

CHAPTER 4

DATA ANALYSIS AND INTERPRETATION OF RESULTS

4.1 INTRODUCTION

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

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

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

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

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

4.2 DATA ANALYSIS

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

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

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

Data analysis occurred simultaneously with data collection.

4.2.1 Population

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

TABLE 4.1: Profile for postnatal patients

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

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

TABLE 4.2: Family members

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

TABLE 4.3: Profiles for Traditional Birth Attendants

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

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

TABLE 4.4: Profiles for registered midwives

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

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

TABLE 4.5: Profiles for Midwifery lecturers

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

TABLE 4.6: Profiles for Maternal and Child healthcare coordinators

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

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

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

4.3 RESEARCH FINDINGS FROM THE DATA

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

4.3.1 Postnatal patients

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

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

Table 4.7: Perceptions of postnatal patients

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

Theme 1: Challenges during the postnatal period

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

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

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

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

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

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

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

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

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

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

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

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

- **Clashing postnatal care advice**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Category 1.2: Lack of postnatal care supervision and follow up

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

4.3.2 Family members and traditional birth attendants

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

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

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

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

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

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

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

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

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

Category 1.1: Lack of support by registered midwives

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

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

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

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

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

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

One family member said:

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

Another family member said:

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

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

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

One of the well-known family member said:

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

Another experienced traditional birth attendants said:

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

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

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

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

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

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

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

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

One traditional birth attendant said:

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

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

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

Another traditional birth attendant said:

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

Another traditional birth attendants said:

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

One family member said:

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

Another family member said:

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

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

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

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

Category 1.3: Witnessing maternal deaths at home

Maternal death is defined by the WHO as:

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

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

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

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

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

One family member said:

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

One experienced traditional birth attendant said:

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

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

Another traditional birth attendant said:

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

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

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

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

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

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

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

One traditional birth attendant said:

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

Another said:

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

Another said:

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

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

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

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

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

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

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

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

4.3.3 Registered midwives

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

TABLE 4.9: Perceptions and experiences of registered midwives

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

One traditional birth attendant said:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Category 2.1: Increasing maternal and child mortality rates

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

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

- **Contributory factors**

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

- **Late booking for antenatal care**

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

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

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

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

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

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

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

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

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

- **Ineffective postnatal check up**

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

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

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

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

One postnatal patient said:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Theme 3: Incorporation strategies

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

Category 3.1: Awareness campaigns

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

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

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

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

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

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

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

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

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

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

Category 3.2: Meetings

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

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

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

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

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

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

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

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

Category 3.3: Training

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

- **Registered midwives**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Theme 4: Outcomes of incorporation

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

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

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

Category 4.1: Empowerment

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

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

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

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

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

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

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

Category 4.2: Teamwork

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

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

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

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

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

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

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

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

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

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

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

Category 4.3: Improved job satisfaction

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

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

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

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

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

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

4.3.4 Midwifery lecturers

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Theme 2: Incorporation strategies

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

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

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

Category 2.1: Involvement and participation of relevant stakeholders in planning

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

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

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

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

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

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

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

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

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

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

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

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

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

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

4.3.5 The maternal and child healthcare coordinators

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

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

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

Theme 1: Sub-standard postnatal care

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

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

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

Category 1.1: Ineffective referral system

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

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

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

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

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

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

Category 1.2: Inadequate resources

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

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

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

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

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

Theme 2: Incorporation strategy

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

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

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

Category 2.1: Team building

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

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

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

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

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

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

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

Theme 3: Outcomes of incorporation

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

Category 3.1: Improved standard of postnatal care

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

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

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

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

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

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

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

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

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

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

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

Category 3.2: Reduced maternal and child mortality rates

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

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

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

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

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

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

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

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

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

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

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

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

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

- **Reduced legal costs**

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

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

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

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

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

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

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

4.4 SUMMARY

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

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

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

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

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