

**AN EXPLORATORY STUDY OF THE PREVALENCE  
OF HOME DELIVERIES AT MPUMALANGA  
TOWNSHIP IN KWAZULU-NATAL**

**BY**

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## TABLE OF CONTENTS

CONTENT	PAGE
DECLARATION .....	(i)
DEDICATION .....	(ii)
ACKNOWLEDGEMENT .....	(iii)
ABSTRACT .....	(iv)
FIGURES .....	(v)

### CHAPTER 1

#### ORIENTATION TO THE STUDY

1.1 INTRODUCTION .....	1
1.2 BACKGROUND OF THE STUDY .....	2
1.3 STATEMENT OF THE PROBLEM .....	2
1.4 THE IMPORTANCE OF THE PROBLEM .....	3
1.5 THE PURPOSE OF THE STUDY .....	3
1.6 OBJECTIVES .....	3
1.7 RESEARCH QUESTIONS .....	4
1.8 DELIMITATION OF THE STUDY .....	4
1.9 LITERATURE REVIEW .....	4
1.10 THEORETICAL FRAMEWORK .....	6
1.11 PILOT STUDY .....	6
1.12 ETHICAL CONSIDERATIONS .....	6
1.13 RESEARCH DESIGN .....	6
1.14 SAMPLING TECHNIQUE .....	7
1.15 SAMPLE AND SAMPLING .....	7
1.16 DEFINITION OF CONCEPTS .....	7
1.17 ORGANISATION OF THE RESEARCH REPORT .....	7

## CHAPTER 2

2.1	INTRODUCTION .....	9
2.2	DEFINITION OF LITERATURE REVIEW .....	9
2.3	ORIGINS OF MIDWIFERY HOME DLIVERIES .....	10
2.4	REASONS FOR HOME DELIVERIES .....	11
2.5	THE CHANGING ROLE OF THE MIDWIRE .....	11
2.6	PRIMITIVE CARE DURING DELIVERY .....	12
2.7	THE CHANGING MIDWIFERY PRACTICAL DURING THE 17 <sup>TH</sup> CENTURY .....	12
2.8	THE ROLE OF COMMUNITY MEMBERS IN HOME DELIVERIES .....	13
2.9	TRADITIONAL HEALER/HERBALIST .....	13
2.10	TBA'S IN MANAGEMENT OF THE FIRST STAGE OF LABOUR .....	13
2.11	SECOND STAGE OF LABOUR .....	14
2.12	THIRD STAGE OF LABOUR .....	15
2.13	METHOD FOR HOME DELIVERIES .....	16
2.14	ADVANTAGES OF HOME DELIVERIES .....	17
2.15	CARE OF THE PLACENTA .....	17
2.16	THEORETICAL FRAMEWORK .....	18
2.17	INTRODUCTION .....	18
2.18	UNIVERSAL SELF-CARE REQUISITES .....	18
2.19	DEVELOPMENT SELF-CARE .....	19
2.20	HEALTH DEVELOPMENT .....	19
2.21	THE THEORY OF SELF-CARE DEFICIT .....	19
2.22	THE THEORY OF THE NURSING SYSTEMS .....	20
2.23	OREM'S THEORY OF NURSING PROCESS .....	20
2.24	REPRESENTATION OF OREMS SELF-CARE MODEL .....	21
2.25	ASSESSMENT OF HEALTH CARE DEFICITS .....	21
2.26	CONCLUSION .....	22

## CHAPTER 3

3.1	INTRODUCTION .....	23
3.2	AREA OF STUDY: MPUMALANGA .....	23
3.2.1	A BRIEF HISTORY OF MPUMALANGA TOWNSHIP .....	23
3.3	PERMISSION TO DO THE STUDY .....	23
3.4	RESEARCH DESIGN .....	24
3.5	QUALITATIVE RESEARCH METHODOLOGY: DEFINITION .....	25
3.6	TYPES OF QUALITATIVE RESEARCH .....	26
3.7	ETHNOGRAPHIC APPROACH .....	26
3.8	MODELS FOR QUALITATIVE RESEARCH .....	26
3.8.1	GUBA'S MODEL FOR QUALITATIVE RESEARCH .....	27
3.9	DISCUSSION OF RESEARCH METHODOLOGY .....	28
3.9.1	DATA GATHERING FROM PREGNANT WOMEN .....	29
3.9.2	SAMPLING OF PREGNANT MOTHERS .....	29
3.9.3	DATA GATHERING FROM TRADITIONAL BIRTH ATTENDANTS .....	30
3.10	MEASURES TO ENSURE TRUSTWORTHINESS .....	32
3.11	METHODOLOGY FOR DATA COLLECTION FROM STAFF MEMBERS .....	32
3.12	SAMPLING OF (PROFESSIONAL MIDWIVES) STAFF MEMBERS .....	33
3.13	METHODOLOGY FOR DATA COLLECTION FROM TRADITIONAL BIRTH ATTENDANTS .....	33
3.14	CONCLUSION .....	34

## CHAPTER 4

4.1	INTRODUCTION .....	35
4.2	BIOGRAPHICAL DATA .....	35
4.3	FIGURES (4.3-4.10) .....	36

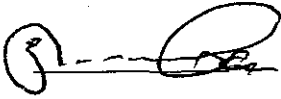
4.11	MODELS FOR QUALITATIVE RESEARCH .....	45
4.12	GUBA'S MODEL FOR QUALITATIVE RESEARCH .....	45
4.13	CONCLUSION .....	48

## **CHAPTER 5**

5.1	INTRODUCTION .....	49
5.2	SUMMARY .....	49
5.3	STATEMENT OF THE PROBLEM .....	49
5.4	THE OBJECTIVES OF THE STUDY .....	49
5.5	RESEARCH METHODOLOGY .....	56
5.6	FINDINGS .....	59
5.7	RECOMMENDATIONS .....	60
5.8	GUIDELINES FOR UTILIZATION OF TRADITIONAL BIRTH ATTENDANTS .....	61
5.9	LIMITATIONS .....	62
5.10	CONCLUSION .....	63

## DECLARATION

I ZANELE VIRGINIA NDABA hereby declare that this is my own work and that all resources that have been used or quoted have been indicated and acknowledged by means of complete references.

A handwritten signature in black ink, consisting of a stylized 'Z' followed by a large loop and a horizontal line.

Z.V. NDABA

## **DEDICATION**

I dedicate this work to my late parents, my husband Percy and my children Njabulo, Sinenhlanhla and Banele.

## ACKNOWLEDGEMENT

I wish to express my sincere gratitude and appreciation to everybody who supported me and contributed directly or indirectly to the completion of this study.

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## **ABSTRACT**

### **1. INTRODUCTION**

The purpose of the study was to explore the prevalence of home deliveries at Mpumalanga Clinic of Region "F" in KwaZulu-Natal. Data to establish the professional nurses' perceptions was collected from Professional Nurses, Traditional Birth Attendants and the clients visiting the clinic. Regarding the word of Traditional Birth Attendants, the findings and recommendations which are made were based on the reasons why clients still preferred to deliver at home and how Traditional Birth Attendants conducted deliveries, and the perceptions of nurses with the aim of improving the antenatal and delivery services to the surrounding communities.

### **2. OBJECTIVES OF THE STUDY**

The objectives of the study were:

- To identify the reasons for preference of unattended deliveries by skilled workers when safe monitored deliveries could be provided by trained midwives.
- To determine knowledge and attitude of clients towards the benefit of monitored deliveries by midwives.
- To develop guidelines for Traditional Birth Attendants.

### **3. RESEARCH METHODOLOGY**

Both qualitative and descriptive methods were used to explore the attitudes of professional midwives on home deliveries conducted by Traditional Birth Attendants, and reasons for preference of home deliveries by clients and the delivery by the Traditional Birth Attendants.

For the study of home deliveries by Traditional Birth Attendants, the researcher needed to ensure trustworthiness and credibility of the information obtained from the

subjects. For this purpose Guba's model was used as cited in De Vos (1998:350). It was necessary to use videotapes to study behaviour and human experience of the Traditional Birth Attendants. The questionnaire consisted of items such as experience that each Traditional Birth Attendant had e.g. how complications such as post-partum, haemorrhage, and asphyxia of the baby were dealt with.

#### **4. FINDINGS OF THE STUDY**

The researcher made the following findings:

- There was no integration of Professional Nurses and Traditional Birth Attendants, but during data collection the professional nurses felt that integration should be established in order to reduce complications by unknown Traditional Birth Attendants.
- The Traditional Birth Attendants could improve their knowledge and skills and thereby prevent complications.
- The Traditional Birth Attendants admitted to having fears to refer their clients to professional midwives because they felt unaccepted and marginalised.
- Some of the pregnant mothers felt threatened by the services of the Traditional Birth Attendants but then they were available and accessible even at night.
- Traditional Birth Attendants came from the village so they were known and pregnant mothers did not have to travel long distances or pay the taxi fare.

#### **5. RECOMMENDATIONS**

The following recommendations were made:

- Regional and district office to liaise with public works department about the upgrading of roads.

- Clinic opening hours into the night to be increased from 8-4p.m. to a 24 hour service.
- Safety of professional nurses to be ensured after hours.
- Traditional Birth Attendants to undergo training for safe care of patients and also for their protection.
- Professional nurses to work hand in hand with the Traditional Birth Attendants.

## **6. GUIDELINES FOR SERVICES OF TRADITIONAL BIRTH ATTENDANTS**

The researcher constructed the following guidelines:

### **6.1 GUIDELINE NO.1**

There should be establishment of database for Traditional Birth Attendants at Mpumalanga. This would assist in tracing Traditional Birth Attendants for important meetings, training sessions or to enquire about certain patients that they had delivered.

### **6.2 GUIDELINE NO. 2**

#### **Training of Traditional Birth Attendants**

It is clear that Traditional Birth Attendants had existed in all cultures and they are still existing and utilized by our communities. Training is therefore essential for safe practice by Traditional Birth Attendants.

### **6.3 GUIDELINE NO. 3**

A curriculum for training of Traditional Birth Attendants should be constructed and sent to the Department of Health, the South African Qualification Association.

#### **6.4 GUIDELINE NO.4**

A body that monitors standards of practice should be consulted or a system whereby the clinics could work hand in hand with a Traditional Birth Attendant should be established.

#### **6.5 GUIDELINE 5**

##### **Prevention of Infection**

The Traditional Birth Attendants should be taught aseptic technique and should undergo a full programme of HIV prevention for safety of both Traditional Birth Attendants and patients that they deliver.

#### **6.6 GUIDELINE NO.6**

The Traditional Birth Attendants should be accepted as counterparts in the management of patients, because at times they perform duties which nurses cannot perform such as in peri-urban and rural areas where there is no transport at night and the client is in labour.

#### **6.7 GUIDELINE NO 7**

A needs analysis what the Traditional Birth Attendants need to learn must be performed so that training is made available to address these needs.

### **7. CONCLUSION**

Not much on the subject of Traditional Birth Attendants has been published although it has existed and continues to exist in every culture. It is for this reason that it is not clearly understood. Also very little research has been done on Traditional Birth Attendants.

During data collection, information obtained from the subjects revealed that the Traditional Birth Attendants are important in our communities for the contributions that they make. The need for professionals to work with Traditional Birth Attendants has also been highlighted for safety of our community as well as Traditional Birth Attendants themselves in terms of safe deliveries and qualifications against infections.

## **OPSOMMING**

### **1. ENLEIDING**

Die hoofdoelwit van hierdie studie was om ondersoek in te stel na die voorkoms van tuisgeboortes by die Mpumalanga Kliniek van Streek "F" in KwaZulu-Natal. Data oor die professionele verpleegster se persepsies is verkfy vanaf professionele Verpleegsters, Tradisionele Geboorte-begeleidsters en die kliënte wat die kliniek besoek. Die bevindinge en aanbevelings is gebaseer op die redes waarom kliënte verkies om tuis geboorte te skenk, how hierdie geboortes deur die Tradisionele Geboorte-begeleidsters hanteer word en die persepsies van die verpleegsters, ten einde die voorgeboortelike dienste en dienste tydens geboorte in die omliggende gemenskappe, te verbeter.

### **2. DOELWITSTELLINGS**

Die doelwitte van die studie was:

- Om te bepaal waarom voorkeur veleen word ann geboortebegeleiding deur kundige werkers wanneer veilige geboortes onder toesig van opgeleide vroedvroue kan geskied.
- Om die kennis en houdings van kliënte ten opsigte van die voordele van geboortes onder toesig van vroedvroue, te bepaal.
- Om riglyne daar te stel vir Tradisionele Geboorte-begeleidsters.

### **3. ONDERSOEKMETODOLOGIE**

Beide die kwalitatiewe en deskriptiewe metodes is gebruik om ondersoek in te stel na die houdings van professionele vroedvroue ten opsigte van tuisgeboortes wat deur Tradisionele Geboorte-begeleidsters waargeneem word, die redes waarom voorkeur verleen word aan tuisboortes en die geboortepraktyke van die Tradisionele Geboorte-begeleidsters.

Vir die ondersoek na tuisgeboortes onder toesig van Tradisionele Geboorte-begeleidsters was dit nodig om die geloofwaardigheid van die inligting wat van die respondente verkry is, te verseker. Guba se model, soos uiteengesit in De Vos (1998:350), is vir hierdie doel gebruik. Daar moes van video-opnames gebruik gemaak word om die gedrag en menslike ervaring tydens geboortes onder toesig van Tradisionele Geboorte-begeleisters te bestudeer. Die vraelys is opgestel met invoeging van items soos die ervarings van elke Tradisionele Geboorte-begeleidster ten opsigte van die hantering van aspekte soos komplikasies tydens geboorte, byvoorbeeld post-partum, bloeding en versmoring.

#### **4. BEVINDINGE VAN DIE STUDIE**

Die volgende bevindinge is gemaak:

- Daar was geen integrasie van Professionele Verpleegsters en Tradisionele Geboorte-begeleidsters nie, hoewel die professionele verpleegsters tydens data verkryging aangedui het dat integrasie bewerkstellig moet word ten einde komplikasies tydens geboortes waarby onbekende Tradisionele Geboorte-begeleidsters teen voordig was, te beperk.
- Die Tradisionele Geboorte-begeleidsters het ook gevoel dat 'n kortkursus deur Professionele Verpleegsters sal bydra tot hulle kennis en ervaring ten einde komplikasies te voorkom.

#### **5. AANBEVELINGS**

Die volgende aanbevelings word gemaak:

- Streeks – en distrikskantore moet met die departement balas met openbare paaie onderhandel vir die opgradering van paaie.
- Kliëniek-ure moet verleng word vanaf 8-4 n.m. tot 'n 24-uur diens.
- Die veiligheid van professionele verpleegsters na ure moet verseker wor.

- Tradisionele Geboorte-befeidsters moet opleiding ondergaan vir die veilig hantering van hulle kliënte asoek vir hulle eie beskerming.
- Professionele verpleegsters behoort saam met die Tradisionele Geboorte-begeleidsters te werk.

Riglyne vir die dienste van Tradisionele Geboorte-begeleidsters

- Die navorser het die volgende riglyne bepaal:

### **6.1 RIGLYN NO. 1**

Daar moet 'n databasis opgestel word vir Tradisionele Geboorte-begeleidsters in Mpumalanga. Dit sal die opsporing van Tradisionele Geboorte-begeleidsters vir belangrike vergaderings, opleidingsessies en navrae oor sekere pasiënte, versgemaklik.

### **6.2 RIGLYN NO.2**

Opleiding van Tradisionele Geboorte-begeleidsters

Dit is duidelik dat Tradisionele Geboorte-begeleidsters in alle kulture teenwoordig is en steeds deur die gemeenskappe gebruik word. Opleiding is noodsaaklik vir veilige praktyke deur Tradisionele Geboorte-begeleidsters.

### **6.3 RIGLYN NO.3**

'n Kurrikulum vir die opleiding van Tradisionele Geboorte-begeleidsters moet opgestel word en aan die Departement van Gesondheid en die Suid-Afrikaanse Vereniging vir Kwalifikasie Standaarde voorgelê word.

#### **6.4 RIGLYN NO.4**

'n Liggaam wat standarde monitor moet genader word of 'n sisteem moet ingestel word wat klinieke in staat sal stel om saam met Tradisionele Geboorte-begeleidsters te werk.

#### **6.5 RIGLYN NO.5**

Voorkoming van infeksie:

Die Tradisionele Geboorte-begeleidsters moet geleer word om aseptiese tegnieke te volg en 'n volskaalse program van HIV-voorkoming vir die veiligheid van beide Tradisionele Geboorte-begeleidster en pasiënte, moet ingestel word.

#### **6.6 RIGLYN NO.6**

Die Tradisionele Geboorte-begeleidsters moet aanvaar word as mede-rolspelers in die hantering van pasiënte, aangesien hulle by tye die dienste van verpleegsters in buitestedelike en landelike gebiede lewer waar daar snags vervoer is wanneer die pasiënte hulle benodig nie.

#### **6.7 RIGLYN NO 7**

'n Behoeftentleding moet uitgevoer oor wat die Tradisionele Geboorte-begeleidsters nodig het om te leer sodat opleiding aangebied kan word om hierdie behoeftes aan te spreek.

### **7. SLOT**

Daar is nie veel gepubliseer oor die onderwerp van Tradisionele Geboorte-begeleidsters nie, alhoewel dit nog altyd in elke kultuur bestaan het en steeds sal bly

voorbestaan. Daar is ook baie min navorsing oor Tradisionele Geboorte-begeleidsters gedoen, wat begrip daarvoor in die wiede ry.

Tydens die insameling van data is inligting verkry vanaf respondente wat aangedui het dat die Tradisionele Geboorte-begeleidsters 'n belangrike bydrae maak in ons gemeenskappe. Die behoefte vir professionele verpleegsters om saam met die Tradisionele Geboorte-begeleidsters te werk is in hierdie studie uitgelig sodat veilige praktyke in die gemeenskappe wat hulle bedien, asook hulle eie beveiliging in terme van veilige geboortes en stappe teen die opdoen van infeksies, bewerkstellig kan word.

# **AN EXPLORATORY STUDY OF THE PREVALENCE OF HOME DELIVERIES AT MPUMALANGA TOWNSHIP IN KWAZULU-NATAL**

## **CHAPTER 1**

Chapter one of the study gives a detailed description of how the study will be conducted. The following aspects are presented:

Introduction, purpose of the study, research questions and research methodology that serve to orientate the reader to the study and guide the researcher during the study.

### **1.1 INTRODUCTION**

There is generally a complaint from the health services that pregnant mothers still use traditional methods to care for the unborn child while health services are provided for communities. It is important for the health care personnel with community structures such as traditional healers and Traditional Birth Attendants as systems to provide an accessible, acceptable and equitable health care. However, presently there is no joint co-operation between Traditional Healers, Traditional Birth Attendants and the health Care Providers as they practice separately. Traditional Healers and Traditional Birth Attendants play a prominent role in health care delivery in general in every township in KwaZulu-Natal (Nolte, A. 1992:34). It is generally recognised that much needs to be done to bridge the gap between traditional and modern medicine, possibly by starting with joint meetings of traditional healers and health workers to explore areas of co-operation of Initiate Sub-District Support (ISDS).

Other countries have recognised the importance of Traditional Birth Attendants and have implemented simple interventions to optimise the quality of care they provide

e.g. by providing them with birth kits and to help to ensure clean and hygienic cord management (ISDS) (November 1997: Health and Health Care in Mount Frere Technical Report No. 2C. Health System Trust, Durban.

## **1.2 BACKGROUND OF THE STUDY**

On the 24<sup>th</sup> May 1996 the State President declared in his National speech that health care would be free for pregnant women. This change was implemented by various institutions particularly the public sector, i.e. clinics. Mpumalanga clinic also implemented the policy of free health services for pregnant mothers and for children under 6 years of age. Mpumalanga clinics have a small number in spite of increased number of antenatal attendants. There are few deliveries at Mpumalanga clinic compared to the antenatal cases. This is revealed in the statistics presented.

The researcher working at Mpumalanga clinic as a professional nurse made the following observations from the clinic records. In 1996 ante-natal attendance was 650; in 1997 it was 700 and clinic deliveries 15; in 1998 ante-natal attendance was 820 and clinic deliveries 20. The statistics presented, reveal an increase in antenatal attendance by pregnant women while there is a reduction in institutional deliveries. The pregnant women prefer to deliver at home under the supervision of unskilled Traditional Birth Attendants.

## **1.3 STATEMENT OF THE PROBLEM**

There is a high rate of home delivery in Mpumalanga area in Region "F: of KwaZulu-Natal. This arouses concern for the professional nurses who conduct antenatal services and have fewer patients coming for delivery. Home deliveries are conducted under unsafe conditions, which can be detrimental to both the mother and the baby.

#### **1.4 THE IMPORTANCE OF THE PROBLEM**

Unskilled workers conduct deliveries and a delivery under unskilled relatives and helpers usually results in complications which may be so severe as to cause death. Unless health care workers can initiate contact with these structures this problem will continue to exist and more infant deaths will occur.

#### **1.5 THE PURPOSE OF THE STUDY**

The purpose of the study is to explore the prevalence of home deliveries at Mpumalanga Township in KwaZulu-Natal. To identify the reasons for home deliveries among pregnant mothers as well perceptions of nurses with regard to the practice of unmonitored deliveries by traditional healers and Traditional Birth Attendants, with the aim of improving the antenatal and delivery services to community members.

#### **1.6 OBJECTIVES**

The objectives of the study are:

- To explore the prevalence of home deliveries at Mpumalanga Township of KwaZulu-Natal.
- To identify the reasons for preference of unattended deliveries by unskilled workers when safe monitored deliveries could be provided by trained midwives.
- To determine the knowledge and attitude of clients towards the benefits of monitored deliveries by midwives.
- To make recommendations to improve health care delivery systems.
- To develop guidelines for integration of the Traditional Birth Attendants into health services.

## **1.7 RESEARCH QUESTIONS**

The following research questions are posed:

- i) What are the perceptions of professional nurses at Mpumalanga Clinic concerning the services of Traditional Birth Attendants?
- ii) Why do clients still cling to the services of the Traditional Birth Attendants in preference to clinic services by professional nurses?
- iii) What are the practices and experiences of the Traditional Birth Attendants?

## **1.8 DELIMITATION OF THE STUDY**

The study is delimited to cover only the township of Mpumalanga which consists of units 1, 2, 3, 4, and 6 which is a newly and recently established part of the township. Areas such as Sankontshe, Mophele, Ntshongweni and Georgedale will be excluded from this study since they are rural areas surrounding the township.

## **1.9 LITERATURE REVIEW**

Literature review is a critical summary of research on a topic of interest, generally prepared to put a referral problem in context or identify gaps and weakness in prior studies so as to justify a new investigation. In this study the researcher will explore the attitudes of pregnant mothers and nurses towards institutional deliveries, and also study the trends of hospital deliveries followed over the years, since there seems to be a lowering of statistics for clinic deliveries against the increasing number of antenatal cases.

The supporting studies that have been undertaken include the following:

According to Chipfakacha 1994 the majority of women in the remote areas still prefer home deliveries. A number of personnel will have to change a few of their rules and attitudes and co-operate with patients.

According to Chipfakacha 1994, there are three main types of communities served by Traditional Midwives (TM's). The first is the isolated and remote community, located far from road networks and health facilities; the second type is the rural community with access to road networks and health facilities. In such communities Traditional Midwives usually work together with scientific medicine medical personnel. Women usually attend antenatal clinics of health facilities but prefer to deliver at home. The third type of community is the urban/peri-urban community which, despite having a central system of service, still prefers Traditional Birth Attendants. In the majority of African countries. Traditional Midwives are still utilised.

According to David Patterson, the project manager of the Ndwedwe child survival project, the role of the Traditional Birth Attendants needs to change to that of health educators who encourage other women to access the formal health sector and for them to learn better maternal care. Dr Pattern's project provides training for Traditional Birth Attendants on how to assist in birth procedure and to give proper prenatal advice.

According to Searle (1978:260), the majority of the deliveries in the world are attended by untrained persons. Traditional Birth Attendants form part of the basic primary health care workers in all developing countries. In developing countries efforts are being made to provide some form of training and supervision of these birth practitioners by qualified midwives. However, distance, cultural practices, financial and human resources for providing training and supervision largely negate such efforts (Searle, 1978:260).

## **1.10 THEORETICAL FRAMEWORK**

This study is based on Orem's theory of self-care. This model is used by Orem to present the individual's abilities to engage in self-care. The individual's abilities to engage in self-care are conditional by age, developmental state, life experience, socio-cultural orientation, health and available resources. Orem presents three categories of self-care requisites i.e. universal, development and health deviation. Self-care requisites are common to all human beings during all stages of the life cycle and should be viewed as interrelated factors. In this study patients may not cope with all stages of life due to conflict caused by traditional and modern medicine.

## **1.11 PILOT STUDY**

Pilot study is a small-scale version or trial run, done in preparation for a major study (Polit and Hungler, 1993). The instrument will be constructed and tested on 5 antenatal cases; thereafter the whole study will be done on 50 subjects reporting to the clinic for Ante-Natal Care. Such subjects will be excluded from the major study.

## **1.12 ETHICAL CONSIDERATIONS**

Permission to conduct the study will be acquired by writing letters to authorities in the Department of Provincial Health and the local health services, which include the Director of Nursing Services and the Deputy Director at Edendale Hospital.

Permission will also be sought from the research participants after the researcher has given a full explanation and understanding of the study by the participants has been attained. Informed consent will be obtained from the subjects and they will be assured of anonymity. Participation will be voluntary and subjects will not be coerced to take part.

### **1.13 RESEARCH DESIGN**

A descriptive survey will be used. Three types of questionnaires will be designed for data collection. Each questionnaire will be administered to the groups presented; Professional Nurse, pregnant mothers and Traditional Birth Attendants respectively.

### **1.14 SAMPLING TECHNIQUE**

Sampling is the process of selecting a portion of the population to represent the entire population Polit (1993:445).

### **1.15 SAMPLE AND SAMPLING**

A simple random sampling method will be used to collect data from antenatal cases coming to the clinic, the professional nurses and Traditional Birth Attendants.

### **1.16 DEFINITION OF CONCEPTS**

**Traditional Birth Attendants**

### **1.17 ORGANISATION OF THE RESEARCH REPORT**

The research report will be organised as follows:

#### **CHAPTER ONE**

Chapter one will discuss orientation to the study.

#### **CHAPTER TWO**

Literature review.

### CHAPTER THREE

Research Methodology.

### CHAPTER FOUR

Data presentation analysis and interpretation of results.

### CHAPTER FIVE

Summary and recommendations.

## **CHAPTER 2**

### **LITERATURE REVIEW**

#### **2.1 INTRODUCTION**

This chapter deals with literature that has been reviewed as well as previous studies that have been done.

#### **2.2 DEFINITION OF LITERATURE REVIEW**

Literature review can be defined as a critical summary of research on a topic of interest generally prepared to put a research problem in context or identify gaps and weakness in prior studies so as to justify a new investigation (Polit, 1995:439).

According to Nolte (May, 1998) Government has launched a Reconstruction and Development (RDP) as well as a new health policy for the country. The key focus of the material and child health policy is on improving the health status of women and ensuring that mechanisms are created to ensure that no mother dies owing to her inability to gain access to health services. This programme must therefore also include training programmes for traditional midwives.

The majority of women in the remote areas still prefer home deliveries. For this reasons a number of personnel will have to change a few of their rules and attitudes in order to meet traditional midwives half way (V Chipfakacha, 1994).

It is unavoidable that women make use of traditional birth attendants. They should be trained and become part of the health team. They are, however, practising illegally, and it is therefore essentially to win their confidence first, otherwise they will not be

willing to expose themselves or make themselves publicly known. Various training programmes of this nature have been implemented successfully in South Africa (Nolte, 1992:36).

In addition, both traditional midwives (TM's) and health personnel have to co-operate more and co-ordinate their activities to improve this essential service (Chipfakacha, 1994).

### **2.3 ORIGINS OF MIDWIFERY HOME DELIVERIES**

The art of practice of assisting women in child birth must be one of the oldest forms to those in need of a special kind of help. Childbirth was a natural process in more primitive societies and still is today. There was a multiplicity of Gods and Goddesses who were thought to be concerned with fertility and childbirth. Many extremely bizarre practices are recorded including techniques aimed at scaring the baby from the body of the woman in labour. In some primitive communities, it was the practice for a woman in labour to be left alone to assist herself. In some instances a woman who had recently given birth was allowed to assist the mother about to give birth. Midwifery practice became well established by the hipocratic era. Well defined duties were spelt out for the midwife, while the traditional healer attended to the spiritual aspects considered necessary for safe delivery by singing spiritual songs (Mellish, 1978:48).

There are three main types of communities served by Traditional Midwives (TM's). The first type is the isolated and remote community located far from road networks and health facilities. The second type is the rural community with access to roads and health facilities. In such communities the TM's usually work together with scientific medical personnel. Women usually attend antenatal clinics of health facilities but prefer to deliver at home. The third type of community is the urban / peri-urban community which despite having a central system of service, still prefers traditional

birth attendants. In the majority of African Countries most traditional birth attendants are women (Chipfakacha, 1994).

## **2.4 REASONS FOR HOME DELIVERIES**

Many women giving birth in rural areas use the services of traditional birth attendants because primary care clinics are inaccessible. Traditional birth attendants are people who have home experience in midwifery, and often also have skills in traditional healing. However, this may simply be the neighbour or even a family member who usually acts as the "midwife" during births in the area. The project manager of the Ndwedwe child survival project, David Patherson, says the role of traditional birth attendants needs to change. "We want Traditional Birth Attendants to encourage other women to access the formal health sector and to learn better maternal care", says Patterson, D. (1998:5). The aim of the project is to identify traditional birth attendants within a community and to train them for a month on how to assist in the birth procedure and how to give proper pre-natal advice (Patterson, D. 1998:5).

Nearly all developed and developing countries have Traditional Midwives (TM's or Traditional Birth Attendants. In developing countries, however, very few TM's still practice. For two thirds of the births in the world, these people are not trained in modern medicine but are experienced in traditional birth systems. In developing countries this practice is mostly followed in rural areas, where they serve the poor and illiterate (Chipfakacha, 1993).

## **2.5 THE CHANGING ROLE OF THE MIDWIFE**

From the literature review it became obvious that the community clinic is going to be the place where most midwives will practice in future. This fact not only requires that she be highly skilled, since she will practice on her own and very often in remote areas, but also that sufficient numbers of midwives should be trained to staff these

clinics. The question has arisen, however, whether or not the practice of the midwife could be expanded in areas lacking in manpower by mobilising existing resources such as Traditional Birth Attendants (TB's) and lay workers, who work with and under supervision of midwives (Nolte, 1998).

## **2.6 PRIMITIVE CARE DURING DELIVERY**

With regard to the indigenous population of South Africa the role of the witch doctor and the traditional birth attendant is still enough in evidence to be understood by all of us. Some practices were primitive and positively dangerous. The cutting of the cord and its management, the placenta, the puerperium and lactation varied according to the place and the tribe. Maternal and child mortality occurred, but these also appeared with alarming frequency among more civilised Western nations. There was a general lack of knowledge regarding childbirth that only changed with the usage of scientific enquiry in both the medical and nursing fields (Mellish, 1978:51).

## **2.7 THE CHANGING MIDWIFERY PRACTICES DURING THE 17<sup>TH</sup> CENTURY**

With the event in 1652 of White Settlement in South Africa we have some record of birth practices. The Hottentot woman who, on 18 April 1654, gave birth unattended, close to the fort in Cape Town on the banks of a river, is described in Van Riebeeck's diary. This causes much surprise that it can safely be assumed that Dutch women were used to receiving the help and care of others when delivering their children and during the lying in period (Mellish, 1978:52).

The majority of the deliveries in the world today are attended by an untrained person. Traditional Birth Attendants form part of the basic care of primary health care workers in all developing countries. In developing countries efforts are being made to provide some form of training and supervision on these birth practitioners by

qualified midwives. However, distances, cultural practices, financial and human resources for providing training and supervision largely negate such efforts (Searle, 1978:260).

## **2.8 THE ROLE OF COMMUNITY MEMBERS IN HOME DELIVERIES**

An important duty of the Traditional Birth Attendant is to provide prenatal care. The traditional birth attendant's role is that of providing herbal medicine which are usually made from the roots, bark or leaves of locally available plants. This had been reported from Kenya, Malawi, Nigeria and South Africa in 1981. The medicines serve different purposes such as preventing abortion or ensuring a pregnancy, enlarging the birth canal and inducing stronger contractions during labour (Leféber, 1994:15).

## **2.9 TRADITIONAL HEALER / HERBALIST**

In Kenya herbal medicine is given to the woman in labour in the first stage of the delivery. The herbal medicines may be administered orally, applied vaginally or rubbed into the skin of the abdomen. Most of these medicines are administered orally and their scientific names are unknown (Liféber, 1994:23).

## **2.10 TBS's IN MANAGEMENT OF FIRST STAGE OF LABOUR**

There is little preparation for labour with very little equipment such as rugs, pots for water and an instrument to cut the cord. Facilities and equipment generally consist of a woven mat for the mother to lie on, home made soap for washing the baby and Traditional Birth Attendants' hands, pots for water and to mix medicine in, a razor blade and kitchen knife to cut the cord (Liféber, 1994:21).

The Traditional Birth Attendants will be able to advise the mother about collecting and preparing the things needed for her delivery and for care of the new-born baby, for example, clean clothes for drying and wrapping the baby, pots and pans for boiling water, newspapers or plastic sheets on which to conduct the delivery, cloth pads to serve as sanitary napkins, candles or a lantern, a watch, antiseptic pollution and materials for hand washing a new blade, thick sewing thread, gauze, and pieces of equipment for boiling (WHO, 1992:57-58).

Traditional Birth Attendants perform an external examination according to a report from Kenya. The contractions are examined for strength and frequency. The position of the child is observed or palpated in order to know whether the child has descended into the pelvis. The Traditional Birth Attendants palpate the abdomen to determine the presentation and degree of engagement. She may also put her head on the fundus of the abdomen to listen for sounds or to feel for foetal movements (Liféber, 1994:22).

The Traditional Birth Attendants stay with labouring women until delivery, without either further checking of foetal condition and material condition abdominally or vaginally (Selepe, 1992:3).

Traditional Birth Attendants in Kenya may perform the cervical dilatation. The Traditional Birth Attendant's hands may or may not always be washed with water and soap before the performance of vaginal examination. Traditional Birth Attendants of Zulu in South Africa recognise the need to wash the hands and use a vaginal lubricant e.g. the herbal medicine with the vernacular name "sihlambezo" (Liféber, 1994:22).

## **2.11 SECOND STAGE OF LABOUR**

An upright position; either kneeling, sitting, squatting or standing is the most common position for delivery in Ghana. Mothers in Kenya may deliver sitting with the legs partly abducted to allow passage of the baby (Liféber, 1994:24). In several reports from different countries of Africa it is mentioned that Traditional Birth Attendants try to minimize laceration of the perineum by lubricating the rim of the birth canal with palm oil. In South Africa the woman in labour support her perineum and birth takes place in a kneeling position. In Nigeria Traditional Birth Attendants may assist during delivery, placing the woman in a squatting position, which stretches the perineum and reduces tearing (Liféber, 1994:25).

## **2.12 THIRD STAGE OF LABOUR**

In cases of retained placenta a number of therapeutic methods are administered by Traditional Birth Attendants in Kenya; e.g. abdominal massage and fundal pressure or sometimes giving the woman a liquid made of herbs to drink. If the placenta is retained beyond an hour, abdominal massage and fundal pressure will be exerted. If placental expulsion does not occur, the cord will be cut and an axe will be tied to the end of the cord. Manual removal of the placenta may be attempted by the Traditional Birth Attendants or the mother may be taken to another indigenous practitioner with more "magic" and skills or to hospital (Liféber, 1994:29).

Brink (1992) observed a delivery in Nigeria whereby baby's head was born face down and the Traditional Birth Attendant helped the baby out by pulling out one arm, then the other, twisting the baby gently, until finally the baby boy was born. The attendant manipulated until the placenta was delivered. A newborn is placed on the lower abdomen of the woman while in the squatting or kneeling position. The Traditional Birth Attendant pulled and manipulated until the placenta was delivered. A new broom is placed on the lower abdomen of the woman while squatting or

kneeling position. The abdomen is pushed towards the diaphragm with the aid of the broom. The Traditional Birth Attendant removes the broom and allows the abdomen to fall back suddenly, helping to expel the placenta (Liféber, 1994).

A wooden spatula is inserted into the woman's mouth carefully, pushed deep down the throat to cause the woman to vomit. The movement of the body and the strain the woman experiences on the abdomen helps to expel the placenta (Liféber, 1994).

Bitter paper called "Borkomo" is placed onto a fire near the woman in labour. The woman sneezes as the strong smell from the burning paper reaches her. According to the Traditional Birth Attendants the placenta is expelled as the woman continues to sneeze vigorously (Liféber, 1994).

Traditional Birth Attendants in South Africa give the mother a liquid made by soaking "ilala" palm roots and mixed herbs in water to reduce the risk of a postpartum haemorrhage. Traditional Birth Attendants were unable to estimate the amount of blood loss. If the mother started to feel weak, they thought that she was probably losing too much blood (Liféber, 1994:31). Traditional Birth Attendants do not recognise postpartum haemorrhage as a serious complication as they believe that the blood loss is excessive it is because the mother has too much blood in her and the correct procedure is to allow it to flow (Liféber, 1994).

Traditional Birth Attendants believe that a prolonged delivery is dangerous, since a spirit or a witch can be the cause, and that the baby will then not be healthy and may perhaps die (Liféber, 1994:49).

### **2.13 METHOD FOR HOME DELIVERIES**

In Iran herbal medicine are given to the woman in labour at the time of the delivery in order to stimulate the birth process. When Traditional Birth Attendants are attending to the prospective mother, the mother-in-law and the Traditional Birth

Attendant, who themselves have experience in childbirth, sit beside the woman, talking to her and giving all possible comfort.

The labouring woman is given advice on how to squat, sit and press and not to touch their genital area. Traditional Birth Attendants will start massaging the woman's abdomen gently with coconut oil. In long and difficult labour they give narcotics such as betel leaf in conjunction with prayers (Liféber, 1994:46). Women deliver in an upright position either kneeling, squatting, standing or sitting (Liféber, 1994).

Massage of the woman's abdomen in order to stimulate the birth of the placenta has been reported in Iran. Traditional Birth Attendants use several methods to expel the placenta e.g. putting garlic in the mother's mouth inducing vomiting (Liféber, 1994:48).

## **2.14 ADVANTAGES OF HOME DELIVERIES**

Home deliveries may be unsafe, but they are common in most cultures. In Malta the mothers are kept indoors and the mother is only allowed to leave the house for a very short time. This restriction is to protect her and has to be continued until the cord drops. Mothers are isolated and confined to a small dark corner for three to four weeks, and in the majority of households up to 40 days. They are allowed to leave the delivery area for toilet requirements. The mother has to take a lot of rest and has to be held. As she is still unclean, she is not allowed to cook for a couple of weeks, as she would pollute the food (Liféber, 1994:55). In Indonesia the mother may be given indigenous herbs to accelerate the exit of unclean blood from the uterus and the excretion of mothers (Liféber, 1994:56).

## **2.15 CARE OF THE PLACENTA**

The placenta is buried outside or inside the hut according to reports from India, or it will be buried in an earthenware pot and thrown into the sea, or suspended from the overhanging lower edges of the roof (Liféber, 1994:58).

## **2.16 THEORETICAL FRAMEWORK**

### **Definition**

Theoretical framework refers to a well-formulated deductive system of abstract formal statements. Theoretical frameworks deal with constructions that are assembled by virtue of their relevance to a common theme (Polit, 1993:109).

## **2.17 INTRODUCTION**

Orem sees self-care as activities that individuals practice in maintaining life, health and wellbeing. The purpose of self-care actions is to satisfy self-care requisites. The self-care model is used by Orem to motivate the individuals to engage in self-care. Individual ability to engage in self-care is auditioned by age, development state, life experience, socio-cultural orientation, health and available resources.

Health personnel have to change a few of the current rules and attitudes and meet the traditional midwife halfway. Traditional midwives and health personnel have to cooperate more and co-ordinate their activities better to improve essential services. Normally adults voluntarily care for themselves. Infants require complete care for assistance with self-care activities. The researcher in this study explores the prevalence of home deliveries in Mpumalanga Township in KwaZulu-Natal. The terms that will be used frequently in this study are identified. Orem presents three categories of self-care requisites i.e. universal, developmental and health deviation.

## **2.18 UNIVERSAL SELF-CARE REQUISITES**

Universal self-care requisites are associated with life processes and maintenance of human structure and functioning e.g. water and food. Self-care requisites are common to all human beings during all stages of the life cycle and should be viewed as interrelated factors. Previous studies indicate that pregnant women may not cope with all stages of life due to conflict caused by traditional and modern medicine. According to Orem's model of Self-care model labouring women are to be assisted in order to cope with self-care activities.

## **2.19 DEVELOPMENTAL SELF-CARE**

Developmental self-care refers to specialised needs for developmental processes of traditional medicine given to pregnant women during pregnancy to assess in the growth of the unborn child. This statement is confirmed by George (1985:125) in Orem's developmental self-care theory.

## **2.20 HEALTH DEVELOPMENT**

Health development is requested to correct the condition, nursing labour e.g. Traditional Birth Attendants give certain medicines during first stage of labour to increase contractions as well as dilation of the cervix. Orem develops her general theory of nursing in three related parts i.e. self-care, and nursing system (George, 1985:127).

## **2.21 THE THEORY OF SELF-CARE DEFICIT**

Self-care always has to be met individually. It cannot be met by a self-care agency or by a dependant care agency, as self-care deficit occurs, nursing action may be needed to overcome this deficit. Self-care requisites are those requisites common to all

human beings through life, associated with life processes and the integrity or human structure and function. Self-care agency is the human ability to engage in self-care and self-care deficit is the inability of an individual to carry out all necessary self-care activities.

## **2.22 THE THEORY OF NURSING SYSTEM**

The nursing system is based on the self-care needs and abilities of the patient to perform self-care activity. A nursing system is described by Orem in terms of regulating and promoting the capacity of patients to engage in self-care.

A patient is a person with problems who needs to be cared for because of not being able to wholly care for himself. It is the duty of the nurse to overcome the self-care deficits by assisting the patients.

## **2.23 OREM'S THEORY OF NURSING PROCESS**

For Orem, nursing process entails assessing the therapeutic self-care demand, the potential for self-care agency and the deficit of the latter which would indicate that a nursing agency is needed (first stage). The second stage would be a design of a system which mobilises the self-care agency and dependent care agency resources.

The last stage involves the implementation of actions which compensate for and if possible, overcome the patient's self-care limitations, so that self-care requisites can be met and existing self-care abilities are protected and fastened. It is during the third stage that self deficits are specified in the "intervention focus" and nursing actions are specified in the intervention made.

## 2.24 REPRESENTATION OF OREM'S SELF-CARE MODEL

Assessment of Therapeutic Model       $\longrightarrow$       Assessment of Self-care agency

Universal	Health Deviation	Age, Sex, Health
Air, water, food	Changes in the human structure	Stage
Excrements	Changes in physical functioning	Developmental state
Activity and rest	Changes in behavioural and habits of daily living	Socio-cultural factors
Hazards to life		Significant Others
Normally		
Solution and social interaction		

## 2.25 ASSESSMENT OF HEALTH CARE DEFICITS

- i) Knowledge deficits.
- ii) Skills deficits.
- iii) Motivation deficit.
- iv) Orientation deficit.

Design of nursing system (e.g. partly compensatory)

### Implementing the nursing system

- i) Intervention focus.
- ii) Intervention mode.

For Orem self-care behaviour is the coping mechanism in the event of frequency and should this be deficient then nursing intervention is capable of overcoming such deficiency.

### **Participatory model**

Participatory models are recent trends used in that communities cannot be left alone but need to be involved. Home deliveries are still participants in the model of health education to Traditional Birth Attendants, communities and traditional healers. This would facilitate use of safe practices thus reducing the high incidence of infant and maternal deaths.

## **2.26 CONCLUSION**

From the information obtained from various studies in books, it can be confirmed that the Traditional Birth Attendant is a phenomenon here to stay. Home deliveries have both advantages and disadvantages, therefore Traditional Birth Attendants need to be trained and the working relationship needs to be developed between the Traditional Birth Attendants and the professionals.

## **CHAPTER 3**

### **RESEARCH METHODOLOGY**

#### **3.1 INTRODUCTION**

In this chapter the researcher describes the research design used in this study and methods used. The area where the study was undertaken is also described.

#### **3.2 AREA OF STUDY : MPUMALANGA CLINIC**

##### **3.2.1 A brief history of Mpumalanga Township**

Mpumalanga Township is situated in Camperdown district about 5km from Hammarsdale industrial area and only 9km from the N3 to Pietermaritzburg. The township was established in 1961. Mpumalanga Township is a peri-urban area, with an urban life style as well as a traditional life style. Transport is poor resulting in problems for the people to reach the Health Centre.

#### **3.3 PERMISSION TO DO THE STUDY**

Permission to do the research is one of the most important elements of the study because it ensures the protection of the rights of the respondents.

The researcher consulted the Research Section in the Department of Health of the KwaZulu-Natal Province. The following recommendations made by the Department were adhered to:

- a) A letter from the researcher's Supervisor confirming that she is indeed a registered student, was obtained.
- b) The researcher had to write a letter of application requesting permission to carry out the study using the provincial peri-urban and rural clinics, nursing colleges, personnel working in these institutions and the student nurses.
- c) A clearance certificates signed by the Supervisor and the Faculty Head was granted after careful scrutiny of the research proposal by the Research Committee of the University. The proposal satisfied all criteria set in the clearance certificate.
- d) Another letter was written by the researcher, requesting the Assistant Director of Primary Health Care based at Edendale Hospital and in charge of the respective clinics to grant her permission to explain the instrument s to the respondents. Each of the institutions mentioned above demanded to see letters that granted the researcher permission to undertake research in the colleges and clinics respectively.
- e) Permission was also obtained from the participants, namely nurse educators, professional nurses and student nurses. Informed consent, anonymity and confidentiality of results was guaranteed.

### **3.4 THE RESEARCH DESIGN**

The research design is the overall plan for collecting and analysing data including specification for enhancing the internal and external validity of the study (Polit, 1993:45).

The researcher preferred to use a descriptive Cross-sectional Survey Design including the qualitative research. The main advantage is that it is practical, easy to manage and economical. A Cross-sectional Survey Design is a method of collecting data using interviews and questionnaires, and the whole population under study can be fully represented.

In using this design the researcher was hoping to identify reasons for home deliveries as well as perceptions of nurses and midwives with regard to preference for such unmonitored deliveries. Through the use of qualitative research in-depth knowledge will be obtained from the subjects.

### **3.5 QUALITATIVE RESEARCH METHODOLOGY: DEFINITION**

Qualitative research is especially useful where little is known about the area of study and the particular problem or situation, because the research can reveal processes that go beyond surface appearances (Holloway and Wheel 1996:2). Qualitative research is concerned with understanding the individual's perceptions and the variables under study, it seeks insight rather than statistical analysis. In this study it became necessary to use qualitative research methods in order to get in-depth knowledge of the problem. A convenience sample was used because only a few TBASs were available.

A qualitative, exploratory descriptive design was utilized to get in-depth knowledge regarding the feeling of people on the prevalence of home deliveries at Mpumalanga Township in KwaZulu-Natal. Nurses who were working in clinics conducting deliveries suddenly realised that the number of cases coming for ante-natal care were increasing and those coming for delivery were reduced, and this was affecting nurses working in ante-natal clinics, labour wards as well as post-natal wards. The researcher used a descriptive cross-sectional survey qualitative phenomenological design to gain insight into this occurrence.

### **3.6 TYPES OF QUALITATIVE RESEARCH**

Two types of qualitative research i.e. phenomenology and ethnomenology, are applicable to this type of study. These approaches aim to understand and interpret the meaning that subjects give to their everyday lives. In order to accomplish this, the researcher should be able to enter into the subjects' life world and place himself in the shoes of the subjects. This is mainly done by means of naturalistic methods of study, analysing the conversations and interaction that researchers have with subjects.

The researcher using these strategies of interpretative enquiry mainly utilised participant observation and interviewing as methods of data collection. Data were systematically collected and analysed within a specific context i.e. the role of the Traditional Birth Attendants.

### **3.7 ETHNOGRAPHIC APPROACH**

This strategy of enquiry is characterised by observation (participant observation) and description of the behaviour of a small number of cases. Data analysis is mainly interpretative, involving description of the phenomena. The main aim is to write objective accounts of lived experiences. The main data collection method is participant observation (De Vos, 1998:80). This approach was also used by the researcher by letting the Traditional Birth Attendants account on how they deliver patients, supported by demonstrations.

### **3.8 MODELS FOR QUALITATIVE RESEARCH**

For the study of home deliveries by Traditional Birth Attendants the researcher needed to ensure trustworthiness and credibility of the information obtained from the subjects. It therefore became necessary to utilise models for qualitative research. The model of choice was that developed by Guba as cited in De Voc (1998:350).

### **3.8.1 GUBA'S MODEL FOR QUALITATIVE RESEARCH**

This model is concerned with trustworthiness of the qualitative research. It consists of four (4) criteria as follows:

#### **i) Truth value**

This refers to the extent to which the researcher is confident about the truthfulness of the research findings. This criterion makes use of the respondent's lived experiences. This statement is confirmed by Brink (1991:120) in her phenomenological qualitative research method, where she states that the researcher should develop an awareness of the lived experiences of the respondents, without forcing prior expectations or knowledge about the process. The author added that the researcher should take the phenomenon under study as it is described by the subjects (Brink, 1991:119).

Guba's model has been utilised by the researcher in order to view information described by the subject objectively. The researcher in the present study ensured truthfulness and trustworthiness by conducting interviews of the respondents under conditions that would provide for confidentiality, honesty and trust by the subjects, and which would in turn elicit truthfulness of subjects and credibility of the information obtained.

Life experiences concerning home deliveries by both Professional Nurses and Traditional Birth Attendants were narrated in response to the interview schedules that were presented by the researcher and research assistant. This was recorded live on audio-cassette tape with the respondents freely verbalising their feelings, opinions, perceptions, experiences and knowledge about home delivery practices by Traditional Birth Attendants.

## **ii) Applicability**

The second criterion according to Krefting (1990) cited by De Vos (200:349), applicability is concerned with the ability to generalise the findings to larger populations Guba (1981) cited in De Vos (2000:350), states that applicability should allow for a situation to be transferred to similar context outside the area of study. This is important for this study because home deliveries are increasing in number and yet there is concern by professional nurses that it could easily become a vehicle for the spread of HIV/AIDS, and it can also become a cause for maternal deaths.

## **iii) Consistency**

According to Guba's model cited by De Vos (2000:350), trustworthiness refers to freedom from bias in the research procedure and the results, while neutral, is referred to as the degree to which findings are the function of the information and indicates that the conditions of the methodology are not biased. The subjects should therefore not be coerced to participate.

In the present study, these aspects were guarded against by the researcher.

## **iv) Triangulation**

In the present study, the researcher decided to use more than one research method i.e. both the qualitative and quantitative research methods.

## **3.9 DISCUSSION OF RESEARCH METHODOLOGY**

The research methodology in this study is divided into three (3) phases i.e. phase one for data collection, phase two for data analysis and phase three for evaluation and construction of a model for training birth attendants.

### **3.9.1 DATA GATHERING FROM PREGNANT WOMEN**

Methodology for data gathering for this group included information to pregnant women who visited the clinic between May and June 2000.

The clinic was conducted every Tuesday, and the appropriate number of clinic attendants per day ranged between 20 and 25 per day. The focus of the study was on first visits by pregnant women. All age groups were represented and parity not limited and after explanation of the research to the pregnant women the subjects gave informed consent.

The researcher selected every fifth (5<sup>th</sup>) pregnant mother visiting the clinic per day to collect data. The clients were ensured of anonymity of results, privacy and availability of results to participants after the study. Participation was voluntary and clients were told that withdrawal was also possible if the client was not more willing to participate. Twenty (20) pregnant women were finally randomly selected for the study. The researcher administered the questionnaire to participants who responded to questions in the questionnaire.

### **3.9.2 SAMPLING OF PREGNANT MOTHERS**

Four simple random sampling technique was used to allow all the subjects a chance to be selected. A questionnaire consisting of biographical data of open and closed-ended questions was used for data collection. The questions explored the reasons for preferring delivery services by Traditional Birth Attendants against delivery by trained midwives.

The subjects were informed about the research as they were being chosen. A separate quiet room was used to prevent distractions and subjects responded to the questions in

the questionnaire. Where further explanation and clarity was needed the researcher was available to give assistance.

### **3.9.3 DATA GATHERING FROM TRADITIONAL BIRTH ATTENDANTS**

The Traditional Birth Attendants from a support system for Mpumalanga clinic in that they operate when the clinic is closed. Meetings with the Nursing Service Manager and the Traditional Birth Attendants are held quarterly every year to facilitate community involvement in the rendering of midwifery services at Mpumalanga clinic. Data gathering was therefore easy for the researcher. Ten Traditional Birth Attendants who usually attend meetings participated in the study.

A convenience sample was used since the number of Traditional Birth Attendants was only ten (10). A qualitative research method was used. The Traditional Birth Attendants formed a focus group. The researcher formulated an interview scheduled and prepared videotapes for the venue where the meeting was to be conducted.

Permission was obtained to conduct the study prior to the focus interview. The Traditional Birth Attendants were called to the briefing meeting where the researcher explained about the research. The Traditional Birth Attendants were told that participation was voluntary and they were not coerced to participate. Their anonymity and confidentiality was ensured, including the availability of results for the participants. It was important to ensure trustworthiness and honesty in the giving of information by the participants. A separate quiet room was used as venue in the clinic to ensure privacy and to prevent distraction.

The researcher conducted the study by interpreting the meaning that the Traditional Birth Attendants gave to their everyday lives with regard to home deliveries. The researcher conducted conversations with the Traditional Birth Attendants and recorded the interaction that the researcher had with the Traditional Birth Attendants.

Participant observation and interviewing were used as a method of data collection. In-depth semi-structured phenomenological interviews were also used to gather data concerning experiences of Traditional Birth Attendants and the professional nurses regarding home deliveries (De Vos, 1998:80). A tape recorder was used to record the experiences accurately.

The phenomenological interviews were taped via audiotapes and transcribed verbatim. Communication techniques were used to motivate the phenomena to unfold in an unbiased way. Communication techniques like probing and summarising were used to encourage respondents who were interviewed to freely articulate their views concerning home deliveries by Traditional Birth Attendants. Three sets of instruments were constructed for data collection for Traditional Birth Attendants, pregnant women and staff members. A research instrument consisting of items that were testing out the feelings of Traditional Birth Attendants was administered. It was also necessary to find out the views of health workers regarding the delivery practices that the Traditional Birth Attendants were providing in the community.

Special permission was obtained from the sister in-charge of the Mpumalanga clinic. Meetings were arranged with Traditional Birth Attendants to obtain information, including venue and time, regarding the practice of home deliveries by the Traditional Birth Attendants and the need to conduct a research project. In planning for data gathering, the researcher prepared audiotapes and a C.D. player to obtain information. A camera was also made available. On the day of the meeting that was attended by the Traditional Birth Attendants, the researcher greeted the audience and to allay fears and anxiety, explained why the videotape was going to be used.

She also checked if all Traditional Birth Attendants were willing to participate, and encouraged them to sign an informed consent for their participation.

### **3.10 MEASURES TO ENSURE TRUSTWORTHINESS**

The researcher explained that it was necessary that trustworthiness is maintained particularly because the results needed to be proved for credibility as they would be used for the improvement of the quality of home deliveries by Traditional Birth Attendants.

A specific questionnaire to obtain data from the Traditional Birth Attendants was constructed. The questions were open-ended and needed to explore the in-depth knowledge of participants regarding the practice of home deliveries by Traditional Birth Attendants. The questions that were asked included the procedure that was used for conducting home deliveries by Traditional Birth Attendants:

- How an aseptic technique was maintained during delivery to prevent infection particularly HIV/AIDS.
- How complications such as Post-partum haemorrhage and asphyxia of the baby was dealt with.
- How the cord was cut.
- The referred system that was used by the Traditional Birth Attendants.

### **3.11 METHODOLOGY FOR DATA COLLECTION FROM STAFF MEMBERS**

A written permission was obtained from the sister in-charge after a request to conduct the study was submitted, including permission from the Department of Health and Edendale Hospital.

Staff members were invited for a briefing meeting and it was explained that the research was to be conducted of which participation was voluntary. A day was arranged with staff members for the researcher to obtain data.

The research study was explained to staff members, confidentiality was ensured and coercion to participate was as much as possible. After full explanation by the researcher, the subjects showed understanding by asking related questions on the study and thereafter gave their informed consent.

A questionnaire consisting of open-ended questions was used. The principles suggested in Guba's model were used. The following questions were asked based on the following special information that the Traditional Birth Attendants had:

- The number of people delivered by Traditional Birth Attendants and when.
- The criteria for referral of patients to hospital and whether complications had occurred during delivery.
- Precautions which were taken by each Traditional Birth Attendants against HIV/AIDS including the basic knowledge they had about HIV/AIDS. Interviews were conducted using focus groups whereby the themes provided were discussed with each Traditional Birth Attendant.

### **3.12 SAMPLING OF (PROFESSIONAL MIDWIVES) STAFF MEMBERS**

The researcher randomly selected staff members who formed the sample for the study. The researcher went through the list of all categories of staff members to select the third name on the list. This procedure was followed to maintain objectivity and give member a chance of being selected.

### **3.13 METHODOLOGY FOR DATA COLLECTION FROM TRADITIONAL BIRTH ATTENDANTS**

Immediately before the ten Traditional Birth Attendants that attended the data gathering sessions started responding to questions, the video camera was switched on and the researcher together with the research assistant started collecting data. The

advantage of this method was because of the density and performance of the information obtained, the researcher would be able to retrieve the information at a later stage. It was necessary to use video tapes to study the behaviour and human experience of the Traditional Birth Attendants. According to Bottorff (1994:244-259); cited by De Vos (1998:329), recording is a way of direct observation in the study of behaviour and human experiences as they occur in daily life in a variety of settings and contexts.

The researcher and the research assistant helped each other with data collection. The questionnaires consisted of items such as the experience that each Traditional Birth Attendant had, namely:

- The training they had to be able to do deliveries.
- The number of deliveries that each Traditional Birth Attendant had done in a period of three (3) years.
- Whether any form of contact was made with pregnant women prior to delivery.
- How they identified complications and the procedures each Traditional Birth Attendant used for referral.
- Precautions for cutting the cord and asepsis.

### **3.14 CONCLUSION**

In conclusion the researcher after intensive data collection and exposure to the responses of the relevant midwives, TBA's and pregnant mothers strong recommend that further studies should be undertaken in both urban and rural clinics. The academic undertaking of this study should involve professional nurses working in these clinics so that they can take interest and learn to solve practice problems using scientific principles.

## **CHAPTER 4**

### **INTERPRETATION OF RESULTS AND DISCUSSION OF FINDINGS**

#### **4.1 INTRODUCTION**

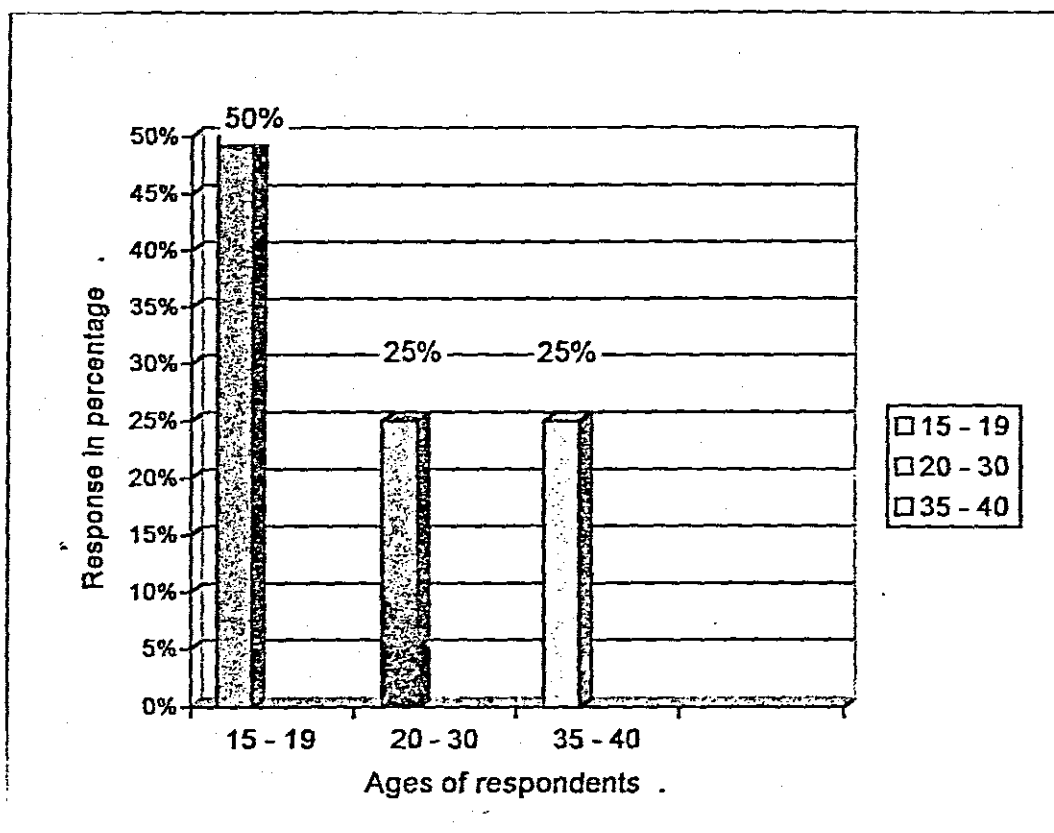
The purpose of this study was to identify reasons for home deliveries as well as perceptions of nurses with regard to preference from such unmonitored deliveries by midwives.

This chapter deals with data analysis. According to the Concise English Dictionary (1994:32) data analysis refers to tracing things to their source and to discovering individual phenomena.

The information presented in this chapter was obtained from questionnaires completed by pregnant women, Traditional Birth Attendants and Professional Midwives in peri-urban and rural clinics.

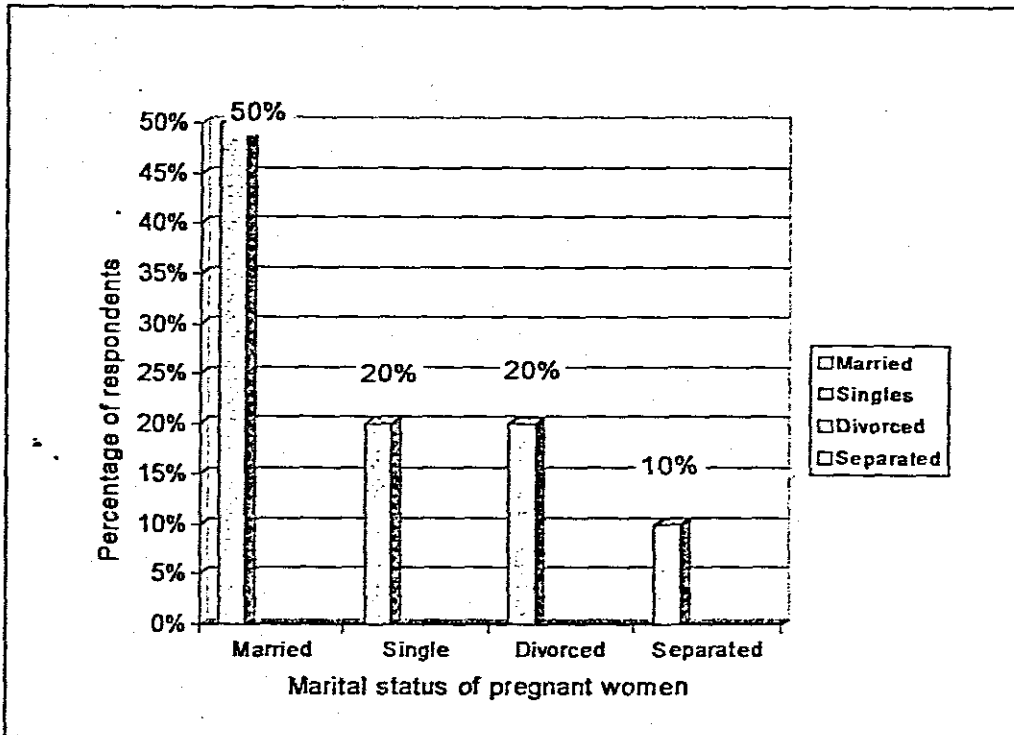
#### **4.2 BIOGRAPHICAL DATA**

The researcher included the biographical data of the respondents. The reason is that variables such as age, parity and marital status might have an influence on the role of Traditional Birth Attendants and Professional Nurses in peri-urban and rural clinics. This is confirmed by Polit and Hungler (1995:292) who state that the reason for collecting biographical data is that personal characteristics have shown some correlation to persons' behaviour and attitudes in a given situation. Tables or histograms are used for data analysis and presentation.



**Figure 4.1 : A distribution of the pregnant women interviewed**

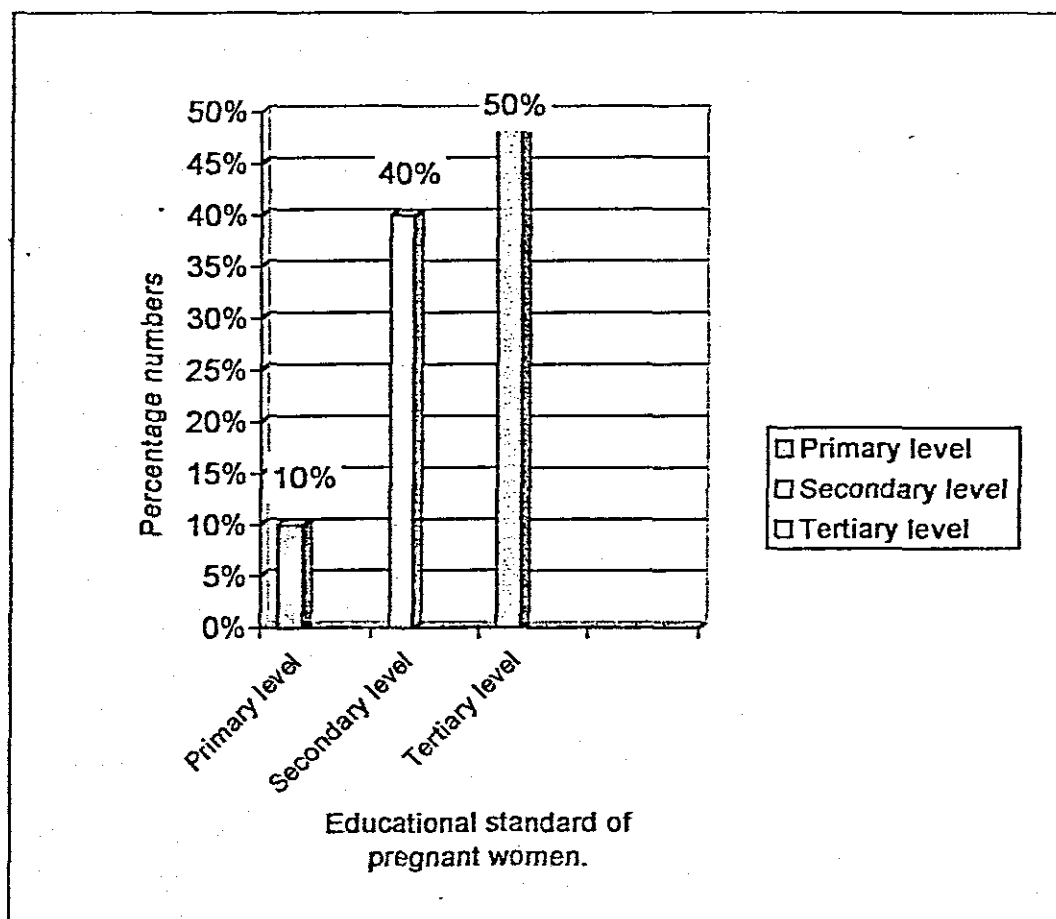
According to figure 4.1, mothers between 15-19 years of age have the highest percentage of home delivery because of financial constrains since they are not working, and the majority of them are at school at Health Centres in order to be cared for by Professional Midwives.

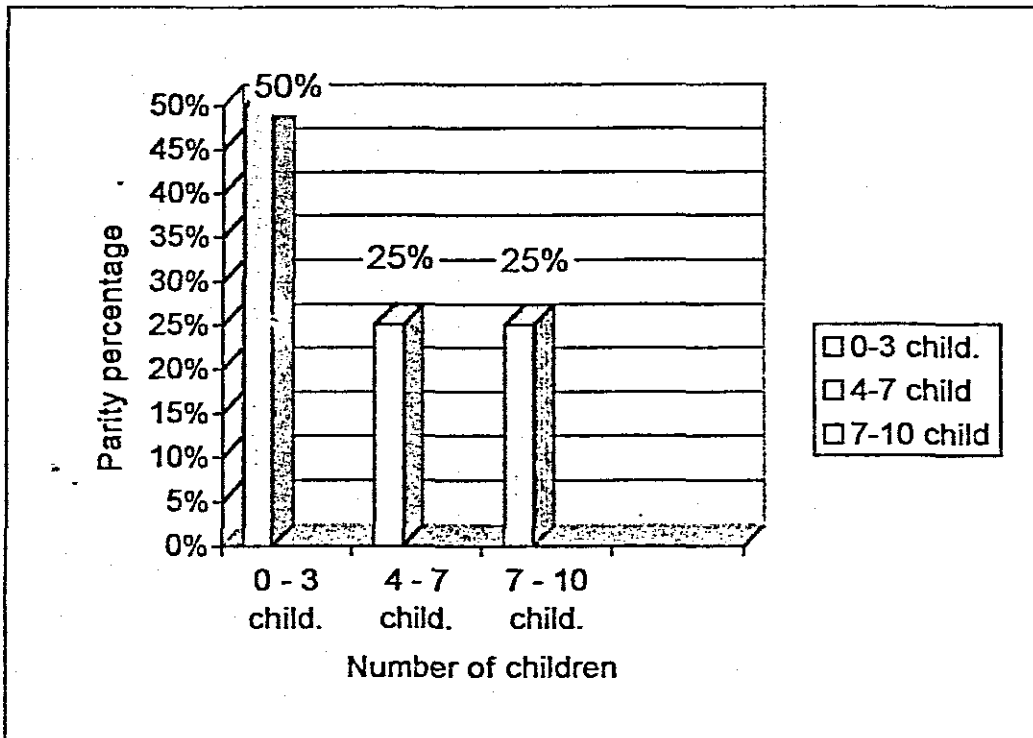


**Figure 4.2 : Marital status of pregnant women interviewed**

Figure 4.2 shows that the majority 50%(10) of married women prefer delivery at the Health Centre. Married mothers know the dangers and consequences of home deliveries. Working mothers and supportive fathers have an interest in the welfare of their children, so they are not in favour of Traditional Birth Attendants' services. Single and divorced mothers show equal percentages, each being 20% (4) followed by separated women at 10%(2).

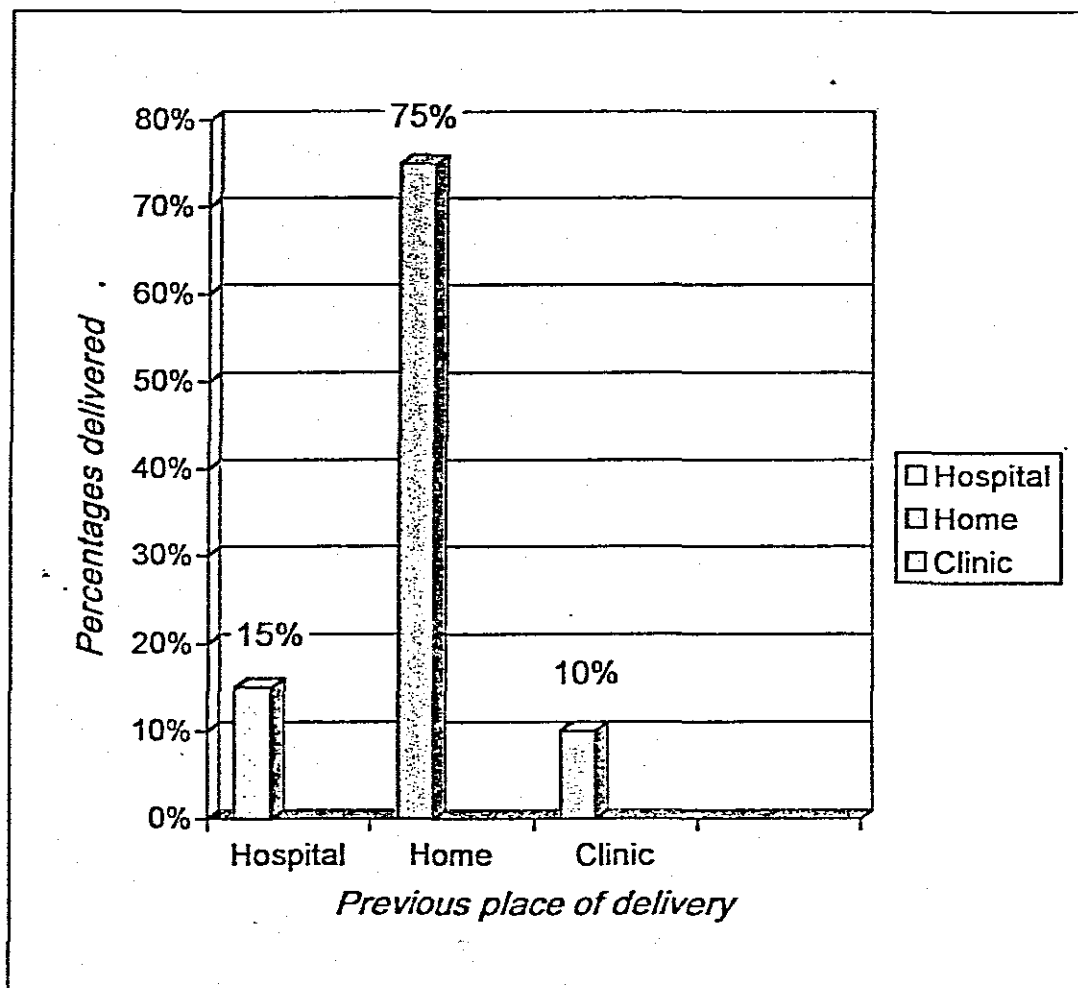
Figure 4.3 (Educational Standard of Pregnant women ) is a histogram that presents the educational qualification of pregnant women. According to the figures, the majority (50%) 10 of the pregnant women, followed by (40%) 8, are of tertiary and secondary level educational standards respectively, which means more knowledge and more access to money as well as better services. People who obtained primary education only prefer Traditional Birth Attendants' services probably due to ignorance or since they cling to cultural belief.





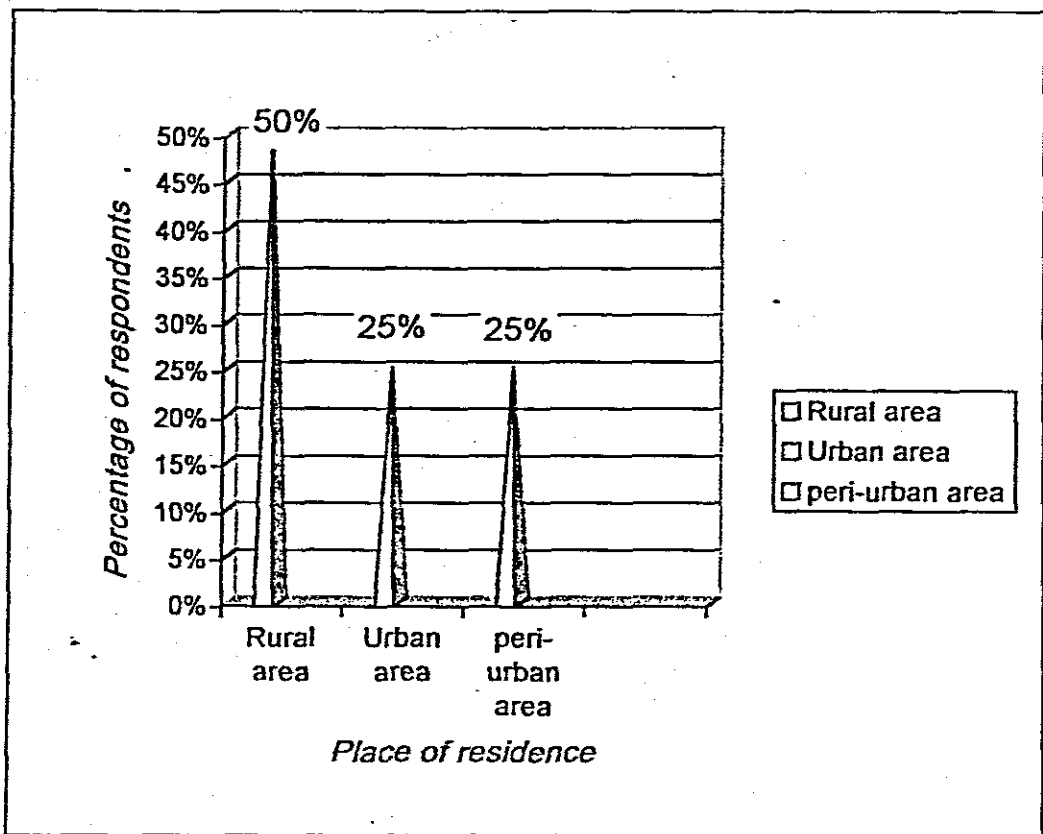
**Figure 4.4 : Parity of women interviewed**

According to figure 4.4 the percentage of parity 4-7 and 7-10 is equal being followed by parity 0-3 of mothers who have more children and did not experience any complications, like to deliver at home and for them Traditional Birth Attendants are seen as heroes.



**Figure 4.5: Presents place of previous deliveries**

From figure 4,5 presents that the majority 75% (15) of previous births occurred at home, and were attended by either Traditional Birth Attendants, a family member or nobody at all. There is a slight difference between clinic and hospital deliveries 25%(5).

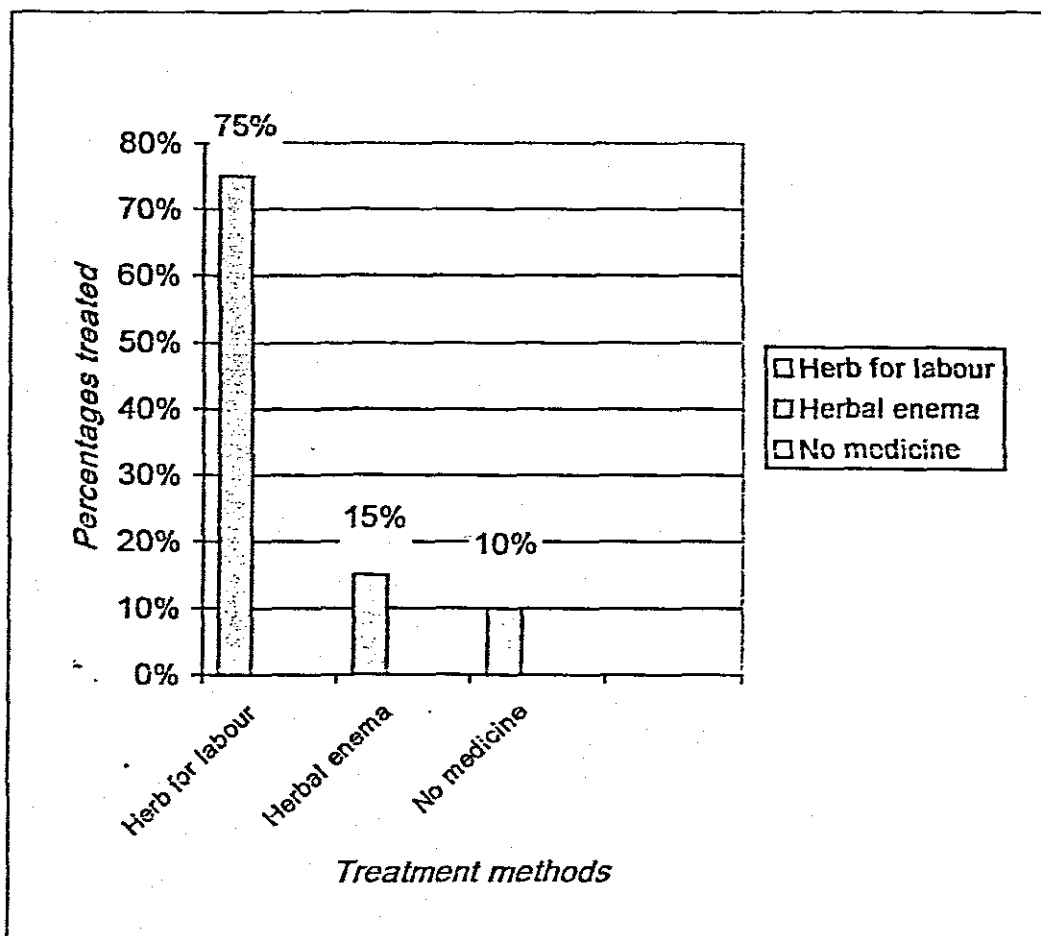


**Figure 4.6 : Area of residence of Pregnant mothers**

Figure 4.6 shows that in rural areas, 50%(10) pregnant women use Traditional Birth Attendants' services due to unavailability of health services, whereas people in urban and peri-urban areas have access to professional midwives' services.

**Figure 4.7 : Methods of treatment used by Traditional Birth Attendants**

Figure 4.7 shows that the majority of Traditional Birth Attendants 75%(15) prescribe certain medicine during labour, and that very few Traditional Birth Attendants give Umuti enema to empty the lower bowel 15%(3) while only 10% (2) of Traditional Birth Attendants give no medication.



**Figure 4.8 : Categories of respondents**

Figure 4.8 presents the categories of respondents. It shows that the majority 60%(12) of Professional Midwives have formal training, followed by Traditional Birth Attendants with no informal training 15%(3), and Traditional Midwives without any form of training.

One can conclude that the training of Professional Nurses, Traditional Birth Attendants and Traditional Midwives should be integrated for quality care.

- P.M. - Professional Midwives
- T.M. - Traditional Midwives
- T.B.A. - Traditional Birth Attendants

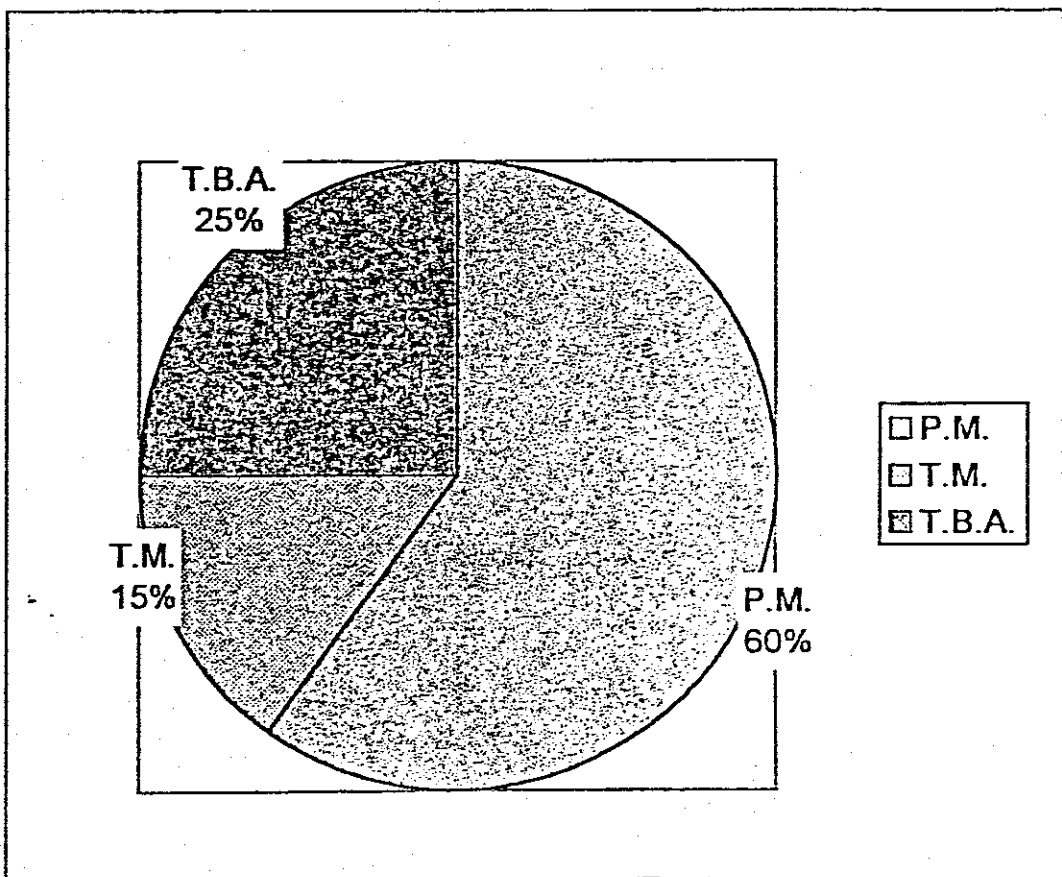


Figure 4.9 : Nurses' perceptions on home deliveries

Figure 4.9 is a pie graph, which presents nurses' perceptions on home deliveries. According to the graph 70%(14) of pregnant mothers still cling to cultural beliefs as the reason why they prefer Traditional Birth Attendants' services, whole 20% (14) of pregnant women believe that health personnel are less friendly, and 10%(2 claimed that clinics are far away.

#### **4.10 FORMAT OF PRESENTATION OF QUALITATIVE RESULTS**

This section has been presented in the form of "themes" that have been extracted from responses made by pregnant women, Traditional Birth Attendants and staff members who participated in this study.

Questionnaires were also designed in such a way that they do not seek the same responses from the three aforementioned groups of respondents. Where the researcher solicited the opinion of all the respondents regarding the improvements of home deliveries in peri-urban and rural clinics, the respondents drawn comprised of a certain number sensitive mothers and important mothers. This demanded from the researcher in the present study to devise a strategy whereby each individual point be given its due attention and emphasis, in order to do justice to responses of the three different categories which participated in this study.

#### **4.11 MODELS FOR QUALITATIVE RESEARCH**

For the study of home deliveries by Traditional Birth Attendants the researcher needed to ensure trustworthiness and credibility of the information obtained from the subjects. It therefore became necessary to utilize models for qualitative research. The model of choice was the model developed by Guba as cited in De Vos (1998:350).

#### **4.12 GUBA'S MODEL FOR QUALITATIVE RESEARCH**

This model is concerned with trustworthiness of the qualitative research. It consists of the following four criteria:

##### **Truth value**

This refers to the extent to which the researcher is confident about the truthfulness of the research findings. This criteria makes use of respondents' lived experiences. This statement is confirmed by Brink (1991:120) in her phenomenological qualitative research method, where she states that the researcher should develop an awareness of the lived experiences of the respondents, without forcing prior expectations or knowledge about the process. The author added that the researcher should take the phenomena under study as the subjects describe it (Brink, 1991:119).

Guba's model has thus been utilised by the researcher in order to view information described from the subjects objectively. The researcher ensured truthfulness and trustworthiness by conducting interviews with the respondents under conditions that would provide for confidentiality, honesty and trust by the subjects, and which would in turn elicit truthfulness of the subjects and credibility of the information obtained.

Life experiences concerning home deliveries by both Professional Nurses and Traditional Birth Attendants were narrated in response to the interview schedules that were presented by the researcher and research assistant. This was recorded live on an audiocassette tape and the respondents were allowed to freely verbalise their feelings, opinions, perceptions, experiences and knowledge about home delivery practices by Traditional Birth Attendants.

#### **4.13 CONCLUSION**

The majority of professional midwives thought it is a good idea to have traditional Birth Attendants who have undergone that form of training in order to improve their standard of practices and to teach them the early symptoms of complications.

##### **Applicability**

The second criteria according to Krefting (1990) cited by De Vos (2000:349), is concerned with the ability to generalise the findings to large populations. According to Guba (1981) cited by De Vos (2000:350), applicability should allow for a situation to be transferred to a similar context outside the area of study. This study is important because home deliveries are increasing in number and consequently there is concern by professional nurses that it could easily become a vehicle for the spread of HIV/AIDS, and can also be a cause for neo-natal deaths.

##### **Consistency**

According to Guba's model cited by De Vos (2000:350), trustworthiness refers to freedom from bias in the research procedure and results, while neutrality is referred to as the degree to which findings are the function of the informants and that the conditions of the methodology are not biased. The subjects should therefore not be coerced to participate. In the present study these aspects were guarded against by the researcher.

##### **Triangulation**

In the present study the researcher decided to use more than one research method i.e. both quantitative and qualitative research methods.

Methodology for data gathering for this group included giving information to pregnant women who visited the clinic between May and June 2000.

The clinic was conducted every Tuesday, and the approximate number of clinic attendants per day ranged between 20 and 25 per day. The focus of the study was on first visit by pregnant women. All age groups were represented and parity was not limited. After explanation of research to the pregnant women the subjects gave informed consent.

The researcher selected every 5<sup>th</sup> pregnant mother visiting the clinic per day to collect data. The clients were ensured of anonymity of results, privacy and availability of results to participants after the study. Participation was voluntary and clients were told that withdrawal was also possible if the client was no more willing to participate. Twenty pregnant women were finally randomly selected for the study. The researcher administered the questionnaires to participants who responded to questions in the questionnaire.

#### **4.13 CONCLUSION**

The majority of professional midwives thought it is a good idea to have Traditional Birth Attendants who have undergone that kind of training in order to improve their standard of practices and to teach them the early symptoms of complications.

## **CHAPTER 5**

This chapter deals with findings, conclusions, limitations, implications and recommendations of the study.

### **5.1 INTRODUCTION**

The purpose of this study was to identify reasons for home deliveries as well as perceptions of nurses with regard to preference from such unmonitored deliveries. Areas that will receive attention will be summary of findings and recommendations for further study including the guidelines for working with Traditional Birth Attendants in the clinic.

### **5.2 SUMMARY**

Both qualitative and quantitative research methodologies were used to get in-depth knowledge regarding the feelings of people about the prevalence of home deliveries at Mpumalanga Township in KwaZulu-Natal. The findings will be presented with special reference to the problem statement, objectives of the study and methodology used to collect data.

### **5.3 STATEMENT OF PROBLEM**

There is a high rate of home deliveries in the Mpumalanga area in region "F" of KwaZulu-Natal.

### **5.4 THE OBJECTIVES OF THE STUDY**

- To identify causes of home deliveries.

- To identify alternative people who conduct home deliveries in Mpumalanga Township.
- To bring to the awareness of the Department of Home Affairs that such a problem exists so that a joint intervention could help to eradicate the problem.
- To develop guidelines to work with Traditional Birth Attendants in the clinic.

### **Objective number 2**

To identify the causes of home deliveries.

This objective was achieved in that the questionnaires were administered and interviews with stakeholders were conducted.

The following responses were obtained:

#### **Traditional Birth Attendants**

This objective was achieved because the Traditional Birth Attendants were called to meetings with clinic staff members and ten Traditional Birth Attendants were identified. A convenient sample was used since the number of Traditional Birth Attendants formed a focus group. The researcher explained about the research and participation was voluntary.

The ten Traditional Birth Attendants attended the data gathering session. The tape recorder was switched on and the researcher with the research assistant started collecting data. It was necessary to use the taperecorder to study behaviour and human experience of the Traditional Birth attendants. The researcher and research assistant helped each other with data collection. A specific questionnaire to obtain data from Traditional Birth Attendants was constructed. The questions were open-ended and needed to explore the in-depth knowledge of participants regarding the practice of home deliveries by Traditional Birth Attendants. The questions that were

asked included the procedure that was used for conducting deliveries by Traditional Birth Attendants. It also consisted of items such as experience that each Traditional Birth Attendant had. The following items were included in the questionnaire:

- Experience
  - The number of deliveries that each Traditional Birth Attendant delivers in 3 years.
  - The training that they had to do deliveries.
  - How aseptic technique was maintained during delivery to prevent infection particularly HIV/AIDS.
  - How complications such as post-partum haemorrhage and asphyxia of the baby was dealt with.
  - How they identified complications and procedures for referral.
  - Precautions for cutting the cord and asepsis.
- 
- Precautions which were taken by each Traditional Birth Attendant against HIV/AIDS including the basic knowledge that they had heard about HIV/AIDS.
  - Precautions that were taken by each Traditional Birth Attendant to prevent complications.

### **Responses**

- Out of ten Traditional Birth Attendants, six indicated that they delivered fifteen clients per year. For each Traditional Birth Attendant no deaths were recorded.
- Traditional Birth Attendants use a herbal preparation called “isihlambezo” to speed up delivery during first stage of labour. They also stressed the importance of washing of hands before and after conducting delivery.

- Traditional Birth Attendants prefer the kneeling position during delivery to this also prevents perineal tears.
- In order to let the baby's head descend into the pelvic cavity, the Traditional Birth Attendants assist the mother by wrapping a cloth around the abdomen. They know that bleeding is a bad sign and when this occurs, they call for a professional midwife for assistance or refer the patient to the clinic.
- Traditional Birth Attendants remove the excess mucus from the baby's mouth by means of a finger and if the baby show no signs of breathing, they suck the mucus out with their mouths.

### **Prevention of perineal tears**

The position that is used for delivering is the kneeling position. The heel of the woman in labour is positioned in such a way that it blocks the back of the perineum during delivery in which case, it is believed, it would prevent the woman from sustaining perineal tears.

### **The Criteria for referral of patients to hospital**

The traditional Birth Attendants pointed out that a bleeding patient prior to delivery and post delivery was referred to hospital.

- Any tired mother that could not be delivered was referred to hospital.
- Any baby that was not breathing well at birth was referred to hospital.

### **Precautions against HIV/AIDS**

- All Traditional Birth Attendants believed that for every mother that they came into contact with, there was a possibility that such a mother as HIV positive and they use plastic gloves to protect themselves against HIV/AIDS.
- They also indicated that they know that their hands should not have cuts, because the HIV virus spreads easily.

### **Questions regarding maternal and infantile deaths experienced by Traditional Birth Attendants**

The Traditional Birth Attendants were asked if during their practice they have come across such deaths. None of the ten Traditional Birth Attendants had been exposed to either maternal neonatal or deaths.

### **Professional midwives' perceptions**

It is clear from the foregoing that Traditional Birth Attendants are from a homogeneous group. Although they share the same ethos with the women that they attend, they are diverse in their roles, practices, habits and skills. The fact that a number of professional nurses were not fully informed about the practices of Traditional Birth Attendants may be due to the fact that there may be some geographical areas where Traditional Birth Attendants no longer practise.

The majority of professional midwives thought it a good idea to have Traditional Birth Attendants who have undergone some form of training in order to improve their standard of practices and to teach them the early symptoms of complications. There was some skepticism, however, among others about the feasibility of such cooperation.

Implications for future practice will therefore be, amongst others, to start with training programmes for Traditional Birth Attendants. An assessment in each community of the best way to do so should first be done.

Other countries have recognised the importance of Traditional Birth Attendants and have implemented simple intervention to optimise the quality of care they provide to them e.g. providing them with birth cord kits to ensure clean and hygienic cord management.

The key focus is the health status of the mother and the child ensuring that mechanisms are enacted to make sure that no mother dies owing to her inability to gain access to health services. The primary health care approach is the underlying principles of the restructuring of the health care system in the new South Africa.

### **Pregnant women**

The researcher selected every 5<sup>th</sup> pregnant mother visiting the clinic per day to collect data. Twenty pregnant women were finally randomly selected for the study. Participation was voluntary and clients were told that withdrawal was also possible if the client was no more willing to participate.

Questionnaire consisting of biographical data of open and close-ended questions was used for data collection. The questionnaire explored the reasons for preference of delivery services by Traditional Birth Attendants against clinic delivery by trained midwives. A separate quiet room was used to prevent distraction and subjects responded to the questions in the questionnaire. Where further explanation and clarity was needed the researcher was available to give assistance.

### **Responses**

The Traditional Birth Attendants were community members known by the patients and had a 'good reputation' as against a midwife who was skilled but a strange person who is not known. Transport was also a problem as deliveries occurred at night. Money for payment of transport was a problem. Clinics were far and not within walking distance.

The researcher deemed it necessary to include the biographical data of respondents. The reason for collecting biographical data is that variables such as age, parity and marital status have an influence on the role of Traditional Birth Attendants and professional nurses in peri-urban and rural clinics. The following responses were identified:

- A low socio-economic status of pregnant women between 15-19 years was identified as this group presented the highest percentage for home deliveries. This was as a result of financial constraints which were revealed during data collection since they are not working and the majority of them were school drop-outs.
- Mothers who are 30 years and above preferred delivery at the health centre in order to be cared for by professional midwives. According to the study, married mothers know the dangers and consequences of home deliveries, working mothers and supportive fathers showed an interest in the welfare of their children, therefore they were not in favour of Traditional Birth Attendants' services.

Attendants form a support system for Mpumalanga clinic, they should be accepted in the management of patients, because at times they perform duties which nurses cannot perform, such as in peri-urban and in rural areas when there is no transport at night and the patient is in labour.

The key focus of the maternal and child health policy is to improving the health status of women and ensuring that mechanisms are created to ensure that no mother dies owing to her inability to gain access to health services. This programme must, therefore, also include a training programme, for traditional midwives. The primary health care approach is the underlying principle for the restructuring of the health care system. Traditional Birth Attendants still practice under unsafe conditions without any supervision by professional midwives. The referral system is still poor in rural areas due to poorly constructed roads.

Ideally Traditional Birth Attendants should be working together with professional midwives. Traditional Birth Attendants are encouraged to refer their patients to service providers in the formal health care system if complications are anticipated. It is essential for good cooperation between the two categories of health providers that

they understand each other's role. The knowledge of traditional practices may positively influence the outcome of both mother and infant once they reach hospital.

## **5.5 RESEARCH METHODOLOGY**

The methodology for data for this group included giving information to pregnant women who visited the clinic between May and June 2000. The focus of the study was on first visit by pregnant women. All age groups were represented and parity was not limited. After explanation of the research to pregnant women the subjects gave informed consent.

## **5.6 FINDINGS**

The researcher made the following findings:

- There was no integration of professional nurses and Traditional Birth Attendants, but during data collection the professional nurses felt that integration should be established in order to reduce complications by unknown Traditional Birth Attendants.
- The Traditional Birth Attendants also felt that a short course should be given to them by professional nurses that could improve their knowledge and skills and thus prevent complications.
- The Traditional Birth Attendants admitted to having fears to refer their clients to professional midwives because they felt unaccepted and marginalized.
- Some of the pregnant mothers felt threatened by the services of the Traditional Birth Attendants but then they were available and accessible even at night.
- Traditional Birth Attendants came from the same village so they were known and pregnant mothers did not have to travel long distances or pay the taxi fare.
- From the interviews that the researcher conducted with pregnant mothers it was clear that they were aware of complications when delivery was conducted at home

by an unskilled Traditional Birth Attendant. This motivated them to co-operate and care for themselves and the family members were readily available to help.

- It can be confirmed that deliveries conducted by the Traditional Birth Attendants at Mpumalanga Township focused on both peri-urban and rural communities. This is type three of the communities screened by Traditional Birth Attendants as described by Chipfakachan (1994) which is a community that utilizes the services of the Traditional Birth Attendants in an urban / peri-urban community which, despite having a central system of services still prefers Traditional Birth Attendants.

## 5.7 RECOMMENDATIONS

- The role of the Traditional Birth Attendants needs to change and they should be taught how to assist in the birth procedure and how to give proper pre-natal care.
- To render a health service to the largest part of the population in the most economical way, taking into account the availability of personnel, funds and facilities.
- To render community services within an easily accessible distance of residential areas.
- The majority of professional midwives thought it's a good idea to have Traditional Birth Attendants also undergo some form of training in order to improve their standard of practice and to teach them the early symptoms of complications.
- The quality of the antenatal services should be improved and quality care given to pregnant women should be improved, by providing in-service training to all professional midwives.
- To improve the route access to clinics, the regional and district office should liaise with the public works department about the upgrading of roads.

- Clinic opening hours should be more convenient for members of the community. However, a decision to increase the opening hours of the clinics into the night will have to be accompanied by measures to improve security.
- To improve the mobile clinic areas that are not within close reach of fixed clinics.
- The mobile clinic supervisor and the environmental health officers should map out the current mobile routes and identify areas that are not adequately covered e.g. more than 10km away from the nearest facility.
- To provide waiting facilities at clinics for expectant mothers, which has been shown in other countries to be a very useful strategy for improving perinatal and maternal health outcomes.
- Integration of Traditional Birth Attendants' services as well as professional midwives' services is recommended since they play a prominent role in health care delivery in Mpumalanga Township in KwaZulu-Natal.

## **5.8 GUIDELINES FOR UTILIZATION OF TRADITIONAL BIRTH ATTENDANTS**

The following guidelines for incorporation of Traditional Birth Attendants into the district health system are recommended.

### **Guideline no. 1**

A database should be established for Traditional Birth Attendants at Mpumalanga Township. This would assist in tracing Traditional Birth Attendants for important meetings, training sessions or to inquire about certain patients that they had delivered.

## **Guideline no. 2**

It is clear that Traditional Birth Attendants had always existed in all cultures and that they are still being utilized by our communities. Training is therefore essential for safe practices by Traditional Birth Attendants.

## **Guideline no. 3**

A curriculum for training of Traditional Birth Attendants should be constructed and be submitted to the Department of Health, the South African Nursing Council (SANC) and the South African Qualifications Association (SAQA).

## **Guideline no. 4**

### **Prevention of infection**

The Traditional Birth Attendants should be taught aseptic techniques and should undergo a full programme for prevention of infection for safety of both the Traditional Birth Attendants and the patients they deliver.

## **Guideline no. 6**

The Traditional Birth Attendants should be accepted as counterparts in the management of patients, because at times they perform duties which nurses cannot perform such as in peri-urban and rural areas where there is no transport at night when the client is in labor. This statement is confirmed by the South African Police at Hammersdale who, according to the information that they gave, have had deliveries that take place at the Police Station while the client is waiting for an ambulance to take her to Edendale Hospital. According to Station Commander Dlamini home deliveries are frequent occurrences at this Police Station.

## **Guideline no. 7**

A needs analysis on what the Traditional Birth Attendants should learn must be performed so that training is made available to address these shortcomings.

### **5.9 LIMITATIONS**

- Financial constraints prevented the researcher from extending the study and cover the whole of KwaZulu-Natal.
- Clients coming to the clinic are not free to give information.
- Traditional Birth Attendants were conducting deliveries in their own natural way which could at times be dangerous. Some of the procedures could be extracted from Traditional Birth Attendants through asking them to conduct demonstrations to show how deliveries were actually conducted. Each step was then explained and demonstrated thoroughly by a Traditional Birth Attendant and observed by the researchers, who kept on asking questions for clarification.

### **5.10 CONCLUSION**

Not much on the subject of Traditional Birth Attendants has been published although it has existed and continues to exist in every culture. It is for this reason that it is not clearly understood. Also very little research has been done on Traditional Birth Attendants.

During data collection, information obtained from the subjects revealed that the Traditional Birth Attendants are important in our communities for the contributions that they make. The need for professionals to work with Traditional Birth Attendants has also been highlighted for the safety of our communities as well as the Traditional Birth Attendants themselves in terms of safe deliveries and precautions against infections.

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