Minnie (2018: 1) suggest that continuous support during childbirth provided by health professionals, doulas, or laypersons, including family members, is of benefit to the mother and the baby. This is one of the non-pharmacological pain-relief methods provided by all these stakeholders. The selected mother and child hospital where this study was conducted does cater for this practice, with doulas that are chosen by the women themselves. However, owing to the Covid-19 protocols, this type of practice has been removed. Chattopadhyay, Mishra, and Jacob (2018: 8) state that in their study conducted in rural Northeast India, one woman reported that when she vocalised her pain during labour, the doctors wanted her to tolerate the pain, not twitch, and to suppress the pain. In this study one medical practitioner verbalised her belief that many women screamed during labour not

because of real pain but because the screams of other women in labour in the labour ward compelled them to join in communal screaming, whether there was real pain (Chattopadhyay, et al 2018).

Men/partner not to be around during labour

The fifth sub-theme was that men or the woman's partner should not be around during labour. Support during childbirth is needed but according to this belief it should not be the partner who provides this support. One participant discussed this practice.

The results of this study indicated that this practice can be the result of women feeling ashamed, worried, and uncomfortable in their partner's presence. They are worried that the partner may not look at them in the same way in future after witnessing childbirth. The woman's discomfort in the presence of the partner may lead to prolonged labour because the woman will not abide by the assisting midwife's advice. In addition to the woman's preference for not having her partner present, in some areas, culture or tradition prevents the woman's partner from being around. In some traditions only other women can be around or the mother-in-law.

Honkavuo (2021: 8) gives the example of a cultural practice and belief that during childbirth the woman gives birth alone without a next-of-kin. The accompanying person visits the child later. Cheboi, et al (2019: 5) write that companionship and support is very important with the Makwaret women, even though in their study there was no mention about man or partner, but they state that ommunity companionship and participation is the epitome of labour and Childbirth. A child is a blessing to a society, therefore an opportunity to usher a child to the world is treasured by all particularly grand's mothers. Peters, et al (2021: 4) also found that in certain tribes some mothers deliver their children without the help of other tribe members owing to their tradition that men are not allowed to be present at and witness the birth of a child.

No eating during labour

The sixth sub-theme identified was no eating during labour. Although this could be the result of a loss of appetite from contractions or labour, the participant who identified this practice stated that the women were offered a fluid diet as these women associated eating in labour with the fact that they might pass faeces during childbirth, which they wanted to avoid because they believed it brought bad luck to the baby.

Research consulted has had different findings, with some studies reporting on women being offered light meals and fluids, especially hot beverages, during labour so that they do not get

dehydrated and lose energy before childbirth. Roy, et al (2021: 222) study found that women in labour were offered light foods and fluids to keep up their strength and energy in preparing for childbirth, with Shiferaw and Modiba (2020: 7) finding that some women preferred to deliver at home, where they were offered light meals such as porridge and coffee, which they were not offered at the health facility. WHO (2018: 125) encourages offering food for low-risk women in labour as the restriction of food intake has no beneficial effects on the progress of labour?

No shade of someone when drinking this things (traditional medicine)

The seventh sub-theme under this theme was to avoid the shade of someone falling on you when drinking these things, referring to the drinking of TM or herbs. One participant supported this. This participant stated that the rule was that pregnant women needed to make sure before they drank anything that there was no shade of anyone falling on them because that shade was like the spirit of that person. If the shade of someone that did not like them fell on them, then things could go wrong during labour. For this reason, most patients made sure that they took their TM at home before coming to a health institution and some opted for home delivery with their family members where no bad spirits or shades could follow them. However, some women preferred to deliver at health institutions because the midwives there were western trained and most of these women relied more on western medicine than on TM.

There are many beliefs associated with pregnancy and childbirth. Thipanyane, et al (2022: 10) found that women in Ghana avoided strolling near graveyards, going out at specific times of the day, and mingling with people who were wicked because they were afraid of being harmed by evil spirits and ghosts.

No plaiting/braiding hair

The eighth sub-theme that was identified under this theme was no plaiting or braiding of hair when in labour. Three participants described this practice.

One participant stated that plaiting the hair makes you tight and pointed to the associated belief that when a woman in labour is tight, the cervix becomes tight also and the baby will not come out. This belief is associated with obstruction of labour and holds that the woman should be free when she is in labour, so that everything goes smoothly. This practice was stressed by the participants as they had observed women in labour unplaiting their hair in health institutions. After unplaiting the hair, the progress of labour was believed to go smoothly.

The participants' observations support the findings of certain studies. Karahan, et al (2017: 193) confirm that unfastening a woman's hair and letting it loose in labour is a belief and

custom aimed at ensuring a smooth labour and delivery. If the hair is tied with knots, braids, and plaiting, it means the labour will be tied up also and will not progress. Roy, et al (2021: 223), in their study in India, found that one of the functions of the dais when women are in labour is to open or loosen threads, buttons, clothes and jewellery or to untie a woman's guth (hair braid), which is believed to help her relax. At the same time, dias monitor the progress of labour, help the mothers gain confidence in their bodies and labour, and facilitate their mental and physical preparation for birth. In response, women tolerate pain, loosen and warm up, and ease into the final stages of labour and delivery.

Doulas, Tshitanga and Squatting and kneeling birthing position

The ninth sub-theme involves doulas, tshitanga and squatting and kneeling birthing position. These will be discussed separately. Regarding doulas the participants identified was the importance of doulas during labour. Even though this practice is scientifically proven to provide benefits during labour, only one participant mentioned this.

The participant emphasised the importance of doulas, and how they ease the midwives' job by being there. They support and encourage women in labour. Some believe that the doula should strictly be the mother-in-law; others believe that it can be anyone that the woman in labour is comfortable with as long as that person provides support in labour. While it has been shown that doulas play a vital role during childbirth, whether it is a partner, midwife or doula, anyone that the woman feels comfortable with is beneficial to prevent labour and childbirth complications. As mentioned above, the presence of the doula has been scientifically proven to be of benefit to the mother and the baby during childbirth; hence, this practice should be allowed without any hindrances. The selected mother and child hospital where this study was conducted is one of the institutions that allow doulas in its labour ward during the intrapartum period.

Ahmad, Nor and Daud (2019: 23) state that doulas provide support in the physiological paradigm of birth and birth care that makes women feel safe. Women believe that doulas have the necessary knowledge and skills to anticipate and manage complications in labour, which is why they strongly rely on TBAs because they become doulas when managing the intrapartum period. That is also the reason they prefer TBAs over healthcare institutions, which are unwelcoming and unsupportive. Peters, et al (2021: 3) suggest that doulas are important for providing nonclinical support during labour and birth. Unlike midwives, doulas do not require formal training nor certification to practise. Many expectant mothers prefer midwives over doulas for this reason alone. Yet, some women prefer doulas over midwives. Their most important function is to offer additional emotional support to expecting couples, which lessens

complications during childbirth. The Guidelines for Maternity Care in South Africa (South Africa. National Department of Health 2016) “allow family and friends to provide companionship during labour” (p. 41) and “promote companionship in labour” (p. 42) as a strategy to promote non-pharmacological pain relief.

Regarding tshitanga (keeping room warm)

This is where the delivery room is prepared for childbirth. One participant identified this practice. The participant stated that a fire is made to keep the room warm, and the family elders sing to make noise so that children do not hear the woman screaming, especially during home deliveries. Keeping the room warm is a common practice in labour and childbirth settings whether homebirths or institutional births. The practice in health facilities is the same, where the midwife needs to prepare an area for childbirth for both mother and baby. That includes equipment, a resuscitation area and for the delivery room to be warm, which is also beneficial for the mother and the baby.

In some tribes, it is traditional for women in labour to depart alone to a secluded place near a brook, or stream of water and prepare a shelter for themselves for childbirth with mats and coverings (Peters, et al 2021: 4). Withers, et al (2018: 164) found that warmth being available in the birthing room was important in the Nepalese community during their study. In rural Laos, women prefer home deliveries because of the emotional and physical support from family members, who provide warmth by providing a coal fire for the mother and to keep the baby warm after birth (Shah, et al 2018: 3).

Regarding squatting/kneeling birthing position

This was the most common under this sub-theme as it was supported by four participants. These traditional birthing positions have been proven scientifically, even WHO recommends it to be used (WHO 2018: 125). It has been found to be effective and conducive for childbirth as lithotomy position, if women are comfortable with it, even though midwives still prefer the supine or lithotomy positions, which are comfortable positions for them.

The participants indicated that these traditional birthing positions were mostly adopted by Africans from Malawi, as they were socialised to use these positions during childbirth as part of their tradition. It is important that women feel comfortable during childbirth to reduce the chances of child and maternal mortality. This can be achieved by using, understanding, and accepting their traditions by allowing them to deliver in any position that they are comfortable with. This is particularly true considering that these positions have been researched and

proven to be conducive to and effective in childbirth and are not of any detriment to the mother and the child.

Konje, et al (2020: 6) support this view by indicating that it is a cultural belief that women assume a squatting position during childbirth aside from comfort and individual preferences. That is a further reason why women prefer to deliver at home: at home they can deliver in the squatting position that they were socialised to and find culturally acceptable in contrast to health institutions, where they are expected to lie down during childbirth.

Peters, et al (2021: 2) supports the different types of birthing positions such as sitting, squatting, standing, and giving birth on hands and knees. Each position has its own benefits additional to gravity. Giving birth on hands and knees allows for comfort through pelvic tilts, back massages, or counter pressure; sitting can ease contraction pains and open the pelvis; and squatting opens the pelvis. Birthing in these positions is aided by gravity and pressure is taken off the back and spinal cord nerves, making delivery less painful.

Many women wanting to follow cultural practices feel unable to deliver or awkward about delivering in medical facilities, which can be detrimental to the mother and/or baby. A study conducted about midwives indicated that they prefer supine or lithotomy positions during childbirth for their own comfort. In the study, one midwife stated that a Shona woman did not follow instructions and continued to squat and said it was her culture: they prefer to squat (Musie, et al 2022). In the same way some midwives follow the lithotomy position because it is part of the culture that they found being practised when they entered the profession. This is despite the maternity guidelines of South Africa (South Africa. National Department of Health 2016) indicating that women should be given options and that these other positions have been researched and approved to be of benefit to women (Musie, et al 2022: e6).

4.3 SUMMARY

This chapter explored, discussed, and interpreted the eight themes with further sub-themes indicated by midwives from a selected hospital in Gauteng regarding traditional practices used during the intrapartum period. The discussions of the identified themes and sub-themes were supported with findings and information from previous studies.

CHAPTER 5 RECOMMENDATIONS, LIMITATIONS AND CONCLUSION

5.1 INTRODUCTION

The previous chapter presented a discussion of the findings of the research conducted. The findings revealed the knowledge of midwives regarding traditional practices used during the intrapartum period, which are: knowledge of practices that facilitate or hasten labour; kknowledge of using traditional rope/band/wool/cloth/elastic; kknowledge of prolonging labour using a stone; knowledge of eating different things in labour; knowledge of different types of clothing; knowledge regarding protection/calmness/prevention of preterm labour and caesarean section, and safe delivery; knowledge of praying; and knowledge of the do's and don'ts of labour. In this chapter, recommendations are made based on the findings of the study. The study limitations are then outlined, and the chapter concludes the dissertation with a summary of the conclusions reached by the study.

5.2 RECOMMENDATIONS OF THE STUDY

The findings revealed that the midwives had incomplete and uncertain knowledge about many of the traditional practices practised by their patients. The following recommendations have been drawn up to improve the midwives' knowledge and understanding of these practices and ability to deal with and accommodate all individuals from different traditional backgrounds.

5.2.1 Recommendations for healthcare practice

The midwives indicated that they encountered patients from several different traditional backgrounds, with different traditional practices. Traditional practices are very dynamic in the way that they influence individuals. This means that they are not a group phenomenon and that the midwives need to treat each patient's needs as unique. Understanding the different cultural and traditional practices and the different ways that they are practised by individuals is essential in ensuring that professional practice and care are matched to the needs of the patients and to provide quality patient care. Healthcare institutions to ensure that the institution's environment is conducive and accommodates harmless traditional practises such as ensuring that there's enough space so that women can be allowed to squat, allow doulas, allow them to pray, etc. Midwives need to understand the role that tradition plays in pregnancy and childbirth so that services are planned and delivered to meet the health needs of the community that they serve by adding more traditional practises on their curriculum and providing more workshops and training on proving traditionally and culturally congruent care.

5.2.2 Recommendations for future research

The study recommends further research that is not specific to a selected hospital to explore and provide more knowledge regarding traditional practices used during the intrapartum period. More research on expanded literature review should be conducted regarding traditional practices used during the intrapartum period, as for some of the practices mentioned by participants not much literature was found.

5.2.3 Recommendations for future nursing education

It was evident from the interviews that the midwives were concerned to learn more about all the traditional practices used during the intrapartum period and the reasons for the practices. It would benefit midwives if a module on traditional practices was to be included in the nursing midwifery curriculum both undergraduate and postgraduate student midwives to equip midwives with more knowledge regarding these practices because midwives who are not equipped with knowledge tend to make assumptions about these traditional practices. Traditional practises can also be added on short courses and workshops such as ESMOE, PEP, sensitive midwifery and SOMSA to keep midwives updated regarding these traditional practises used during intrapartum period.

5.2.4 Recommendations for policy makers

Registered traditional healers and TBAs should be considered during policy making. Referral system between TBA's and traditional healers with the health institutions. Educational programmes for traditional healers and TBA's regarding the risks of other practises. Educational programmes or courses are recommended that focus on cultural and traditional norms around the world between traditional care and institutional care in relation to intrapartum care. Combined workshops are recommended with western practitioners and traditional practitioners to learn from each other's practices. Protocols and guidelines to be put in place for traditional healers and TBA'S.

5.3 LIMITATIONS OF THIS STUDY

The study had the following limitations:

5.3.1 The study was conducted in a selected mother and child hospital in Gauteng, which means that the findings cannot be generalised to other maternity settings in South Africa.

5.3.2 The interviews of the participants that were working in the labour ward were conducted by an appointed interviewer who was also an experienced midwife to prevent bias because the researcher was working in the labour ward during the time of data collection. The

researcher had to reimburse the appointed interviewer, and this had a negative impact on the researcher's finances as it was not planned.

5.3.3 Interviews were conducted during working time during the day and at night. Owing to business of the departments, the researcher had to wait longer for participants irrespective of appointments that were made because the participants were busy with patient care but that did not affect the quality of the interviews.

5.4 CONCLUSION AND SUMMARY

The aim of this study was to explore and describe midwives' knowledge regarding traditional practices used during the intrapartum period in a selected hospital in Gauteng. The midwives' knowledge was explored and described using a qualitative, exploratory, and descriptive research design to answer the research question posed at the outset of the study. In the main study, in-depth interviews were conducted to collect data in a selected hospital after an uneventful pilot testing was carried out prior to the main. Eight themes identified from the midwives' knowledge were: knowledge of practices that facilitate or hasten labour; kknowledge of using traditional rope/band/wool/cloth/elastic; kknowledge of prolonging labour using a stone; knowledge of eating different things in labour; knowledge of different types of clothing; knowledge regarding protection/calmness/prevention of preterm labour and caesarean section, and safe delivery; knowledge of praying; and knowledge of the do's and don'ts of labour. These themes were divided into sub-themes that were used to represent accurately the knowledge of midwives regarding traditional practices used during the intrapartum period.

The findings of this study reveal that the midwives have knowledge of the traditional practices used during the intrapartum period although they are unaware of why some of them are practised. From the findings, it is evident that not all traditional practices that are used during the intrapartum period are dangerous. Some have a good effect and positive reasoning behind them. It is also evident that the patients need sensitive, respectful, and understanding midwives who are sensitive to traditions and considerate towards the traditional practices that the patients use during the intrapartum period.

This chapter concludes the dissertation with recommendations for education, healthcare, and policy makers. Recommendations for further research are also made.

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7 ANNEXURES

ANNEXURE A: PLAGIARISM DECLARATION

Full names	SILINDILE MARCIA SITHOLE
Student number	18232061
Topic of work	KNOWLEDGE OF MIDWIVES REGARDING TRADITIONAL PRACTICES USED DURING THE INTRAPARTUM PERIOD

Declaration

1. I understand what plagiarism is and am aware of the University's policy in this regard.
2. I declare that this dissertation is my own original work. Where other people's work has been used (either from a printed source, internet or any other source), this has been properly acknowledged and referenced in accordance with the requirements as stated in the University's plagiarism prevention policy.
3. I have not used another student's past written work to hand in as my own.
4. I have not allowed and will not allow anyone to copy my work with the intention of passing it off as his or her own work.

Signature

Silindile M Sithole (signed)

ANNEXURE B: PERMISSION LETTER TO GAUTENG DEPARTMENT OF HEALTH

The Researcher

Miss Silindile Sithole

2073 flycatcher str

Riverlea Ext 3

Mobile no 0723228656

Gauteng Department of Health

45 Commissioner Street

Marshalltown

Johannesburg

2107

RE: APPLICATION TO CONDUCT RESEARCH IN RAHIMA MOOSA MOTHER AND CHILD HOSPITAL

I am currently registered for MCUR with University of Pretoria and working in Rahima Moosa Mother and Child Hospital. I hereby kindly request to conduct the research in the above-mentioned hospital. The title of the study is:

KNOWLEDGE OF MIDWIVES REGARDING TRADITIONAL PRACTICES USED DURING INTRAPARTUM PERIOD IN A SELECTED HOSPITAL IN GAUTENG

I am of intend to publish the findings of the study in a professional journal. I undertake not to proceed with the study until I have received approval from the Faculty of Health Sciences Research Ethics Committee, University of Pretoria.

Hoping my request will be considered

Yours sincerely

Silindile Sithole (Researcher)

ANNEXURE C: PERMISSION LETTER TO THE CEO OF THE INSTITUTION

The Researcher

Miss Silindile Sithole

2073 flycatcher str

Riverlea Ext 3

Mobile no 0723228656

The CEO

Rahima Moosa Mother and Child Hospital

Cnr Fuel Road & Oudtshoorn Road

Coronation Ville

2112

RE: APPLICATION TO CONDUCT RESEARCH IN RAHIMA MOOSA MOTHER AND CHILD HOSPITAL

I am currently registered for MCUR with University of Pretoria and working in Rahima Moosa Mother and Child Hospital. I hereby kindly request to conduct the research in the above-mentioned hospital. The title of the study is:

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I am of intend to publish the findings of the study in a professional journal. I undertake not to proceed with the study until I have received approval from the Faculty of Health Sciences Research Ethics Committee, University of Pretoria.

Hoping my request will be considered

Yours sincerely

Silindile Sithole (Researcher)

ANNEXURE D: PARTICIPANT'S INFORMATION LEAFLET & INFORMED CONSENT FOR AN INDIVIDUAL IN-DEPTH INTERVIEW RESEARCH STUDY

STUDY TITLE: KNOWLEDGE OF MIDWIVES REGARDING TRADITIONAL PRACTICES USED DURING INTRAPARTUM PERIOD IN A SELECTED HOSPITAL IN GAUTENG

Principal Investigator: Miss Silindile Sithole

Institution: Rahima Moosa Mother and Child Hospital

DAYTIME AND AFTER-HOURS TELEPHONE NUMBER(S):

072 322 8656

DATE AND TIME OF FIRST INFORMED CONSENT DISCUSSION:

			:	
Date	**Month**	**Year**	**Time**	

Dear Prospective Participant

1) INTRODUCTION

You are invited to volunteer to participate in a research study. I am conducting research for Mcur degree purpose at the University of Pretoria. This information in this document is to help you to decide if you would like to participate. Before you agree to take part in this study you should fully understand what is involved. If you have any questions, which are not fully explained in this document, do not hesitate to ask the researcher. You should not agree to take part unless you are completely satisfied about all the procedures involved.

2) THE NATURE AND PURPOSE OF THIS STUDY

The aim of this study is to explore and describe the knowledge of midwives regarding traditional practices used during intrapartum in a selected hospital in Gauteng.

EXPLANATION OF PROCEDURES AND WHAT WILL BE EXPECTED FROM THE PARTICIPANTS

If you agree to participate, you will be asked to participate in a face-to-face interview which will take about 45 - 60 minutes. The individual interview will be a one-on-one meeting between the researcher and participant. I will ask one main question followed by probing questions about the research topic. This study involves answering some questions. With your permission, the interview will be recorded on a recording device to ensure that no information is missed. You will not be identified during the interview.

4) POSSIBLE RISKS AND DISCOMFORTS INVOLVED

There are no risks involved in the study. The information obtained will only be used by the researcher.

5) POSSIBLE BENEFITS OF THIS STUDY

Although you may not benefit directly. The knowledge gained after this study might empower midwives with knowledge to enable them to identify safe and harmful practises. The maternal and child healthcare might be improved and be culturally sensitive because the midwives will be able to show understanding of different cultural practises when caring for patients with traditional and cultural diversity.

6) COMPENSATION

You will not be paid to take part in the study.

7) VOLUNTARY PARTICIPATION

The decision to take part in the study is yours and yours and you do not have to take part if you do not want to. You can also stop at any time during the interview without giving a reason. If you refuse to take part in the study, this will not affect you in any way.

8) ETHICAL APPROVAL

This study was submitted to the Research Ethics Committee of the Faculty of Health Sciences at the University of Pretoria, Tswelopele Building, Level 4-59, telephone numbers 012 356 3084 / 012 356 3085 and written approval has been given by that committee.

9) INFORMATION ON WHO TO CONTACT

If I have any questions concerning this study, I should contact:

Researcher: Silindile Sithole 072 322 8656 email: slindile.s05@gmail.com

Supervisor: Dr RN Ngunyulu 072 240 1696 email: roinah.ngunyulu@up.ac.za

Co-supervisor: Dr PM Jiyane 073 4357949 email: priscilla.jiyane@up.ac.za

10) CONFIDENTIALITY

We will not record your name anywhere and no one will be able to identify you to the answers you gave. Your answers will be linked to a fictitious code number, or a pseudonym (another name) and we will refer to you in this way in the data, any publication, report, or other research output.

All records from this study will be regarded as confidential. Results will be published in medical journals or presented at conferences in such a way that it will not be possible for people to know that you were part of the study.

The records from your participation may be reviewed by people responsible for making sure that research was done properly, including members of the Research Ethics Committee. All these people are required to keep your identity confidential. Otherwise, records that identify you will be available only to people working on the study, unless you give permission for other people to see the records.

11) CONSENT TO PARTICIPATE IN THIS STUDY

- I confirm that the person requesting my consent to take part in this study has told me about the nature and process, any risks or discomforts, and the benefits of the study.
- I have also received, read, and understood the above written information about the study.
- I have had adequate time to ask questions and I have no objections to participate in this study.

- I am aware that the information obtained in the study, including personal details, will be anonymously processed, and presented in the reporting of results.
- I understand that I will not be penalised in any way should I wish to stop taking part in the study.
- I am participating willingly.
- I have received a signed copy of this informed consent agreement.

_____ _____

Participant's name (Please print) Date

_____ _____

Participant's signature Date

_____ _____

Researcher's name (Please print) Date

_____ _____

Researcher's signature Date

I understand that the interview or discussion will be audio taped. I give consent that it may be audio taped.

YES / NO

ANNEXURE E: UNIVERSITY OF PRETORIA ETHICS APPROVAL

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

Faculty of Health Sciences

Institution: The Research Ethics Committee, Faculty Health Sciences, University of Pretoria complies with ICH-GCP guidelines and has US Federal wide Assurance.

- FWA 00002567. Approved on 22 May 2002 and Expires 03/20/2022.
- ORG #: IORG0001762. OMB No. 0990 0279 Approved for use through February 28, 2022 and expires: 03/04/2023.

31 August 2020

Approval Certificate
New Application

Ethics Reference No.: 514/2020
Title: Knowledge of midwives regarding traditional practices used during intrapartum period in a selected hospital in Gauteng

Dear Miss SM Sithole

The **New Application** as supported by documents received between 2020-07-30 and 2020-08-26 for your research, was approved by the Faculty of Health Sciences Research Ethics Committee on 2020-08-26 as resolved by its quorate meeting.

Please note the following about your ethics approval:

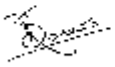
- Ethics Approval is valid for 1 year and needs to be renewed annually by 2021-08-31.
- Please remember to use your protocol number (514/2020) on any documents or correspondence with the Research Ethics Committee regarding your research.
- Please note that the Research Ethics Committee may ask further questions, seek additional information, require further modification, monitor the conduct of your research, or suspend or withdraw ethics approval.

Ethics approval is subject to the following:

- The ethics approval is conditional on the research being conducted as stipulated by the details of all documents submitted to the Committee. In the event that a further need arises to change who the investigators are, the methods or any other aspect, such changes must be submitted as an Amendment for approval by the Committee.

We wish you the best with your research.

Yours sincerely



Dr R Sommers
MBChB MMed (Int) MPharmMed PhD
Deputy Chairperson of the Faculty of Health Sciences Research Ethics Committee, University of Pretoria

The Faculty of Health Sciences Research Ethics Committee complies with the SA National Act 61 of 2003 as it pertains to health research and the United States Code of Federal Regulations Title 46 and 45. This committee abides by the ethical norms and principles for research, established by the Declaration of Helsinki, the South African Medical Research Council Guidelines as well as the Guidelines for Ethical Research: Principles Structures and Processes, Second Edition 2016 (Department of Health)

Research Ethics Committee
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ANNEXURE F: RAHIMA MOOSA MOTHER AND CHILD ETHICS APPROVAL

GAUTENG PROVINCE
HEALTH
REPUBLIC OF SOUTH AFRICA

RAHIMA MOOSA MOTHER AND CHILD HOSPITAL

Enquiries : Karen Marshall
Tel : (011) 470 9284
Fax : 086 553 4623
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TITLE OF RESEARCH PROJECT:
"KNOWLEDGE OF MIDWIVES REGARDING TRADITIONAL PRACTISES USED DURING INTRAPARTUM PERIOD IN A SELECTED HOSPITAL IN GAUTENG"

NAME OF SUPERVISOR:
PROFESSOR PN NGUNYULU

NAME OF RESEARCHER:
MS. SILINDILE SITHOLE
DEPARTMENT OF NURSING SCIENCE
SCHOOL OF HEALTH CARE SCIENCES
FACULTY OF HEALTH SCIENCES
UNIVERSITY OF PRETORIA

NHRD REF NO: GP_202009_018

Dear Ms. Sithole,

Permission is granted for you to conduct the research as indicated in the title above.

The terms under which this permission is granted is contained in the Researcher Declaration form that you have signed. Failure to comply with these conditions will result in the withdrawal of such permission.

It is crucial for you to inform the Research Coordinator, Karen Marshall of the actual start and end dates of your study. This could be done by e-mail.

Should the study commence more than 12 months after receipt of this approval letter you will have to go through the process of applying again.

You are strongly advised to keep a signed copy of the declaration form to ensure that the terms of this agreement are complied with at all times.

Yours sincerely,

DR FREW BENSON
ACTING CHIEF EXECUTIVE OFFICER
2020:12:09

ADDRESS: Cnr FUEL & OUDSTHOORN STREET CORONATIONVILLE 2093 / PRIVATE BAG X20 NEWCLARE 2112 JHB

ANNEXURE G: INTERVIEW GUIDE

1. What do you regard as traditional birth practices?

The question was followed by probing questions that were formulated according to the responses of participants to the main question, only if a participant's responses did not cover the scope of the main question:

1. What's your first reaction when you hear that the woman is using/has used traditional practices during the intrapartum period?

2. Tell me more about your knowledge regarding the traditional practices used during the intrapartum period.

3. Is there anything else you would like to tell me regarding traditional practices used during the intrapartum period? Or are there any other questions that you think I should have asked regarding traditional practices used during the intrapartum period?

ANNEXURE H: LANGUAGE EDITOR CERTIFICATE

expertenglisheditorscc

CERTIFICATE

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TO WHOM IT MAY CONCERN

This is to certify that I have edited this document for English style, language usage, logic and consistency; it is the responsibility of the author to manually accept or reject the suggested changes and interact with the comments in order to finalise the text. The references are to be finalised by the client too.

Author:	SILINDILE MARCIA SITHOLE
Title:	**Knowledge of Midwives Regarding Traditional Practices Used During Postpartum Period in a Selected Hospital in Gauteng**
Degree:	MCur
Institution:	School of Nursing Faculty of Health Sciences University of Pretoria South Africa

Sincerely,

Dr Felicity Horne for Expert English Editors
B. A. (Wits); T.T.H.D (Wits); B.A. Hons (Unisa); M.A. (Unisa); D. Litt. et Phil. (Unisa)

Electronically signed
2022-06-09