CULTURAL CONGRUENT NURSING CARE OF BLACK PATIENTS IN THE MATERNITY SECTION OF PUBLIC HOSPITALS IN BLOEMFONTEIN

by

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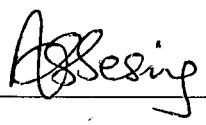

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CHAPTER ONE

INTRODUCTION AND PROBLEM FORMULATION

1.1 INTRODUCTION

South Africa is a multicultural society composed of Asian, Coloured, Black and White groups of people. Each population group has its own culture which influences its way of living, behaviour and health practices. Although every group has its own cultural orientation, every person in the cultural group is a unique human being and therefore must receive human health care. As such, humanness in health care is health care (as nursing care) which is comprehensive in as much as it meets all the needs of a person, including his or her socio-cultural needs. Thus, to meet all these needs it is necessary to use a holistic nursing care model. Holistic nursing is comprehensive as it always takes the cultural orientation of the person into consideration and as such fulfills all the health needs (including his or her cultural health needs) of an individual. Leininger (1990:54) states that the use of a model which does not reflect holistic or comprehensive care creates a serious problem because, if the cultural orientation of the patient is not taken into consideration, the values, beliefs, practices and ways of functioning that guide the behaviour of the patient are negated and thus he or she is dehumanized.

1.2 PROBLEM STATEMENT

Nursing is human care between nurse and patient tailored to meet the individual's (namely the patient's) needs. Both nurse and patient are human beings and as such

live according to their own cultural beliefs, practices and values. Because their cultural background/orientation or world-view cannot be separated from them, both patient and nurse bring their own world-view/cultural background to the nursing situation.

"Nursing care is an interpersonal process between the person expressing need for help and the helping person" (Chao, 1992:182). Nursing as an interpersonal process is, according to Hall and Dornan (1988:936), the art of caring and it includes warmth, respect, patience, kindness, sincerity, willingness to listen and the use of interpersonal skills. According to Sharts-Hopko (1995:343) for caring (whether nursing or health care) to be effective it must be offered in such a way that it actually brings the recipient comfort. For nurses to be sure that they are caring for their patients, they need to involve the patients, be available for them, see patients as resourceful persons (especially when dealing with cultural issues) and inform patients by giving clarification of biomedical and technical issues with which the patients are not conversant. Papo (1996:10) states that only the patients themselves can give the necessary information about their cultural orientation, their cultural health needs and their caring expectations. Therefore nurses cannot presume what their patients' cultural world-views are and cannot plan nursing care based on these assumptions. Greeneich, Long and Miller (1992:43) reported that patients mentioned abruptness, disrespectful behaviour and behaviours which elicited shame, guilt and/or emotional or physical pain related to cultural beliefs and practices of the patient, because nurses either negated or made fun of their cultural beliefs and needs. Herbst (1990:23) explains this phenomenon when stating that in the African situation, nurses (both black and white) tend to assume that all patients, despite their ethnocentricism, have a western cultural view.

Chao (1992:182) states further that if nursing care is offered in such a way that it satisfies the person who is giving it (namely the nurse) and not the person who is receiving it (namely the patient) it is not human care that has been given to the pa-

tient by a health care practitioner. According to Lupuwana (1991:8) nurses must know and fulfil the patient and family's cultural needs and understand their perceptions and behaviour. Nolte (1986:27) indicates that this is also true in the midwifery situation. Although midwifery is a special nursing care situation, it is still and will always be an interpersonally relationship between the nurse and the pregnant woman and her family. As such Nolte (1986:26) states that the midwife's main role is that of adviser and supporter of the pregnant woman and her family. As adviser and supporter of the pregnant woman and her family, the midwife must educate and prepare the pregnant woman to cope with pregnancy, confinement and child-bearing within the borders of her cultural orientation to life. Thus, to render holistic maternity care, the midwife must understand the patient's cultural orientation when educating and preparing the pregnant woman and her family for labour and child-bearing. Penny Simkin (1989) underwrites this statement when stating that there is a special need to explain unfamiliar concepts relating to pregnancy, childbirth events and medical care according to the cultural view of the patient, because the medical care to be rendered can be confusing as it does not always accommodate the cultural practices and beliefs of the pregnant woman and her family.

To the above, Martinez (1993:88) reported that pregnant women had complained that midwives gave neither individualized nor culturally orientated medical and nursing education, were unable to speak the patient's preferred language, did not make use of an interpreter and used written materials to communicate with illiterate pregnant women. This writer also reported that nurses tend not to use the traditional birth attendant as an interpreter to enhance specific cultural practices during pregnancy, childbirth and child-rearing. Therefore cultural congruent nursing care was negated because nurses tend to minimize differences and maximize generalities in patients.

"*All nursing care must be based on respect for the beliefs, attitudes and cultural lifestyles of patients*" (Callister, 1995:176). Thus it is of utmost importance to nurse

all patients in a way that is acceptable to them and not only to the nurse. Cultural congruent nursing care is crucial in maternity nursing because maternity patients and their families need support to help them cope with many life events which are culturally determined, such as pregnancy, childbirth and child-rearing. The midwife must therefore honour the patient's cultural practices and beliefs if she wants to render holistic nursing care.

Brindley (1983:46) explains that traditional African health practices regarding pregnancy and birth appear to reflect a mixture of physical and spiritual activities. Dietary restrictions during pregnancy and positions for the delivery are practised to strengthen the well-being of both mother and child. The burial of the placenta and other birth products is adhered to, to avoid sorcery and appease the spirits which control and guide birth. According to Lupuwana (1991:14) the wearing of ankle, wrist, neck and abdomen bands by both mother and child as well as the cleansing of the baby according to cultural practices help to prevent harmful spirits from entering the baby's body.

Chalmers (1988:14) claims that traditional health practices are not followed in western health care institutions because professional health care is based on high technology medicine which emphasises antenatal care for the mother only, (excluding the support network system). Delivery conducted in the supine position with the aid of standard medical interventions (not the normal squatting position as practiced in African cultures) and the postpartum care of mother and infant does not include cultural practices (the burial of the placenta and membranes and the cleansing of the baby are usually not permitted). The delivery of the baby is conducted only by doctors or midwives and members of the support network are not allowed to support the mother during the delivery. Therefore, when a delivery takes place in a western health care institution most black families are concerned for the well-being of both mother and baby as all future illnesses of the baby will be linked to the absence of

the cultural practices that were not performed during the intra natal care of mother and baby in the hospital.

The health care system in the Republic of South Africa is based on the western health care model. The western health care model focuses mainly on the physical aspect of health and uses scientific methods to obtain health data (Spector, 1991:44). Because the health care model is grounded in the scientific method, scientifically objective data are mostly taken into account. Thus the cultural orientation and cultural beliefs that underlie the patients' health behaviour are not taken into account as they cannot always be scientifically explained. Therefore, according to Tshotsho (1993:28) the western health care model may be inappropriate for people from traditional African cultures because they have their own unique cultural way of viewing health and health care. As Shisana and Versfeld (1993:7) state "... *people from one area may not share similar beliefs and customs.*" This unique cultural orientation to health and health care does not always fit in with scientific objectivity.

Changes are also taking place in the Republic of South Africa affecting the health care system in such a way that nurses from western and traditional African backgrounds find themselves integrated in the health care setting. Both black and white nurses now nurse patients from different cultures in the same hospitals or clinics. According to Tshotsho (1992:46) these changes make the cultural background or orientation of both nurses and patients extremely important. Because of the differences between western and traditional African culture, it is sometimes difficult to understand both the patient's and the nurse's behaviour. And for the nurse to fulfil all the health needs of a patient of a different culture it is of utmost importance to understand and be sensitive to the cultural orientation of the patients - both the similarities and differences.

In the light of the above, it is very important for nurses to know the community they serve. Therefore, in order to render holistic nursing care to all patients, whether of

the same or a different culture, it is necessary for the nursing curriculum to emphasize cultural congruent nursing care in nursing education. Zeelie (1996:7) states that nursing education must be based on a curriculum which reflects the context within which the nurse has to function. Burk, Wieser and Keegan (1995:39) underline this approach by stating that a holistic model is the only perspective that enhances the nurse-patient relationship. This approach requires that three distinct cultures must be considered, namely the culture of the patient, the culture of the nurse and the culture of the health care system. Integration of the three cultures must be accomplished to fulfil the patient's needs that include her socio-cultural needs.

Regarding the nursing curriculum, Tshotsho (1992:47), wrote that the nursing education curriculum is based on the western health care model. The traditional African cultural orientation is seldom taught because the assumption is made that all patients have a western cultural orientation. Nyasulu (1994:35) states that nurses who were trained according to the western health care model cling to their educational philosophies which emphasise biomedical and physical needs with the result that the patient's socio-cultural needs are not fulfilled because nurses were never taught how to fulfill them. Chalanda (1995:19) states further that nurses in contact with patients from different cultures encounter many problems, such as language barriers. Because of these barriers and because of their nursing education, nurses tend to negate the patient's cultural orientation and render only western scientifically-based nursing care.

Pregnancy, childbirth and child-rearing are family and community events and as such the pregnant woman cannot be separated from her people. The western health care model as practised in midwifery tends to exclude family or other support networks except the husband, during the ante-, intra- and postnatal periods. According to Callister (1995:176) it is important to have inputs from both the pregnant woman and her family when assessing her health care needs and formulating a plan of care. But as Mokoena (1991:31) explains, nurses fail to understand this point as they em-

phasize only individual patient care. The family, both the nuclear and the extended family, are seldom involved in nursing care planning and intervention. The midwife thus acts as the only supporter of the patient. Bryanton, Fraser-Davey and Sullivan (1994:638) on the other hand emphasize that nurses must strengthen family support during pregnancy, birth and child-rearing as life events. As the midwife is only one of many supporters of the pregnant woman and her family, the choice of whom she wants as a supporter lies with the pregnant woman and her family.

The pregnant woman's support network, according to Burk et al. (1995:44), can be the nuclear family and/or the extended family which may at times include friends, neighbours and community members such as the traditional birth attendants. According to White (1992:21) the support network of the traditional African pregnant woman and her family includes traditional birth attendant as they are part of the cultural and social life of the women they serve. The traditional birth attendants can help professional midwives to provide cultural congruent nursing care. But, as previously stated, the western health care model excludes traditional birth attendants as multidisciplinary team members and as an integrated aspect of the support network of the pregnant woman and her family. Therefore the support network system of the pregnant woman is severed. When this is done, professional midwives do not render holistic and cultural congruent nursing care to the traditional pregnant woman and her family.

The nursing process is the only instrument available to the midwife to fulfill all the health needs of the pregnant woman including her cultural health needs. According to Leininger (1988:152), Jambunathan (1995:343) and Weber (1996:68) the assessment phase of the nursing process is the most crucial aspect of cultural congruent nursing care. Not only must the physical and emotional health needs of the pregnant woman be determined, but also her cultural health beliefs and practices must be ascertained to predict and understand the patient's response to pregnancy, birth and child-bearing. The following health beliefs and practices **MUST** therefore be inclu-

ded in the cultural assessment: traditional taboos, herbal medicines, how the pregnant woman wants to deal with labour pains, positions during labour, care of the placenta, care of the newborn and the mother after the birth of the baby until they are discharged from the health care institution. According to Callister (1995:176) individualised counselling in a variety of settings should be provided to assist pregnant women in analysing their personal needs and goals for child-bearing and to provide education regarding options. But according to De Villiers (1996:4) a problem still exists in that the nursing process, although it has the potential to fulfill all the health needs of the patient including her socio-cultural needs, is still not used properly and nursing care plans focus only on the biomedical needs and care of the patient.

Another factor that does not enhance cultural sensitive nursing care is health care policies. Most health care policies and facilities were drawn up or designed before 1994, before political changes changed the philosophy underlying the health care system in the Republic of South Africa. Fourie (1994:31) states that many hospitals are not designed to accommodate cultural health practices. Health care policies do not include the traditional birth attendant or *sangoma* as members of the multidisciplinary team. Therefore according to Rosenbaum (1995:189) traditional African patients tend first to use their own traditional health care system before coming to the western health care system. As the policies, daily routines and procedures in the western health care system are based on the western health care model and western time perspective, little time is included for fulfilling the cultural health beliefs of the traditional African patient. This situation makes traditional, African patients, according to Tshotsho (1993:28), to feel that they are not accepted in the western health care system. Therefore they go back to the traditional African health care system that caters for their cultural health beliefs, traditions and practices, even if they do need specialised health care which can only be rendered by modern western health care facilities. In summary, the research problem underlying this study is:

- The inhabitants of the South Africa have different cultural health needs based on their cultural orientations which are embedded in their beliefs, expectations and practices according to which they live.

- The health care system as well as the nursing care system in South Africa are based on the western health care model which is founded on the scientific method that excludes data and practices that cannot be scientifically explained. Health care, including nursing care, tends to negate the socio-cultural health care practices of the traditional African patient because some socio-cultural health care practices and beliefs cannot be scientifically explained.

- Nursing care is an interpersonal process between the patient and the nurse. As such the nurse must render holistic nursing care (that is, care that fulfils the socio-cultural health needs as well as the biomedical needs of a person) to all inhabitants of the Republic of South Africa taking into consideration their cultural orientations. However, nurses tend to focus mainly on the biomedical needs of patients and therefore render only care that can be scientifically explained. Most nurses also tend to assume that all patients have a western cultural world-view despite the patient's ethnocentricity. The same problem is experienced in health care institutions of Bloemfontein and surroundings by some inhabitants. This is also observed by the researcher in these institutions. The problem was confirmed by some nurses/midwives who had an informal conversation with the researcher stressing that the more disadvantaged patients are traditional African patients. Hence it is important and necessary to research "Are nurses knowledgeable of cultural congruent nursing care and do they apply these principles in midwifery care they render to mothers and their babies."

1.3 PURPOSE AND OBJECTIVES OF THE STUDY

Based on the problems above, the purpose of the study is: "to ascertain whether nurses working in maternity units of public hospitals are knowledgeable with regard to patients orientations and whether these orientations are culturally congruently accommodated in the nursing care plan as stipulated in health care policies" and

Based on the purpose, the objectives of the study are:

- To ascertain whether nurses are knowledgeable regarding traditional African cultural practices in midwifery.
- To ascertain whether nurses fulfill these cultural needs when giving nursing or midwifery care and how traditional African pregnant and lactating women experience the midwifery care they received in health care institutions.
- To ascertain how nurses experience phenomena of giving cultural congruent nursing.
- To ascertain whether cultural congruent nursing or midwifery care is accommodated in the nursing care plan and as stipulated in health care policies.

1.4. METHODOLOGY

A descriptive study, according to Burns and Grove (1993:766), must be used when information about real life situations is to be obtained. Therefore a non-experimental research of a descriptive and exploratory nature is to be used. The non-experimental (qualitative) research design is used because nurses and patients (the preg-

nant woman and her family) experience cultural congruent nursing care differently. Because the phenomenon to be researched is unique and new, the study is of a descriptive and exploratory nature (Mouton & Marais, 1989:45). Thus the nurses' knowledge about their patients' orientations and how this information is incorporated in the nursing care the patients receive will be obtained.

The survey method was used as research methodology because it is congruent to the descriptive and exploratory nature of the study. The following research techniques will be used and are appropriate to the survey method:

- a questionnaire will be completed by nurses to ascertain whether they are knowledgeable of cultural congruent nursing care;

- a structured interview will be conducted with pregnant and lactating women in hospital regarding their experiences of cultural congruent nursing care; and

- auditing of the appropriate policies and nursing care documents in the hospital and wards will be done to ascertain whether cultural congruent nursing care is endorsed and whether cultural congruent nursing care are recorded in the nursing care records.

All nurses working in the maternity units of the two public hospitals in Bloemfontein are included in the study. The public hosptials are the academic specialised hospital and a regional hospital for the Free State province. The population of patients will include all pregnant and lactating women hospitalised for 2-3 days and longer during the period of the study. The reason therefore is: these patients will be able to share the experiences of the care they received while in the hospital.

Only the appropriate documents (hospital and ward policies and the nursing documents of the patients included in the study) will be audited. All data will be analysed on a nominal level as no connection will be drawn between different data.

1.5 ETHICAL ASPECTS

The following ethical considerations will be taken in account:

- Approval for the study will be obtained from the Ethical Committee of the Faculty of Health Sciences of the University of the Orange Free State because patients will be included in the study.

- Permission will be obtained from the management of the institutions concerned for carrying out the study in their institutions.

- The respondents will be informed about the study and only those who give informed consent will be included.

1.6 CLARIFICATION OF CONCEPTS

- **Midwife**

Nolte (1992:40) defines a midwife as a nurse who is registered and/or legally licensed to practice maternity nursing. In this study a midwife refers to any person who is registered as a midwife by the South African Nursing Council.

Patient

The South African Nursing Council, Regulation No. 254 of 1987 defines a patient as a person, sick or well, who needs help to supplement his specific ability to accept optimal responsibility for his own health in the various health services and treatment areas and in all age groups. This study underwrites the declaration of the South African Nursing Council but the word "patient" will mostly refer to pregnant and lactating women till otherwise stated.

Culture/Cultural Orientation

Poggenpoel (1993:39) defines culture as a specific world-view in which a person's cultural life is rooted. In this study cultural orientation is the ideas, beliefs, expectations and behaviour that stem from the cultural background of patients according to which they live. Culture and cultural orientation will be used as synonyms unless otherwise indicated.

Nursing care/maternity care

Chao (1992:183) defines nursing care as an interpersonal process between a person expressing a need for help and the helping persons. It is human care which is tailored to meet an individual's needs. As this study concentrates on the nursing care given during pregnancy, birth and (mother and child) care, nursing care refers to the care given by nurses in the antenatal, intranatal and postnatal units where the mother and the newborn baby are cared for till they are discharged. Maternity care and nursing care will be used as synonyms.

* **Antenatal nursing care**: refers to the care given to a pregnant woman from the time she falls pregnant till the onset of labour, regardless of who renders the care.

* **Intranatal nursing care**: refers to the care given to the woman in labour from the onset of labour till the expulsion of the afterbirth products.

* **Postnatal nursing care**: refers to care of the mother and the newborn baby from the time the afterbirth products have been expelled till they are discharged.

- **Cultural congruent nursing care**

According to Rajan (1995:451) multicultural nursing care or cultural congruent nursing care means "to provide human care to people in a way that is meaningful, congruent and respectful of cultural values and lifestyles." It aims at assisting, supporting, facilitating and enabling individuals to maintain or regain their wellbeing. In this study cultural congruent nursing care means care that respects the patient's beliefs, behaviour, cultural lifestyle and includes the nursing care rendered to fulfill all the health needs of the patient.

1.7 OUTLINE OF STUDY

The outline of the study is as follows:

- Chapter One consists of the introduction and problem formulation.
- Chapter Two reviews the literature of the cultural health needs and practices during pregnancy, childbirth and postnatal care of different cultural groups.
- Chapter Three outlines the methodology used.

Chapter Four reports the research findings.

Chapter Five constitutes discussion of data obtained, conclusions reached and the recommendations made.

Chapter Six consists of the conclusion of the study.

.8 SUMMARY

n this chapter it became evident that nurses care for patients from different cultural ackgrounds. The problems underlying cultural congruent nursing care were ex-lored and the reasons why nurses must render holistic nursing care were explained. n the following chapter the cultural orientations of the different cultural groups in ne Republic of South Africa of which the nurse must be knowledgeable, will be iscussed.

CHAPTER TWO

THE CULTURAL ORIENTATION OF THE PATIENT : THE FOCUS POINT OF CULTURAL CONGRUENT NURSING CARE

2.1 INTRODUCTION

The rainbow multicultural nation of South Africa consists of many people of different cultures and the members of the nursing profession reflect this. Therefore, nurses from all cultures enter the nursing profession. All humans, irrespective of their cultural orientation or ethnicity, can become ill or may need health care of some sort during their lifetime. Thus when patient and nurse meet in the nursing care situation, it can happen that the cultural orientation of the patient entering the health care system and the nurse rendering the nursing care may or may not differ (Uys, 1989:16). When nurse and patient are from the same cultural orientation, they do not encounter cultural problems originating in different cultural world views, lifestyles, language, time conception, health practices, education, religion, traditions and beliefs. Breakdown in the nurse-patient relationship seldom occurs. But when the cultural orientation of nurse and patient differ, problems can occur because according to Wuest (1992:91) all persons consider their own cultural perspective, patterns of behaviour and expectations for behaviour as being "normal" and

anything different as being "wrong" or "inferior." The breakdown of the nurse-patient relationship can thus result.

In the light of the above, this chapter focuses on the cultural orientation of the patient - namely the pregnant woman and her family and how cultural congruent nursing care enhances the well-being of the pregnant woman and her family. Attention will also be given to the health care system in which the nursing care takes place; as well as the philosophies embedded in nursing education because it determines the nursing care practice.

2.2 THE SOUTH AFRICAN HEALTH CARE SYSTEM

South Africa has two distinct systems of health care, namely the traditional health care system and the western health care system (Foster & Anderson, 1978:250). Modern western medicine permeates the entire society and serves all population groups while traditional or tribal medicine is well-established and relatively popular among the traditional African population. The two systems differ vastly from each other and very seldom supplement one another. According to Uys (1986:32), the utilization of a specific system is always determined by the patient's perception of illness, what causes it and therefore how and by whom his health may be restored. In line with this, people with a western cultural orientation utilize mainly the western health care system. Traditional African cultural orientated people use both the traditional and western health care systems with the traditional health care system as first choice.

Both the western and traditional health care systems are based on certain philosophies and orientations which determine the care to be given, how health and illness are viewed and the way the health workers are educated. According to Chalmers (1988:12-13) the philosophy of the traditional health care system is as follows: "*The*

black (non-western) perception of health and illness is set squarely into a holistic framework." Man is viewed as an integral part of his worldly environment. Not only are the psychological and physical aspects relevant and important to health and disease, but also the spiritual, the magical or the mystical aspects. For his natural treatment from plant and herbal origin, she (patient) gets prescription from traditional healers. Karlsson and Moloantoa (1986:26) explain that the traditional patient (i.e. traditional African person) consults the traditional healer (doctor) at his home for every matter that affects him and his family's life, including life events such as pregnancy, delivery and postpartum care. When a woman is pregnant or suspects that she is pregnant, the traditional birth attendant can be consulted with or without the traditional healer's consent.

The traditional birth attendant is thus a member of the multi-disciplinary health team of the traditional health system and works hand in hand with the traditional healer. The traditional birth attendant is a woman who is between 35 and 60 years old or who is past child-bearing age. She begins her midwifery work only after she has had children of her own and is usually taught by some close relative who is an established traditional birth attendant (Smit, 1994:25). The traditional birth attendant usually gives antenatal, intra natal and postnatal care. She diagnoses pregnancy by inspecting the breasts, the abdomen and the back of the knee. During antenatal care she focuses mainly on personal hygiene. The physical examination of the woman is prohibited because the birth attendant's role during this phase focuses mainly on health education. As health educator the traditional birth attendant must instruct the patient to adhere to cultural practices during pregnancy and must solve all problems the pregnant woman experiences in collaboration with the traditional healer. During labour, the traditional birth attendant assists the woman in labour by encouraging her to remain ambulant and active during the first stage of labour (Nolte, 1992:28). During the second stage of labour, traditional birth attendants allow a squatting position with the hand supporting the perineum (Brindley,

1983:44) if this position is comfortable for the mother and if it is the patient's preference.

Following delivery the traditional birth attendant makes medical powders from wild animals, burns them and envelopes the baby in the smoke to strengthen it (Brindley, 1985:99). The traditional birth attendant normally visits the woman for eight days during which she baths the baby and gives the mother advice on breast feeding (Nolte, 1992:28). Furthermore the traditional birth attendant must perform other cultural practices such as fumigating the baby and the hut as cleansing and protective rituals, and administering herbal medicines as cleansing agents and to encourage uterine involution.

Groat (1992:28) states that the traditional birth attendant fulfills a very important function in the life of the pregnant woman and her family. "She gives reassurance, comfort and support to the woman's family and finds time to check on other children, if any in the household, liaises with the husband, provides cups of tea to other support persons and/or visitors and checks for other things like groceries, cleaning materials and water." Therefore, based on the philosophy of caring for the woman and her family, it can be stated that the traditional birth attendants render cultural congruent nursing care and thus adhere to the philosophy underlying the traditional care system.

The modern western health care system which is mostly used by persons who have a western culture orientated is based on the scientific approach and western philosophies. Western philosophies, according to Chalmers (1988:12), tend to separate certain aspects from each other because they are based on a concept of mind-body dichotomy, man is divided into three aspects which are mind, body and spirit. This conception sees a man as fragmented rather than being an integrated whole. As a result the physician heals the body, the psychiatrist and psychologist treat the mind and the clergy attend to the soul. In the western health care system antenatal, intra natal and postnatal care are rendered by obstetricians and professional mid-

wives. The professional midwives are nurses who have successfully completed their midwifery educational programme as defined and prescribed by the South African Nursing Council. The professional midwives are members of a multi-disciplinary team in the maternity section of western, modern health care institutions and work hand in hand with obstetricians.

Professional midwives render services according to the scope of practice laid down by the South African Nursing Council (R2598 of 30 November 1984 as amended, regarding the scope of practice of registered nurses and registered midwives). The midwife's role during the antenatal period is that of advisor and supporter: advisor with regard to physical health and supporter of the mother (not always the father). As stated by Nolte (1995:49) "*the midwife is responsible to give the necessary supervision, care and advice to women during pregnancy, labour and the postpartum periods, to conduct deliveries and to care for the newborn.*" The professional midwife is thus not responsible for the total care of the mother and her family. According to Groat (1992:19) the professional midwife in the western health care only assists the obstetrician by preparing the patient for delivery; as well as the bed, the baby crib and the sterile instruments; checks whether there is a need for an analgesic agent delivering the baby if the obstetrician is not available and keeps the necessary records. Goddard (1986:13) stated, as a result of a study, that the health care given by professional midwives during pregnancy only places emphasis on medication, occupational hazards, infections and physical health, other aspects such as premature bleeding, early contractions, premature rupture of membranes, normal labour and delivery, variations of the normal labour pattern and breast feeding. Cultural practices are not included nor excluded but are mostly negated. Van Niekerk (1982:24) found that professional midwives mainly complement the care provided by doctors during intra natal care by assisting the anaesthetist and helping with the administration of drugs. During the postpartum period professional midwives mainly advise, observe and report complications of both mother and baby. Groat (1993:27) states that professional midwives are not expected to take part in cultural

practices such as administering herbal medicines, making provision for dietary taboos, massaging the abdomen and perineum or following the normal traditional procedures of cleansing and purifying with herbs as such practices are not embedded in the nursing education programme. Referring the lactating woman to traditional healers or traditional birth attendants is not welcomed or accepted by the western health care system and is discouraged by all health practitioners. Upvall (1992:32) states that collaboration between professional health care workers and traditional health care workers won't work out unless both traditional health care workers and professional health care workers work in the health care setting together (hospital and community). As traditional birth attendants seldom consult professional health care practitioners, complications of pregnancy, labour and the postnatal period as diagnosed by the traditional attendant such as ipuleti (obstetric complications of some sort) are negated by professional health care practitioners because they are interpreted as unscientific diagnoses which were not made according to scientific methods and cannot be proved technologically (Gcaba & Brookes, 1992:43).

In the light of the above mentioned it can be stated that the care philosophies of the two health care systems differ vastly in the sense that the traditional health system does not deal with only diseases but also include the patient social environment. Another aspect of importance is that care in all South African health care institutions adheres solely to western health care philosophies which excludes the traditional health care system. The result is that health care based only on the western health care philosophy is rendered to all South Africans regardless of their culture, health and life practices (Tshotsho, 1993:30). Based on the political philosophy prevailing in the Republic of South Africa before 1994, separate health care settings were built for the different race groups. The care given in these settings was monocultural as only black African people could care for black African people and white African people for white African people. The care given in these settings is based only on western philosophies because it was and still is based on the western health

care philosophy as all health care education is based on the western health philosophy (Tshotsho, 1992:46). Because of the changed political philosophy after 1994 the care in all health care settings has changed in the sense that all health care institutions now cater for patients from all cultural backgrounds in the same health care setting. Thus patients and care givers differ in their cultural views regarding health and illness, cultural practices and interpretation of life events. When the care givers negate the patients' cultural needs, patients (especially the traditional worldview) may feel uncomfortable and hurt (Burk et al. 1995:39) to such an extent that they avoid the western health care system and only re-enter it as a last resort after all other health care has failed (Spector, 1991:79). The negation of the patients culture does occur daily in health care institutions. According to Tshotsho (1992:46) and Fourie (1994:32) the reason is that all health care givers are educated and socialised in the western health care model. Thus professional health care givers reject the traditional health model as well as the health care givers of that system because of the belief which exists that the western health care model is the answer to all humanity's health needs (Oskowitz, 1991:21).

Based on the fact that patients' cultural orientation and needs are negated by the health care givers, Lea (1994:310) suggests that the two health care models should be "wedded" to enable care givers to fulfil the health needs of patients based on the two models and not exclusively according to the health models the care givers were socialised and educated in. In wedding the two models all care givers should be knowledgeable and educated regarding both the traditional African and Euro-American cultural practices during life events such as pregnancy, labour and childbearing . Thus to render holistic care to all pregnant and lactating women, the two health care models must be used in all health care settings to enable all pregnant and lactating women's cultural orientations to be fulfilled. In "marrying" the two health care models, professional midwives will be able to render holistic maternity care. But in order to do so professional midwives must be knowledgeable of the cultural practices embedded in both the traditional African and western (Euro-American)

culture during the life events of pregnancy, labour and child-bearing and these must be considered during the process of giving health care. Therefore both the traditional birth attendant and the registered midwife must enhance those practices which are beneficial to the pregnant woman while altering those practices that can harm mother and baby.

2.3 NURSING AS A CULTURAL AND AN INTERPERSONAL PHENOMENON

2.3.1 NURSING AS A CULTURAL PHENOMENON

"Early on, care of the sick was provided typically by women in the family" (Oermann, 1994:153). Nursing is thus an interpersonal and cultural phenomenon which has served all human races by caring for the sick and the healthy from the beginning of time (Dolan, Fitzpatrick and Herrmann, 1983:22). The care to the sick and health was given by the family member within the family's cultural orientation. Each family has its own culture which influences or provides a blueprint for their way of living. Thus nursing has and is still taking place between two persons: the person in need of care (the patient) and the person who gives this care and support (the nurse) who have their own cultural orientations. These cultural orientations influence both persons' view of illnesses, expected treatment and outcome. Thus nursing is and will always be embedded in the culture of a community. Nursing is not only a cultural phenomenon but also an interpersonal phenomenon based on the interpersonal relationship between patient and nurse. As time went by professional nurses replaced the family members. Midwifery is a specialised field of nursing - therefore it is also a cultural and interpersonal phenomenon because the professional midwife (nurse) interacts with the pregnant woman and her family when they meet in the nurse-patient relationship or dyad coherence.

2.3.2 NURSING AS AN INTERPERSONAL PHENOMENON

As stated earlier the interpersonal phenomenon called nursing occurs between two persons, a professional nurse and a patient. For it to be effective and efficient nursing must take place in such a way that both parties understand each other. Therefore, it is important for the patient to feel satisfied that all his or her health care needs are met. This can only be achieved if the patient is treated in a human manner. But when care is given across the cultural border the professional nurse and the patient involved may encounter problems originating in different world views, lifestyles, language, time conception, health practices and beliefs. Shisana and Versfeld (1993:7) explain that in South Africa communities in different areas do not share similar beliefs and customs. Therefore to render holistic nursing care the patient's biomedical needs, as well as her socio-cultural health needs must be met. This entails considering, respecting and incorporating the patient's cultural orientation in all nursing care rendered. The nurse-patient relationship can only grow when there is mutual respect and trust (Van den Berg, 1985:363-371) and the nurse must know her patient.. Hence it calls for cultural congruent nursing care as both persons are human beings with similar or different cultural orientations.

2.3.2.1 THE INDIVIDUALS IN THE NURSE-PATIENT DYAD

The persons in the nurse-patient relationship are the patient and the professional nurse. In this case the patient is the pregnant or lactating woman and the professional nurse is the midwife. When the pregnant woman meets the professional midwife in the maternity section, they form the nurse-patient relationship or dyad coherence. According to Burk et al. (1995:39) both the professional midwife and her patient are shaped and formed by the culture into which they were born. A person's culture is his pride, and his childhood perceptions and behaviour remain strong throughout life. Odetola and Ademola (1990:173) state that the culture into which one is born

is of the utmost importance in one's education, health beliefs, health behaviour and the world view of life events are embedded in one's cultural orientation. In view of this it is evident that when a professional midwife and a pregnant or lactating woman meet each other in the nursing care situation each brings her own cultural orientation to the nursing situation and their behaviour is based on their particular cultural views.

2.3.2.1.1 THE PATIENT: THE MOST IMPORTANT PERSON IN THE NURSE-PATIENT RELATIONSHIP

Every pregnant or lactating woman regardless of her ethnical and cultural orientation, is the most important person in the nurse-patient relationship.The pregnant or lactating woman brings her own cultural orientation to the nursing situation as she was socialised by society, community, parents, teachers and friends into her culture specific orientation determines the pregnant woman's perception of health, as well as her expectations of the care to be received. The patient's family is also of the utmost importance, as they are her concern and people who help her (Groat, 1992:28). Therefore, in traditional African culture the woman must be cared for by trusted women. (Poggenpoel, 1993:35).

All cultures have different views about pregnancy, labour and child-bearing. Ramer (1992:31) states that "*Childbirth is viewed by some cultural groups as a normal physiological process, a state of illness, a state of vulnerability and risk or a wellness experience.*" According to the African view as stated by Ntoane (1988:21), pregnancy, labour and child-bearing are natural events which must take place in a relaxed atmosphere and cultural aspects of the woman should be respected. According to Mokoena (1991:30) as well as Chalmers (1988:17) childbirth in the traditional African community is viewed as sacred and social in a natural way. Therefore traditional African cultural practices reflect a mixture of physical and spiritual activities and the pregnant woman must adhere to these. Barnett (1980:36) explains that it is important for the midwife to respect the pregnant or lactating wo-

man's dignity and must never impart a feeling of inferiority. In the light of the above, according to Callister (1995:176), nursing - especially maternity nursing care - is coloured by cultural views, rituals and practices which are not included in the western cultural world orientation and cannot be explained in terms of the western cultural world orientation but only by people of the same cultural orientation.

Western culture views pregnancy and labour as physiological events that lead to health problems that need medical intervention (Karlsson & Moloantoa, 1986:27). When there are complications western women understand the physiological explanations and accept medical interventions. These include technological procedures such as induction, epidural block, Caesarean section, Ventouse and forceps deliveries - concepts that are not new or frightening to the westernized woman (Karlsson & Moloantoa, 1986:27).

2.3.2.1.2 THE NURSE: THE OTHER PERSON IN THE NURSE-PATIENT RELATIONSHIP

The nurse (or midwife) is the other individual in the nurse-patient relationship. She is a person born and bred in a family and has her own orientation acquired through socialisation from the society into which she was born and the community she grew up in. Her parents who brought her up, the teachers who taught her and the peer group she played with also sculptured her or his cultural life. A student entering the nursing profession has her own cultural orientation. During training, she is socialised to the western health care model. Nurses who have a western cultured orientation do not experience problems when socialised to the western health care model because of their culture. Nurses who have a traditional cultural orientation do experience problems in this regard as they must bend or abandon their cultural health care beliefs and behaviour and adopt modern health care behaviour (Karlsson and Molantoa, 1986:27) and (Tshotsho, 1992:46). But in the practical nursing situation nurses give care to patients from different cultural orientations; some same and others different as theirs. That is why they experience problems such as misunder-

standing in communication, when caring for patients from different cultural orientations, views, rituals and practices. Because of these differences in cultural orientation between patient and nurse, the nurse-patient relationship cannot grow.

2.4 THE EDUCATION OF THE PROFESSIONAL MIDWIFE AND THE TRADITIONAL BIRTH ATTENDANT

2.4.1 THE EDUCATION OF THE PROFESSIONAL MIDWIFE

Nursing as a profession holds certain values which are shared and learned by nurses and these values shape their nursing beliefs and caring behaviour. Nurses assimilate the standard behaviour of their peers and eventually they speak and care like them (Anderson, 1990:136). According to Searle and Pera (1994:98) these values include norms such as nursing care should be provided in accordance with human need and with respect for the dignity of man, irrespective of race, creed, nationality, social standing and/or political persuasion. The core element of professional nursing is thus human needs. Tshotsho (1992:46) states the opposite regarding the value system as recognised by nursing professionals because their education and socialization tend to be monocultural and not multicultural since it is based on the western health care model. This means that all pregnant women regardless of ethnical and cultural orientation are nursed in the same way and the socio-cultural needs of the traditional African woman are negated because the western health care model is based on disease, not human needs. Although the core curriculum of the South African Nursing Council endorses cultural congruent nursing care, the culture taught in the classroom consists mostly of religious aspects regarding dietary habits such as vegetarian diets (Mokoena, 1991:30) and death ceremonies based on cultures such as laying out of a corpse by a person of the Jewish community, while singing and prayers to serve as a source of soothing strength, hope and renewal for many people

(Tshotsho, 1993:31) are negated. According to Nyasulu and Mzolo (1993:14) these aspects are inadequate to educate nurses in cultural congruent nursing care. The aforementioned authors, in a study with traditional birth attendants, found that patients from different traditional African cultural orientations felt that the western health care system does not cater for their specific cultural health needs. Melzach and Wall (1988:21) found in a study that nurses use stereotypes and label traditional African patients as "unpopular" because their behaviour is different from the nurse's personal views, world-view, time conception and health care practices. In the end only those with health needs similar to the nurse's health view are met. Thus the nurse-patient relationship broke down because the nurse and patient did not understand one another's language and health behaviour.

The educational programme of professional midwifery as a speciality in nursing, has the goal to ensure that all midwives are able to render holistic care to women of all cultural groups in South Africa. The curriculum for the preparation of professional midwives consists of a system of learning designed to provide adequate nursing care for pregnant and confined women and to promote the health and welfare of mothers and their families (Venter, 1991:3). But the content of the professional midwifery educational programme very seldom reflects cultural congruent maternity nursing care such as taboos, herbalism and traditional African childbirth rituals because the dominant nursing culture is the western health care model while little attention is given to the traditional African culture.

2.4.2 THE EDUCATION OF THE TRADITIONAL BIRTH ATTENDANT

In the traditional African culture education of the traditional birth attendant takes place in an apprenticeship way. It is a shared and learned education from generation to generation. According to Smit (1994:25) a traditional birth attendant is a woman between 35 and 60 years. She begins midwifery work after having children of her

own and she learns from some close relative who is an established traditional birth attendant.

Traditionally established traditional birth attendant is an older, more experienced woman in the family who serves as a role model to teach and advise younger women about how to attend to the pregnant woman from conception, throughout labour and to take care of the mother and the newborn baby immediately after delivery for eight to ten days.

The informal education of the traditional birth attendant include topics such as:

- Care to be given during pregnancy, labour and puerperium with emphasis that the woman during labour must never be left alone or abandon.

- Support to be given to the woman and her family when taking care of their emotional, psychological, social and cultural needs.

- Advice to be given to the pregnant woman and her family regarding pregnancy, birth and child-rearing. The education of the pregnant woman starts immediately after her marriage and continue through pregnancy, labour and child-rearing.

- The preparation of herbal medicines for pregnancy, labour and child- and mothercare from barks, roots and twigs, how to prescribe portions of prepared medicines and how to administer them.

- The performance of traditional rituals and practices to protect the mother and the baby as well as cleansing them.

- Practices like massaging abdomen, back and perineum, rotating the unborn baby to reposition it, fumigation of delivery room, talking to ancestors and making of protective bands are also included.

The novice birth attendant starts her learning period by observing the trained traditional midwife. Later on, under supervision of the trained midwife, the novice actively participates in the practice of maternity care until she has mastered it. Only then is she allowed to practice independently and start teaching another novice.

2.5 THE DICHOTOMY BETWEEN PROFESSIONAL WESTERN MIDWIFERY CARE AND TRADITIONAL AFRICAN MIDWIFERY CARE

According to Mokoena (1991:30) nowadays almost all traditional African women deliver their babies in western health care centres or hospitals, especially in urban areas. Nolte (1992:28) states that in many parts of South Africa most traditional African pregnant or lactating women, including those in urban areas, are still consulting the nearby traditional birth attendant. This is done to supplement the nursing care of western health care institutions which do not cater for their socio-cultural needs. Callister (1995:176) states that professional midwives in maternity nursing must be able to cater for aspects of western and traditional African cultural practices and incorporate them in the nursing care plan. According to Nolte (1986:26) the professional midwife is the pregnant or lactating woman's advisor, supporter and health educator. Pregnant or lactating women need advice, support and education because they have fears, anxieties, concerns and expectations for their pregnancy, labour and puerperium. But the professional midwife and patient have different views with regard to activities during those periods. Professional midwives and women who have a western cutlural orientation as stated earlier by Klerman

(1994:128) view pregnancy and labour as health problems and Werner (1980:33) explains that they make use of medical intervention; whereas according to Pervan, Bryce and Werner (1989:18) non-western (including African) cultural orientated women view pregnancy and labour differently as a condition involving not only the woman's body but also her mind, her self-image, her dependency on the physical and social world. Most professional maternity practices in the western health care system are based on high technology, science and concentrate mostly on the biomedical and physical aspects of the mother and the baby while the socio-cultural aspects are ignored (Chalmers, 1993:200). As a result the African woman sees the professional midwives as being harsh with a woman in labour and interested only in their procedures of childbirth events and administrative work (Ntoane, 1988:21). Chalmers (1984:13) states that professional midwives tend to make use of books, magazines or pamphlets as sources of information during antenatal care in preparation for labour and confinement. Literate women do not have problems with written materials or materials written in Afrikaans and English; but some traditional African women have problems because of the foreign language (English/Afrikaans) they may not understand the languages and, others cannot even read. They need someone who can explain to them in their cultural codes and popular medical beliefs.

All professional midwives understand that during pregnancy all women need a great deal of advice, reassurance and encouragement. Khoza and Kortenbout (1995:10) found that the professional midwife when giving women advice on diet, emphasises the effect of poor nutrition on the unborn child. She is also concerned about special diets for women who have conditions such as eclampsia, diabetes, hypertension or diets which cause or aggravate anaemia and/or low birth weight. Women who have a western cultural orientation, except for their own unique likes and dislikes, cravings and/or allergies do not have to follow any cultural customs; but traditional African women must obey many restrictions, preferences and dietary taboos. Mokoena (1991:30) and Chalmers (1993:201) state that certain foods are taboos such as eggs, particularly scrambled- or boiled eggs as they are believed to delay labour.

Ntoane (1988:21) also mentions that it is taboo for the traditional African women to eat tendons at this time as it may cause delayed labour. Other foods such as meat and milk may also be taboo because they are believed to cause obstructed labour and/or abortion. Professional health care educated midwives do not cater for these taboos and women with this belief usually go without food or have food brought from home by family and/or friends.

The professional midwife as a supporter and adviser in western health care institutions gives reassurance to pregnant or lactating women to allay their concerns and anxieties. When the midwife realizes that her patient has concerns, anxieties or complications with regard to pregnancy, labour and/or the puerperium, she or he refers her to experts such as an obstetrician or support services such as social welfare and supplementary health service personnel. According to Karlsson and Moloantoa (1986:27) most women who have a western cultural orientation do not have a problem with this kind of referral because they understand the cause of the complications to be physiological and they accept medical interventions such as medication, epidural blocks, induction of labour, Caesarean section, episiotomy, Ventouse and forceps delivery. Traditional African pregnant or lactating women believe that complications are due to a variety of reasons. According to Mbiti (1970:19) these reasons are evil spirits, witchcraft, sorcery, magic and by ancestral spirits provoked by the patient's breaking a social rule. Conco (1972:284) explains that if there are any complications in the traditional African culture the referral system is as follows: if there is no perceived threat labour may be conveniently managed at home by family members, or by members such as traditional birth attendants outside the family. Traditional rituals, traditional birth technology and techniques as well as physical support measures are used such as: massaging the mother's abdomen and when the fetus must be rotated, the foetal head is massaged as it helps to position the unborn baby. Massaging the mother's abdomen during labour may only be done by a traditional birth attendant with warmed oil to encourage contractions (Nyasulu & Mzolo, 1993:13). Ntoane (1988:21) explains further that there are also behavioural

taboos designed to avoid witchcraft and to prevent evil spirits from entering the body because it leads to complications during pregnancy, labour and puerperium. These taboos include refraining from sleeping during daylight in case the baby should follow suit on its delivery day, avoiding becoming angry, as well as avoiding taking a photograph because it may cause misfortune and result in stillbirth (Boyle & Andrews, 1995:106). Because of fear of bewitchment Sotho, Xhosa and Zulu women must avoid certain pathways that may harbour the evil spiritis of wizards, witches or wild animals all of which may harm the baby during pregnancy. According to Lupuwana (1991:14) some traditional African women slaughter goats and some make necklaces, wrist- and ankle bands which they and their babies wear as protective measures. If all these measures fail to help and the threatening situation becomes extreme, help is sought from outside the cultural parameters for instance from western health care institutions or hospitals. But Lupuwana (1991:14) states that in most cases professional midwives in the western health care setting do not know the traditional beliefs and customs of the traditional African women in their care. They become critical when the women talk about childbirth practices.

The professeional midwife must offer women reassurance and encouragement by ensuring that they obtain enough support. According to Poggenpoel (1993b:35) personal and social support are of utmost importance to the well-being of the pregnant mother. According to Abrahams (1992:13) the professional midwifery staff must support the mother and they should not leave her alone when she is in labour. They must also encourage their husbands to give support to their wives during labour and delivery. According to Mokoena (1991:31) the women who have a western cultural orientation are accompanied by their husbands because these women have a nuclear support system consisting of her husband or partner and their most intimate family member for instance the mother or mother-in-law. Although the traditional African support system on the other hand consists mostly of immediate family, extended family, traditional healer and/or traditional birth attendant, the traditional African woman comes to western health institutions or hospitals alone mainly because of the

cultural practice(s) that the place of birth or delivery is a taboo for men, including the father of the baby. According to Setiloane (1988:44) the professional midwife emphasises only the presence of the father of the baby during labour.

The most important role played by the professional midwife is to attend to women in labour. Women react and respond differently to labour pains. According to Karlsson and Moloantoa (1986:27) women whoe have a western cultural orientation use medication prescribed by their medical attendant, whereas traditional African women still use traditional herbal medicines. This is emphasised by Scott-Ramos (1995) in his explanation that traditional African culture sees pain as an important aspect of labour and the belief that the more intense the pain, the stronger the love for the infant will be. Schneider (1985) explains further that the traditional African culture forbids any form of pain relief but encourages the traditional birth attendant to slowly and continually massage the woman's abdomen with warmed oil to encourage contractions and ease pain during labour. According to Troskie (1997:18) traditional African women use garlic to ease abdominal pains. Other traditional medicines still used by traditional African women are the following:

- *isihlambezo*is used as a body cleanser while *inembe* can be used alone or in combination with *isihlambezo* for the same reason (Brindley, 1985:99);

- *imbelekisane* can be taken during pregnancy and will prevent miscarriages and premature labour; and

- *Kgaba or Pitsa* is used after the birth of the baby or she is given *Harmansdrup* or *lewenessens* to help the uterus to contract (Troskie, 1997:18).

Traditional African women take traditional herbal medicines because they know that these medicines will help them. But if the professional midwives give them scientific medicines without their consent they feel dehumanised by the care given by the

professional health care giver as only their bodily responses are considered important and not their humanity (i.e., their perception of pain, illness and treatment). Traditional African women also question the use of western medicines and practices. The health professionals, especially professional nurses (midwives) on the other side, are very sceptical about traditional herbal medicines because of their unclear pharmacological actions. According to Upvall (1992:23) and Veale, Furman and Oliver (1992:185) professional midwives (and nurses) have little knowledge of the effects of traditional herbal medicines used during pregnancy, labour and/or the puerperium by traditional African South African women - hence the nurses do not encourage or administer these medicines. Thus, due to professional nurses' attitudes (Abrahams, 1992:13) women do not feel free to talk about these herbal medicines. In view of these facts it is therefore of the utmost importance for the professional midwife to plan with the woman for any form of pain relief during labour. Professional nurses must not only know why some women refuse pain relief medication, but also know what they must do to relieve pain in its cultural context.

During labour the professional midwife concentrates on diagnosing progress in labour, reinforcement of breathing and relaxation techniques learnt earlier, and the detection of any deviation from the normal as the "how" and "when" to bear down are known by the woman who holds a western cultural orientation obtain medical aid early. For the traditioanl African woman it is important that the midwife should be with her throughout labour and sit next to her, brush her hair, pray with her, joke, sing and even wipe her forehead when the woman sweats (Nyasulu & Mzolo, 1993:13). According to Pekane (1989:16) the traditional birth attendant is the most able person to give this care during labour whereas the professional midwife tends to leave this type of support to the husband or to leave the woman alone. According to Groat (1993:27) it is important that in preparing the traditioanl African woman, orientation rounds prior to the patient's admission to the labour ward, must be held in an attempt to "getting to know" the patient and allowing the patients to meet the professional midwives who will be responsible for their care when in labour. Accor-

ding to Ntoane (1988:21) traditional African women complain of not being prepared for the labour ward and that it is frightening to be confronted by noisy machines in a busy ward and that labour language and western labour procedures are confusing.

The position taken up by women during labour differs from culture to culture. Different positions may be adopted by a woman in labour, i.e. lateral, sitting upright and squatting (De Jong, 1994:5). These positions lessen aortic-caval compression, decrease the level of pain and tension and reduce oxygen tension. De Jong also states that prior to the modern practice of recumbent delivery women, preferred to labour in the upright position, often choosing to squat for the actual delivery. This is especially true of traditional African patients. But in health care institutions the patient is placed in the dorsal lithotomy position whilst there are patients whose culture still requires them to adopt other positions, for instance squatting. The World Health Organisation discourages the practice that all women are positioned in the dorsal lithotomy position during labour and states that each woman must decide for herself which position she would like to adopt during delivery. According to Ntoane (1988:21) professional nurses in hospitals adhere to protocols regarding labour as laid down by the institution's policy and very seldom consider the preferred position of the patient. Rather the likes and dislikes of the medical practitioner dictate the position the woman must take up during labour. During bearing down the professional midwife checks the perineum and if necessary performs an episiotomy. But according to Jacobs (1989:18) traditional African women do not like episiotomy, but prefer the massaging of the perineum with warmed special oil during the bearing down stage as it makes the perineum less liable to tear. This practice can only be performed by the traditional birth attendant (Benn, 1993:12).

After delivery the focal point of care is the placenta. In health care institutions the placenta is checked for completeness, abnormalities and then incinerated. According to Chalmers (1990:13) the placenta in the traditioanl African society is a special organ which is disposed of by selected people, for example the grandmother, to pre-

vent witchcraft and to be used for other traditional activities. With this in mind, the African woman may ask to take the placenta home - a practice, according to Chalmers (1993:203) that is frequently prohibited. Also when delivery of the placenta is delayed a variety of interventions are used in traditional African cultures - for instance the mother is asked to blow into her cupped hands or into a bottle or attempt to vomit while in the western health care institution the placenta will be removed manually or surgically.

The care of the mother and the baby immediately after delivery of the placenta are important for both the midwife and the mother (including her family). Normal stay (that is to stay in the hospital for 24 hours after delivery) in the hospital, is no problem to a mother who holds a western cultural orientation because there are no cultural practices to be performed. According to Barnett (1980:39) the mother in the western health care system, is observed after delivery for any complications, taught postnatal exercises and care of the vulva and the perineum is carried out. These procedures do not create many problems for the women who hold a western cultural orientation although Fourie (1994:31) found out that many hospitals in South Africa are poorly designed and lack privacy (twenty or thirty patients have to share the same ward, communal toilets and bathrooms). In the traditioanl African culture these problems do not occur - women are secluded for plus minus ten days. But the traditional African women may experience problems with staying in the hospital after the delivery as there are cultural practices to be performed during seclusion. Cultural practices like preventing evil spirits from entering the secluded room by fumigating the room with burning herbs. To appease the ancestors certain ceremonies, singing, praying and talking to ancestors are carried out (Setiloane, 1988:44). During this period other women in the family or community (trusted women) take the responsibility of caring for the baby and doing other household activities (Chalmers, 1993:201; Mokoena, 1991:31). Perry (1982:25) further explain that care of the new-born baby varies within and between cultures. Setiloane (1988:44) wrote that herbs have to be burned and the newborn baby has to be exposed to the smoke

as a protective and cleansing ritual which must usually be performed within ten days after birth. Should any complications occur to the mother or the baby in future, it is associated with the non-compliance of these cultural practices or rituals and blame will be put on the western health care system which prohibited these cultural practices. Thus traditional African women may prefer delivery at home because people around the mother and the baby are restricted (only trusted people are allowed) and the traditional birth rituals can be carried out.

According to Lupuwana (1991:13) all professional midwives must be knowledgeable about the traditional beliefs and customs of the community to render cultural congruent nursing care. Jambunathan (1995:336) explains further that an understanding of the practices and beliefs surrounding the postpartum period helps the professional nurse to develop appropriate and effective intervention strategies.

2.6 SUMMARY

Professional western maternity nursing care is not the answer to fulfilling all the health needs of a traditional African pregnant or lactating woman. It is partially satisfying to her because it ensures safety but does not fulfil her socio-cultural needs. This emphasises the fact that all people can understand pregnancy and childbirth practices and complications in terms of their specific cultural orientation. Nursing care outside this orientation are often unacceptable and confusing.

The South African health system for traditional African maternity patients is orientated towards patients with western cultural beliefs may not be completely successful. In view of these facts it becomes clear that the professional nursing education and nursing practice in the maternity section face a big challenge to expand professional nurses' cultural awareness, knowledge and sensitivity across cultures for the adequate nursing care of such patients.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 INTRODUCTION

It has become necessary for South African health care settings to provide cultural congruent nursing care to all population groups with their diverse cultures. In view of the evidence in the literature that cultural congruent nursing care in the maternity section of public hospitals rarely exists and that exclusion of traditional African cultures occurs most of the time, the research problem "*ARE NURSES HAVING KNOWLEDGE OF CULTURAL CONGRUENT NURSING CARE AND DO THEY APPLY THESE PRINCIPLES IN MIDWIFERY CARE THEY RENDER TO MOTHERS AND THEIR BABIES*" is justified.

This chapter will consists of a description of the research methodology (design and method); a description of the course of the research process; a discussion of the validity and reliability of the study; as well as a discussion of the ethical considerations taken into account during the study, and the value of the study will be outlined. The research steps will be discussed separately; but the validity, the reliability, the ethical considerations and the value of the study will be discussed after the steps are discussed.

3.2 THE RESEARCH METHODOLOGY USED IN THE STUDY

3.2.1 THE RESEARCH DESIGN

Based on the purpose of the study and to achieve the objectives of the study, a non-experimental research design of a descriptive and exploratory nature in qualitative paradigm was used. The reason for using this design was that an experimental research design could not be used because cultural congruent nursing is a human phenomenon embedded in the life of every human being regardless of age, religion, creed, status or race. Culture develops over centuries and takes years to change (Phillipsen, 1992:7).

The study is descriptive in nature because the area of research is one to which little attention has been paid over the past years because of the assumption that all people have the same cultural orientation. According to Burns and Grove (1993:766) and Polit and Hungler (1987:147) a research design with a descriptive nature must be used to obtain information regarding real life situations such as human experiences, meanings and perceptions. As cultural congruent nursing care is a real life situation no other design could be used.

The study is also exploratory in nature because cultural congruent nursing care is a relatively new domain in nursing as well as in anthropology and other disciplines. Another reason for the exploratory nature of the study lies in the fact that traditional midwifery cultural practices are very seldom written up as they are usually handed down verbally from one generation to another, and thus have to be explored.

3.2.2 THE RESEARCH PROTOCOLS FOLLOWED

The research protocols followed are in accordance with the descriptive and exploratory nature of the study. The protocol followed consisted of the following steps:

- The delimitation of the research field of study.
- The delimitation of the population of the study and the sampling method used.
- Data collection methods used in the fieldwork.

3.2.2.1 THE DELIMITATION OF THE RESEARCH FIELD OF STUDY

The study took place in two public hospitals in Bloemfontein. Statistically not many black patients are admitted to private hospitals or homes because they are expensive. Public hospitals on the other hand deliver a free maternity service to all pregnant women. The one public hospital in Bloemfontein is a regional hospital which admits all pregnant women with minor complications of pregnancy. Normal deliveries are also conducted in the regional hospital; but these mothers and babies are discharged within eight hours after the delivery. The other public hospital is a specialised academic hospital which admits only patients with serious complications of pregnancy and labour.

3.2.2.2 THE DELIMITATION OF THE POPULATION OF THE STUDY AND THE SAMPLING METHOD USED

The population of the study consisted of nurses and patients. The appropriate documents which had to be audited were included in the study.

3.2.2.2.1 NURSE POPULATION

The nurse population included all nurses (midwives and registered nurses) working in the maternity section of the two public hospitals in Bloemfontein. The following inclusion criteria were used:

- all nurses rendering direct care to pregnant and lactating mothers;
- all nurses working in one of the maternity sections (i.e. antenatal clinic, labour ward, antenatal and postnatal units);
- their race, ethnic group, belief, cultural orientation or their age were not taken into consideration; and
- all registered nurses and midwives who gave voluntary consent to participate in the study.

No nurses working in the high risk, premature and nursery units were included. The reason being that this group of nurses were very busy and did not have time to participate and they refused to participate voluntarily in the study.

The sample method used to select the nurses was non-probability convenient sampling. The convenience sampling proved to be the most appropriate method because all the nurses qualified to be included in the study according to the sampling criteria (Polit & Hungler, 1987:209).

* **Sample Size**

According to the staff records the professional midwives (including professional nurses) allocated over a period of a year from August 1997 to August 1998 (the period of fieldwork) allocated to the maternity sections of both hospitals were as follows:

▪	Antenatal clinic	:	8
▪	Antenatal unit	:	28
▪	Labour ward	:	21
▪	Postnatal unit	:	25
▪	High risk unit	:	12
▪	Premature and nursery units	:	10
	Total		**104**

The total number of nurses in both hospitals in maternity sectiosns was 104 (nurses population). For this study the researcher intended to use all nurses population as sample because of the size (104); but nurses working in the high risk, prenature and nursery units were excluded from sample size. Out of hundred and four (104) sample size included only eighty two (82).

3.2.2.2.2 PATIENT POPULATION

The patient population included all black pregnant and lactating mothers admitted in the antenatal and postnatal units of two public hospitals in Bloemfontein for longer than three days. This was to ensure that they could share their experiences of the care they received while in hospital.

The inclusion criterium of the patient subjects were as follows:

- All black pregnant or lactating mothers admitted either in the antenatal unit and/or postnatal unit.

Their ages, ethnic group or number of pregnancies were not inclusion criterium Sick patients were excluded because interviewing them could make them uncomfortable and could aggravate their condition. Also those who did not wish to participate were also excluded.

* **Sample Method**

The sample method used to select the patients was non-probability convenient sampling. The convenience sampling proved to be the most appropriate method because all the patients qualified to be included in the study according to the sampling criteria (Polit & Hungler, 1987:209).

* **Sample Size**

The patient population from the greater Bloemfontein admitted for two to three days or longer to the maternity sections of both hospitals over a period of one year from August 1997 to August 1998 was 436 out of 816 patients admitted. Therefore the sample consisted of 436 patients. This was 54% of the total number of admitted patients.

3.2.2.2.3 THE DOCUMENTS FOR AUDITING

All the hospital and ward policies regarding nursing care and all nursing care documents of the selected patients were audited for the following reasons:

- policies (hospital and ward) govern and guide the nursing care rendered including cultural congruent nursing care; and

- nursing care documents are records of the nursing care rendered including cultural congruent nursing care during the assessment, diagnostic, and planning implementation and phases.

All management policies were included; but only the nursing care documents of the selected patients were included in the study. These were included to confirm what the nurses and patients said during data collection.

3.2.2.3 DATA COLLECTION METHODS USED IN THE FIELD-WORK

3.2.2.3.1 THE PERMISSION TO ENTER THE FIELD

According to Treece and Treece (1986:126) ethical dilemmas such as taking advantage of the respondents must be avoided. To abide by this ethical code permission to carry out the study in the two public hospitals was obtained from the Provincial Administration of the Free State (Department of Hospital Services) (See Addendum, A, B and C).

The approval of the nurse managers of the two hospitals and maternity sections was also obtained.
The voluntary consent of all respondents were obtained (see Addendum D and E).
The Ethical Committee of the faculty of Health Sciences of the University of the Orange Free State also consented to the research (see Addendum F).

3.2.2.3.2 COLLECTION OF THE DATA

Bailey (1987:106) describes different techniques that can be used in a non-experimental design with a descriptive and exploratory nature. In this study the following techniques were used:

- a structured questionnaire;
- a structured interview; and
- an audit by a checklist

These techniques were used for the following reasons:

The questionnaire was used to assess the midwives' knowledge of cultural congruent nursing care.

The structured interview was used to verify the cultural nursing care that was rendered by midwives patients. The documents were audited to confirm what the nurses' and patients' statements correlated with what was endorsed in the policies and recorded in the nursing care documents.

- **Questionnaire** (See Addendum G)

A questionnaire was used because it is less time-consuming than interviews. According to Wilson (1989:436) questionnaires can be used to obtain data regarding respondents' experiences, feelings, relations and perceptions. A questionnaire can also be used to reach a large number of respondents within a short space of time.

The questionnaire was compiled according to the literature. Open-ended as well as closed-ended questions were included. The open-ended questions were included to give the nurses a chance to express their knowledge and experience of cultural congruent nursing. The questionnaire consisted of the following four (4) sections:

Section A: Contained questions regarding personal employment data and the way of communicating with patients.

Section B: The main focus of these questions was to obtain data regarding the specific respondent's nursing educational background regarding cultural congruent nursing care.

Section C: The closed- and open-ended questions focused mainly on the nursing care rendered by midwives and nurses to pregnant women and their families during antenatal, intra natal and postnatal periods to establish whether cultural congruent midwifery care was rendered.

Section D: The questions focused on the nurses' perception of cultural congruent nursing care and how they render and record it.

The validity and reliability of the questionnaire were proved by a pilot study. Eight (8) nurses who were not working in the maternity sections of the hospitals but who worked in the antenatal clinic or unit, in the region were asked to complete the questionnaire. Only two respondents did not complete the questionnaire because they did not understand all the questions. The problematic questions were then reviewed and rephrased. All problematic instructions were identified and rephrased.

The process was repeated until all problems were cleared up. The results of the pilot study corresponded with studies by Van Ort (1981:48) that "*pilot study can be conducted to refine the methodology*" and Prescott and Soeken (1989:61) who found that "*pilot study could be conducted to develop and refine the steps in the research process.*"

Although the questionnaire was designed in English, respondents could answer the questions in Afrikaans.

* **Data Collection Process**

The questionnaires were distributed to midwives after permission was granted by the nurse manager of the section where study was carried out. The nurses were requested in the letter that accompanied the questionnaires to complete questions according to instructions. They had to complete all questions and incomplete questionnaires were regarded as invalid. Nurses could complete the questionnaire in their own time, as it was left with them and collected after seven days.

Sixty-one midwives out of sample size of eighty-two midwives participated. Eleven questionnaires were disqualified as they were not correctly and fully completed.

- **Structured Interview Using a Questionnaire** (See Addendum H)

Patients were interviewed using a structured questionnaire. The reason for using a structured questionnaire in a structured interview was to ensure that the same questions were asked of all respondents (whether literate or illiterate). The questionnaire consisted of both closed- and open-ended questions. The open-ended questions were included to determine the patients' experiences of maternity nursing care given by midwives with special emphasis on cultural congruent care. According to Bailey (1987:174) open-ended questions may be used when obtaining first hand (life experience) information from respondents. Open-ended questions also lend themselves to following up a response or reflecting the response back to the respondent to clarify misunderstanding (whether of the question or of the answer).

The questionnaire was compiled according to the literature. It consisted of three (3) sections:

- In Section A: Questions regarding personal data and the way of communicating with nurses were asked.

- In Section B: Closed- and open-ended questions focused on how the pregnant woman viewed childbirth and how she experienced the nursing care given during the antenatal, intra natal and postnatal periods.

- In Section C: The questions focused mainly on how the pregnant woman experienced the nursing care she received during the period of hospitalization and whether cultural congruent nursing care was rendered.

* **The validity and reliability of the structured interview**

A pilot study was carried out to check the validity and reliability of the structured interview. Interviews were conducted with 16 patients (8 pregnant and 8 lactating mothers) who were not included in the study. Some of the questions were too sensitive for some of the respondents and they became uncomfortable when answering them (they said it was a taboo to talk about them to strangers). The questions were not excluded from the final questionnaire as the researcher was sensitized to this reaction and could handle these questions with tact and sensitivity when conducting the final interviews. Because of this phenomenon the time allocated to the structured interview had to be reviewed. No restrictions were coupled to the interview time as the researcher had to make the respondent comfortable and let her feel at ease before starting with the actual interview.

* **The Data Collection Process**

The structured interview was conducted with only those patients who gave voluntary permission and who were hospitalised for 2-3 days and more. The researcher discussed with the nurse manager of the sections in the maternity wards (antenatal and postnatal units) the most suitable time to conduct interviews with the respondents.

The interview was initiated by creating a friendly and pleasant atmosphere to ensure that the respondent was comfortable. The researcher tried to maintain this atmosphere throughout the interview. The interviews were always conducted in privacy after introductions were made, the purpose of the interview, as well as the importance of the research study was explained. All these were done to gain the respondents' confidence and clear up uncertainties.

The respondents were then asked for consent before continuing with the interviews. It was also explained to the respondents that even if they gave permission they

could withdraw at any time if they felt uncomfortable, threatened or unable to continue with the interview. The respondents were assured of the strictest confidentiality of the data collected. This helped to encourage them to be frank and honest.

The respondents were reassured that the interview would not last longer than 20-30 minutes, but more time could be spent with them if necessary. All questions were asked in their order in the questionnaire - this was done to ensure that no question was omitted. All responses were noted immediately after being given during the interview. At the end of the interview the respondents were thanked for their participation.

Out of a sample of 436 patients who qualified only 328 patients were interviewed. The other 108 patients were not interviewed for the following reasons:

* sixty-four (64) were not willing to participate;
* forty (40) were too sick to participate; and
* four (4) withdrew during the interview and were not included in the data reduction process.

- **The auditing of documents using a checklist** (See Addendum 3)

The policies were audited to ascertain whether they endorsed cultural practices while the nursing care documents were audited to ascertain whether cultural congruent nursing was incorporated into the care rendered to pregnant women and their families and entered in the nursing care records.

A structured checklist was used for the auditing. The checklist consisted of two sections: All the items regarding cultural practices endorsed by the management policy documents were included in Section A. Section B included all those items which

assessed whether cultural congruent practices were incorporated in the nursing care plans and recorded in the nursing care records.

* **The validity and reliability of the auditing process**

All the data in the nursing care documents were written in black ink and signed. The instrument was checked for validity and reliability by auditing the nursing care records of the 16 patients interviewed for the pilot study. A pilot study was also done on the hospital and maternity section management policy document of one public hospital (the district hospital) and one private hospital as these types of hospitals are used for maternity care by all races. Very few items had to be altered to collect the relevant information.

* **Data collection**

The checklist was compiled according to the literature and used to collect data by auditing the appropriate documents.
Permission was granted by the nurse managers of the two hospitals to audit the documents. Items in the checklist were checked to ensure that none were omitted. All documents were endorsed. All the patients' records that were included in the study were audited to ascertain whether the cultural midwifery care practice were recorded.

3.3 THE VALIDITY AND RELIABILITY OF THE WHOLE STUDY

Denzin (1978) in Polit and Hungler (1991:383) recommends triangulation as a strategy to ensure the validity and reliability of a research project. Triangulation is used

to sort "true" information out from "error" information. Kimchi, Polivka and Stevenson (1991:364) confirm that triangulation is a reliable method to be used to show the validity and reliability of the study:

Data triangulation uses multiple data sources with similar foci to obtain diverse views about a topic for the purpose of validation. There are different types to be used, that is time, space and person triangulation.

For this study space triangulation was used. Data was collected from midwives and pregnant/lactating women from maternity sections of regional and academic hospitals.

Methods triangulation is defined as the use of two or more research methods in one study and may occur at the level of design or data collection.

For this study data collection used different research techniques; namely a questionnaire to be completed by nurses (midwives), a structured interview conducted with patients and auditing of different types of documents.

Investigator triangulation is defined as the use of two or more research trained investigator with divergent backgrounds explore the same phenomenon.

For this study the data collection was done by researcher herself but analysis was done with assistance of research leader (supervisor) and principal coder as they are experienced in their subject matters and capacity.

3.4 DATA ANALYSIS

Data analysis is the organisation of the data to answer the research problems and make it known to other people (Wilson, 1989:455). In this case data analysis had three objectives, namely:

- to identify components of the subjects biographical data;
- to analyse the content of the questionnaire and the structured interview; and
- the analysis in order to:
  - to identify the nurses' knowledge of cultural congruent nursing care and how they render it (including recording);
  - to identify the patients' experiences of cultural congruent nursing care; and
  - to identify whether cultural congruent nursing care is recorded in nursing care documents and whether management policies endorse this type of care.

To attain these goals the following steps in line with the data analysis process were taken (Wilson, 1989:455):

- The literature was reviewed for discussion of "culture" and "cultural congruent nursing care" and the data collection instruments were based on this review.
- A questionnaire was given to respondents (nurses) to complete.
- A questionnaire was completed by the researcher during the structured interview with patients.
- The researcher audited documents by means of a checklist.
- The necessary duplicates were made.
- Files were made for the following:

- Pilot study
- Questionnaires and checklists
- Compiled notes
- Methodology files regarding the fieldwork techniques which were used.

The data analysis was only presented in values given in percentages because no connection between data were drawn. Reasons why inferential data analysis were not done are:

(i) the sample size was not equally distributed throughout different groups: that is nurses and patients.

(ii) the total respondents in more than one category were too small to give statistical meanings.

(iii) the descriptive type of the study together with open-ended technique used did not draw any connection and correlation between the data.

3.5 ETHICAL ACCOUNTABILITY ADHERED TO

The ethics of research have been debated over the years because of the complexity of human justice and the abstract nature of some studies. Honesty and integrity are the most important characteristics of the researcher according to Burns and Grove (1997:89). The protection of respondents' rights is equally important.

3.5.1 ETHICAL PRINCIPLES

To comply with the research principles as stated by the South African Nursing Association the following steps were taken:

TABLE 3.1 : RESEARCH ETHICS

ETHICAL RULE	APPLICATION
Planning	The researcher planned thoroughly as described in the methodology (see Chapter 3)
Implementation	The researcher compiled a usable report at the end of the study by use of guidelines
Integrity	The researcher took into consideration all ethical aspects according to Burns and Grove (1997:94) and approached the study with integrity
Honesty	All aspects promised to respondents were fulfilled, e.g., confidentiality and data-analysis was done with honesty
All Findings	All findings were used in the research (see Chapter 4)
All participants must be acknowledged	All participants were acknowledged after consenting to participate
Research leaders must be experienced	The supervisor, co-supervisor and principal coder are experienced in their subject matter and are people with integrity

3.5.2 CONFIDENTIALITY, PRIVACY AND ANONYMITY

The protection of the respondents' rights is of great importance. Burns and Grove (1997:98) explain that the individual's right to privacy is expressed by way of time, general circumstances as well as to a greater extent by providing or withholding in-

formation. The privacy of the two groups (nurses and patients) was respected by giving the nurses a questionnaire to complete individually in their own time and the patients were interviewed individually. The respondents were assured of anonymity and confidentiality. Nurses were not asked to give their identity and information given in the questionnaire was not discussed with others without their permission. The patients were not asked to identify themselves either. They were also assured that information they gave would not be discussed with nursing personnel except as part of a complete report. The research report would not contain any names.

3.5.3 INFORMED CONSENT

Burns and Grove (1997:104) clearly state that informed consent is of the utmost importance to prevent deception. That is why written permission was obtained after the participants were given complete information regarding the study that is, the purpose of the study methods to obtain the information and how the information would be used. The questionnaires were provided with a covering letter explaining instructions, assuring the participants of their anonymity as well as that they were participating voluntarily. The patients who were interviewed were also assured of anonymity and that their participation was voluntary. The background, reasons and purpose of the study were explained to all participants.

3.5.4 ASSISTANCE GIVEN BY OTHERS TO THE RESEARCH

The supervisor and encoder were informed beforehand with regard to the following:

- that they would be expected to be involved in the research according to their professional capacity and they would be liable for their actions and the role they played;
- the research protocol;

- that the participants' anonymity and privacy was to be respected at all times; and
- that everyone would be expected to give input.

3.6 PROBLEMS ENCOUNTERED DURING THE RESEARCH

The following problems were encountered:

3.6.1 NURSING RESPONDENTS

- Some nurses took the questionnaire and when the researcher came to collect them, they asked for new ones and said they did not know what had happened to the ones they were previously given.

- Some nurses did not fully complete the questionnaires.

- Some nurses wrote comments on the questionnaire such as:

  - "I am not working in the labour ward, I cannot answer some of the questions."
  - "This looks more appropriate for antenatal unit."
  - "This will be more appropriate for nurses working in rural areas."
  - "Ek verstaan niks van swart mense se kultuur en rituele en ek kan nie die vraelys invul nie.

3.6.2 PATIENT RESPONDENTS

During the structured interview the following problems were encountered:

- The researcher had to wait until after the nurses had carried out their nursing care duties and if a patient had visitors the researcher had to wait until they left.

- Some patients started to cry during the interview, especially those who did not have a support system such as family or relatives.

- Some patients wanted the researcher to stay with them after the interview and converse in general.

- Some patients were reluctant to talk about their cultural needs and some commented that not all nurses believe that patients' cultural needs are important or beneficial.

3.7 THE VALUE OF THE STUDY

The value of the study lies in the fact that it is not only applicable in the maternity section of hospitals, but in all disciplines of nursing whether general, maternity, community health or psychiatric nursing, because cultural congruent nursing care is part and parcel of health care. The same principles that underlie cultural congruent nursing care are also applicable to health care in its many disciplines.

3.8 SUMMARY

A non-experimental research design with a descriptive and exploratory nature was used to investigate the research problem. Different research techniques were used to collect the data. The steps of the research process were followed and the validity and reliability of the research techniques used and of the study as a whole were ensured. The data analysis will be discussed in Chapter 4.

CHAPTER FOUR

EXPOSITION OF THE DATA COLLECTED

4.1 INTRODUCTION

The aim of data analysis is to condense and organise the data for interpretation. Data analysis consists of three activities; namely the reduction, categorizing and the interpretation of the data. The data was analysed according to the theoretical basis and the results were described in the form of descriptive statistical value at the nominal level. This ensures that the data is presented logically (Treece & Treece, 1986:50).

4.2 THE REDUCTION OF THE DATA

According to Marshall and Rossman (1995:143) there is not enough reliable and validated information available for the analysis of qualitative data (that is, answers to open-ended questions in the questionnaire and interviews). The reliability and validity of the study can be increased if a detailed description of the analysis process is given. Because descriptive data is sometimes vague, unstructured, comprehensive and repetitive, the results of qualitative data can and should be converted to quantitative statistical categorization. The data can now be presented in a logical and simple way.

The qualitative data obtained from the answers to the open-ended questions in both the questionnaire and structured interview, was analysed according to the method described by Tesch (in Crewswell, 1994:145-155). A domain expert acted as the principal analyser and encoder. Both the domain expert and the researcher analysed the content of the answers to the open-ended questions separately thus assuring and increasing the reliability and validity of the study.

The following steps were adhered to during the categorization process:

- To form an idea of the completeness of the data the researcher first carefully worked through all open-ended questions in the questionnaire and structured interview.

- Thereafter the principal analyst and co-encoder (working separately) categorized the data by placing the inferences to the words, the statements and phrases which were used in the content, under categories.

- The coding system was then accepted.

- The responses to the open-ended questions were taken to the concerned groups (midwives and patients) to confirm whether they really were their responses. This control session lasted about two weeks.

- After categorizing, the final framework was drawn and all data was analysed according to this perspective.

The data obtained from the closed-ended questions in the questionnaire and structured interview was categorized as follows:

- **The questionnaire completed by nurse respondents:**

Section A : Biographical data

- The work history of respondents.
- Duration of service in maternity section.
- Languages spoken by nurses.
- Using the services of an interpreter.

Section B : Professional and nursing practice data

- Basic midwifery education received.
- Knowledge of cultural congruent nursing care practices in the maternity wards.
- In-service education received with regard to cultural midwifery practice.
- Assessment of the patient's nursing care needs.
- Inclusion of traditional health practices in the nursing care rendered.
- Evaluation of nursing care to ensure that traditional/cultural practices are included.

Section C : Nursing care rendered during pregnancy, labour and post-partum periods

(Midwifery practices)

- The mother's view of child-bearing according to the midwife.
- The nurses' knowledge of the cultural health practices based on the information gathered during the initial and subsequent interview(s) with the patient to plan nursing care.
- Health education given to prepare patient and her family for pregnancy, childbirth and child-bearing events.

Section D : Evaluation of nursing care rendered by midwives

- Is nursing care evaluated or not.
- Whom do nurses regard as a resource person with regard to cultural health practices.
- Patient involvement in decision-making.
- Inclusion of traditional birth attendant as a multi-disciplinary team member.
- The midwives' experiences of caring across the cultural line.
- Further information wanted with regard to cultural congruent nursing care.

- **The structured interview conducted with patients (child-bearing women)**

In the structured interview the closed-ended questions focuses on the following items:

Section A : Biographical data of respondent

- The age of the patient.
- The patient's ethnocentricity.
- The language spoken.
- Using the services of an interpreter.

Section B : Meeting the cultural needs of the patient

- The respondents' view of child-bearing
- Meeting the patient's cultural health needs based on the information the patient's gave during their initial and subsequent assessment interview(s) by nurses for the nursing care plan, as viewed by respondents.
- Health education given to prepare patients for childbirth events including normal and abnormal deliveries.

Section C : Patient's own experience(s) of the nursing care rendered

- Patient involvement.
- Consultation of the traditional birth attendant.
- Patient's experiences of being cared for by nurses of other cultural orientations.

- **Documents were audited as follows by using a checklist**

Section A of the checklist focused on the policies of the hospital and ward and included the following items:

- The endorsement of cultural health practices by hospital policy.
- Communication to personnel of the childbirth practices in the policy documents.
- The inclusion of cultural health practices in the maternity nursing care policy document regarding:
  * Language
  * Using the services of the interpreter
  * Preferred support person/s
  * Traditional taboos/restrictions
  * Herbalism
  * Traditional midwifery practices
- Involvement of patients, family and other community members.
- Revision of policy documents.

Section B of the checklist focused on the written nursing care documents of the patients included in the study regarding:

- The patient's cultural health needs as stated by the patient herself and recorded in the nursing care documents.

- Patient's preferred language.
- Using the services of the interpreter.
- Patient's preferred person.
- Traditional taboos/restrictions
  * Dietary
  * Behavioural
- Wearing protective bands
- Herbalism
- Patient's preferred method of pain intervention.
- Patient's preferred position during labour.
- Patient's preferred manner of disposing of the placenta.
- Mother's and baby's cultural practices after delivery.
- Consultation of traditional birth attendant during hospitalization.
- Is the evaluation of nursing care rendered entered in the nursing care documents.

4.3 THE EXPOSITION OF DATA COLLECTED DURING THE STUDY

4.3.1 THE EXPOSITION OF DATA COLLECTED BY CHECKLIST

The data collected by auditing the documents consisted of policy document data (Section A) and the data of the recorded items in the nursing care documents (Section B).

The results of the data obtained from the policies (Section A) were as follows (the different items in the checklist will be discussed separately):

- **Endorsement of cultural health practices in policy documents**

- The hospital policy did not endorse any cultural health practices.

- The maternity ward policy did endorse some cultural practices such as:
  * patient's preferred language
  * patient's preferred support person(s).

  Other practices, such as using the services of the interpreter, traditional taboos, herbalism, traditional midwifery practices (cultural rituals or health practices) and consulting traditional birth attendants, were not included.

- Communication of childbirth topics in the policy documents to personnel:
  * the childbirth topics in the policy documents were not communicated to nursing staff by means of ward meetings, in-service training and professional meetings; but informal discussions took place between nursing staff when problems with regard to cultural nursing care occurred.

- Involvement of patients, family and other community members:
  * the maternity section policy did not accommodate the patient, family and other community members in decision-making regarding the nursing care of the patients.

- Revision of policy documents:
  * most of the hospital policy manuals were reviewed when necessary or by request and none were reviewed annually;
  * some of the ward policy manuals were reviewed annually while others were not reviewed at all.

- **Recording of cultural congruent nursing care that were rendered**

- Recording of the patients' cultural needs during the different phases of the nursing process.

  * Only patient's preferred language and preferred support person(s) were recorded.

  * The preferred support person(s) recorded were: husband, mother, mother-in-law, sister, sister-in-law, cousin, aunt, neighbour, friend, brother, father and uncle.

- No written record of the following was made in the nursing care records:
  * use of the services of the interpreter;
  * patient's preferred method of pain intervention.

- The preferred position was not recorded; only the adopted position was recorded and the adopted position for all deliveries was supine.

- The preferred manner of disposing of the placenta was not recorded; the only data mentioned was disposing of the placenta according to hospital policy; that is, checking it for completeness and incineration.

- No record was made of cultural health practices after delivery for the mother and her baby during hospitalization.

- There was no record of traditional birth attendant consultation or the need for one.

- No quality assurance care programs existed in the wards to verify the quality of care given.

4.3.2 THE EXPOSITION OF DATA COLLECTED BY THE QUESTIONNAIRE COMPLETED BY MIDWIVES

The results of the above stated data will be discussed under the following headings:

* Biographical data (Section A)
* Professional and nursing practice data (Section B)
* Midwifery cultural practice data (Section C)
* Evaluation of cultural congruent nursing care data (Section D)

4.3.2.1 THE RESULTS OF THE BIOGRAPHICAL DATA OBTAINED (SECTION A)

The following biographical data was obtained: work history, duration of service in maternity section, languages spoken by midwives and using the services of an interpreter.

- **The work history of the midwife respondents**

The midwives work history involved allocation to the following sections: antenatal clinic, antenatal unit, labour ward and postnatal unit as shown in Figure 4.1 (on page 68).

From Figure 4.1 it is evident that registered midwives were not generally allocated to antenatal clinics.

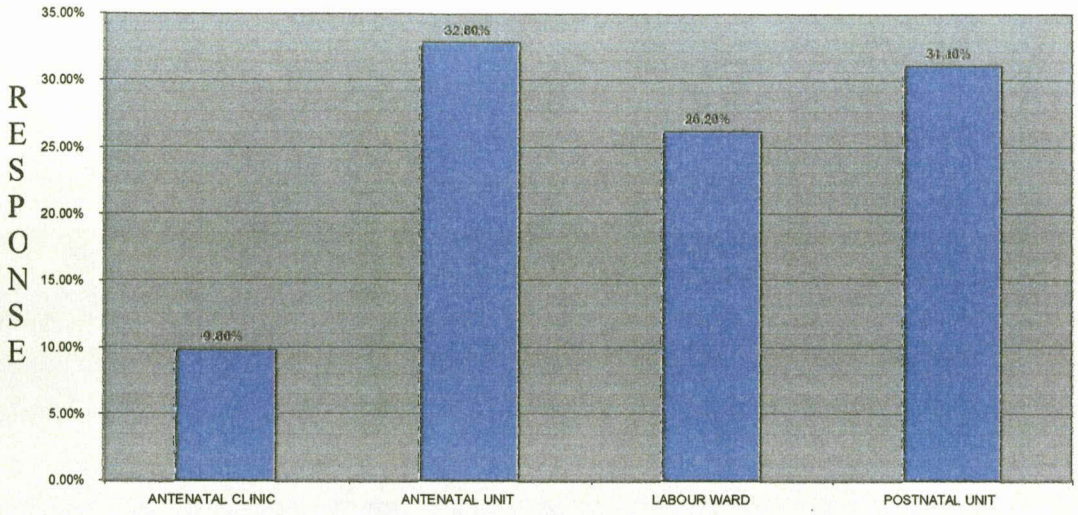

FIGURE 4.1 : WORK HISTORY OF THE MIDWIVES (N = 61)

- **Length of time worked by midwives in the maternity section**

The number of years worked by midwives in the maternity sections as set out in Figure 4.2.

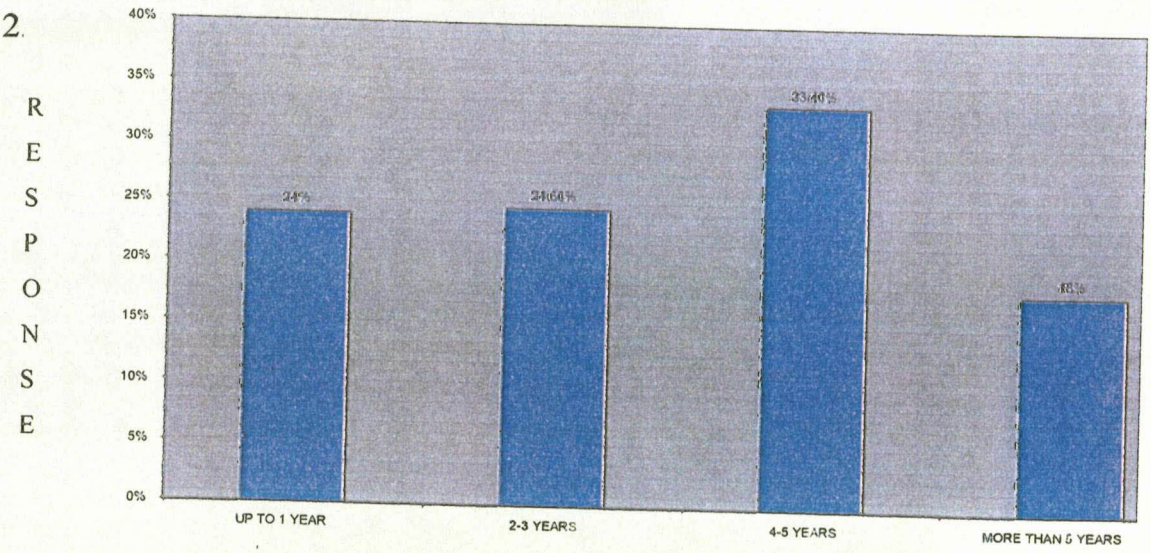

FIGURE 4.2 : NUMBER OF YEARS WORKED

Figure 4.2 shows that 76% of midwives had worked in the maternity section for more than two years.

- **Language(s) spoken by midwives to communicate with their patients.**

The language(s) spoken by midwives to communicate with their patients is shown in Figure 4.3.

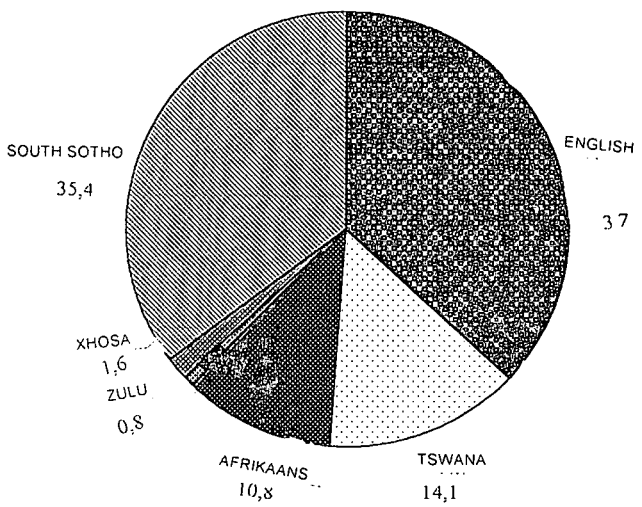

FIGURE 4.3 : LANGUAGES SPOKEN BY MIDWIVES

The results in Figure 4.3 show that midwives communicated mostly in English (37%) while they also spoke South Sotho (35,4%), Tswana (14,1%), Afrikaans (10,8%) and very few in Xhosa (1,6%), Zulu (0,8%) and North Sotho (0,3%).

- **Using the services of an interpreter**

Midwives used the services of an interpreter when they did not know or understand the patient's language.

According to the questionnaire, 54,1% of the midwives used an interpreter when necessary, 44,3% of the midwives did not use the services of the interpreter because they were able to speak the patient's language and 1,6% of the midwives found it unnecessary to use an interpreter.

4.3.2.2 SECTION B: TRAINING AND PRACTICE.

As this section contains several subsections, each one will be discussed separately.

- **Basic midwifery education**

The basic education in nursing must prepare midwives to render cultural congruent nursing care. Figure 4.4 shows how nurses perceive their basis education regarding cultural congruent nursing care.

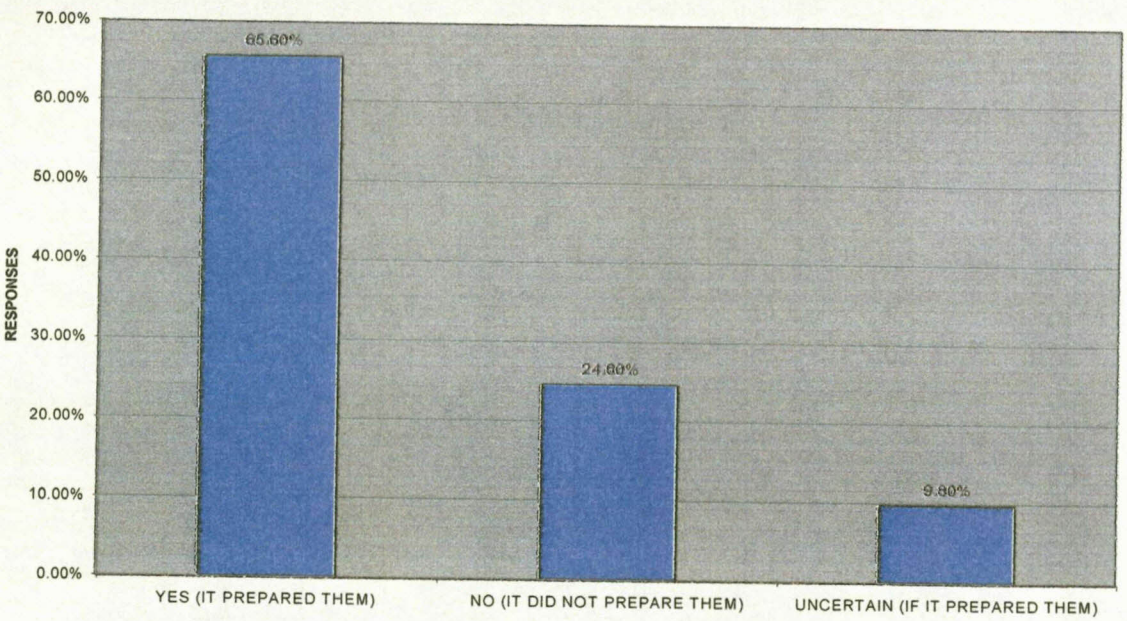

FIGURE 4.4 : BASIC MIDWIFERY EDUCATION WITH REGARD TO CULTURAL CONGRUENT CARE

According to Figure 4.4, 65,6% of midwives felt that they were adequately educated regarding cultural congruent nursing which prepared them to care for patients from different cultural backgrounds/orientations.

- **Cultural congruent nursing care as practised in the maternity wards.**

Implicit to the nursing process is the fact that the patients' cultural health practices must be assessed when planning nursing care. Figure 4.5 sets out the view of midwives regarding this as practice in the maternity section.

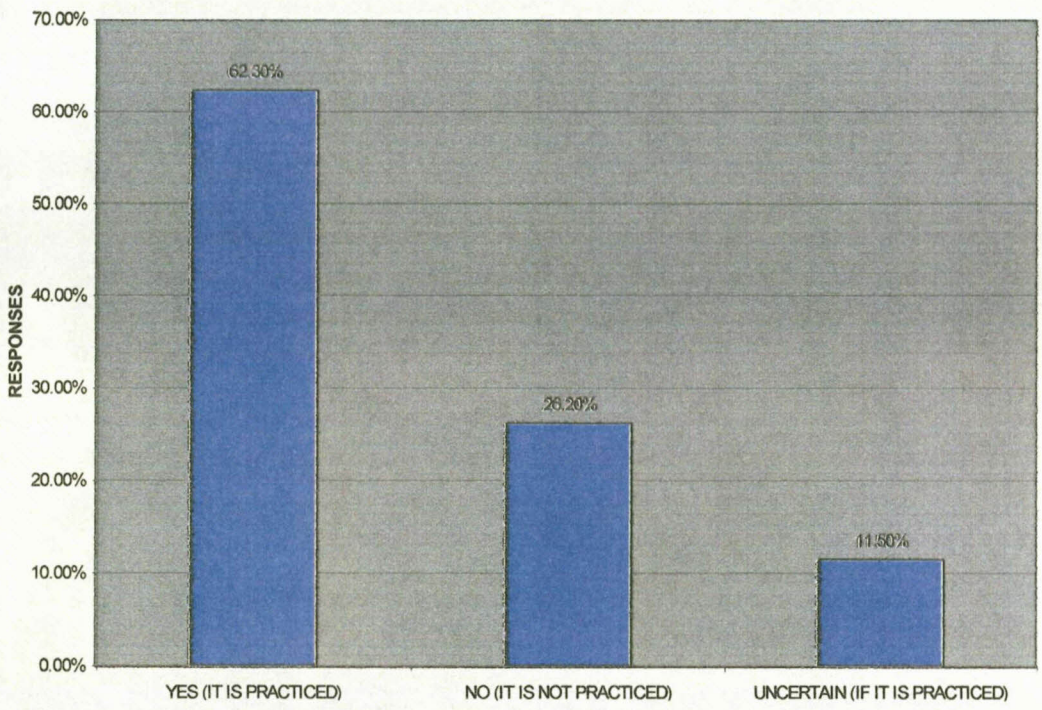

FIGURE 4.5 : THE VIEW OF MIDWIVES REGARDING THE PRACTISING OF CULTURAL CONGRUENT NURSING CARE

According to Figure 4.5, 62,3% of midwives said they included cultural congruent nursing care when using the nursing process to assess a patient's needs and plan nursing care.

- **In-service training received by midwives**

In-service training helps midwives to keep up with standards of nursing care. Figure 4.6 shows whether the midwives received in-service education with regard to cultural congruent nursing care.

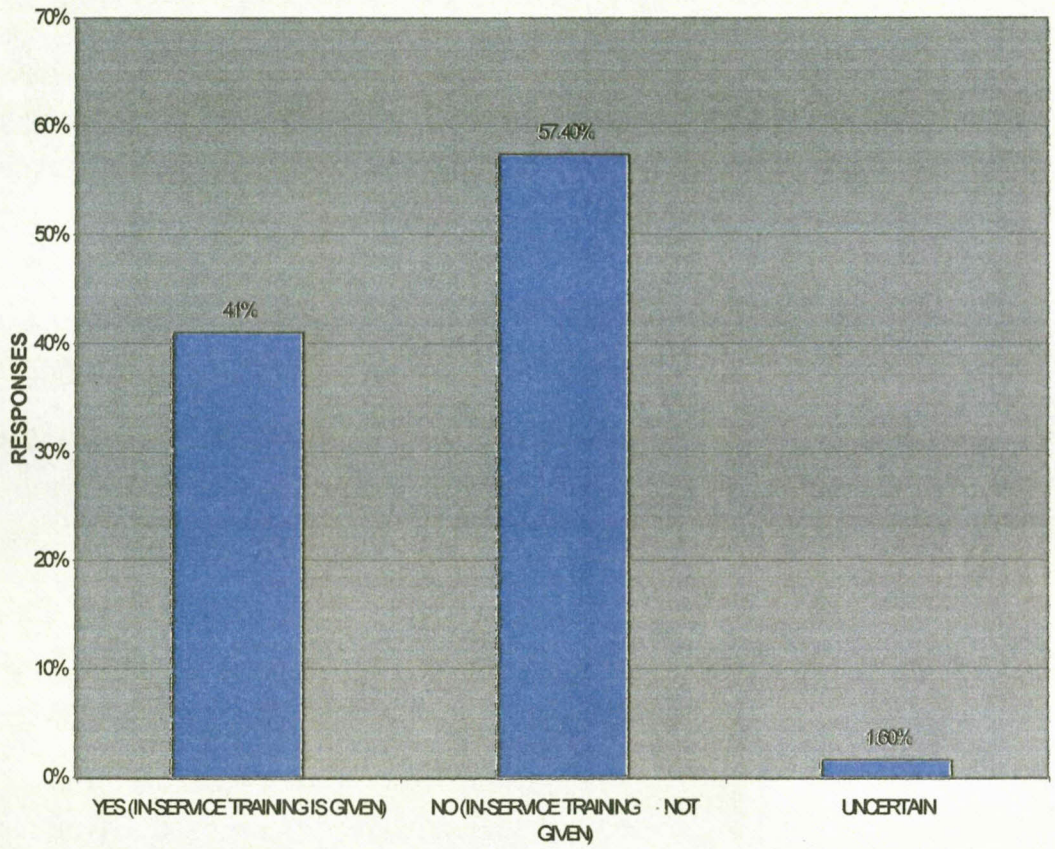

FIGURE 4.6 : IN-SERVICE TRAINING RECEIVED BY MIDWIVES

Figure 4.6 shows that 59% of midwives stated that they had not received any in-service training with regard to cultural congruent nursing care.

- **Assessment of the patient's cultural nursing care needs**

To render quality nursing care to patients it is necessary to assess and plan for their cultural health needs. Figure 4.7 shows whether or not midwives assessed the cultural nursing care needs of their patients.

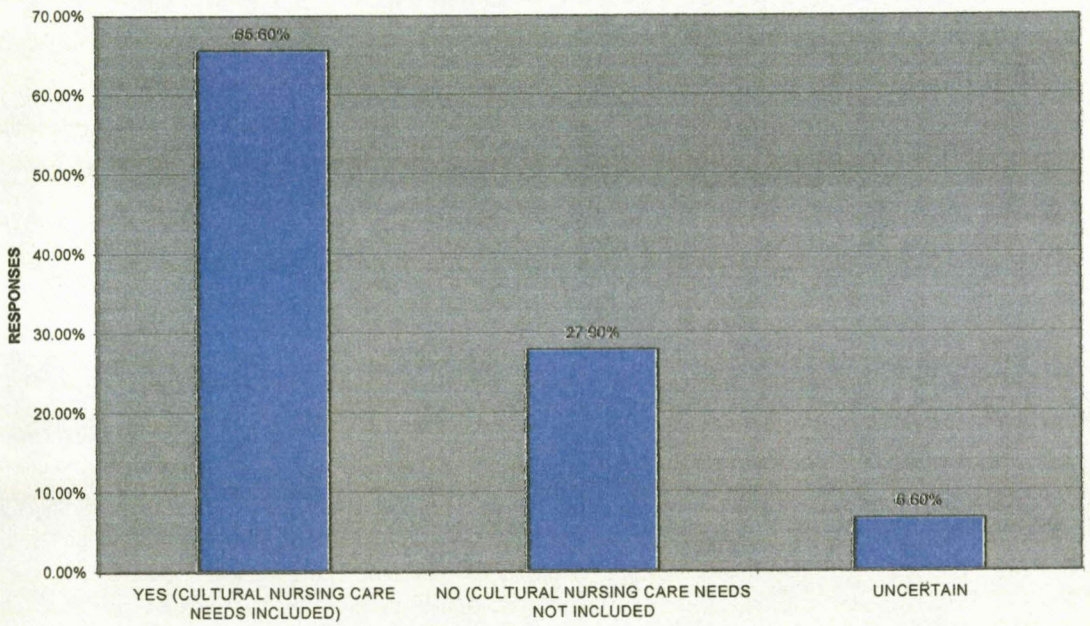

FIGURE 4.7 : ASSESSMENT OF CULTURAL NURSING CARE NEEDS

From Figure 4.7 it is evident that 65,6% of midwives said that they included cultural nursing care needs in the assessment phase of the nursing process.

- **Inclusion of traditional health practices in nursing care**

To render quality nursing care traditional health practices must be included especially during pregnancy, childbirth and child-rearing. According to the survey 63,9% of midwives did not incorporate traditional health practices and 14,8% of them were uncertain if these practices were incorporated.

- **Evaluation of the care rendered**

Nursing care must be evaluated to ensure that all the needs of the patients have been met and if not what the reasons are. This evaluation is of the utmost importance to ascertain whether the cultural health needs of the patient have been met because most assessment forms do not include these needs.

The following information was obtained:

- Cultural congruent nursing was evaluated by 36,1% of midwives.
- Cultural congruent nursing was not evaluated by 47.5% of midwives.
- Sixteen point four percent of midwives were uncertain whether they evaluated cultural congruency.

In the light of the above, it can be stated that 63,9% of midwives do not evaluate nursing care to ascertain whether or not the cultural health care needs of the patient were met.

4.3.2.3 SECTION C - THE DATA REGARDING NURSING CARE RENDERED DURING PREGNANCY, LABOUR AND THE POSTPARTUM PERIOD

This section consists of the midwives view of child-bearing, their assessment of the patients' needs (as well as the inclusion of cultural health practices in the planned nursing care) and health education given to patients to prepare them for pregnancy, childbirth and child-rearing.

- **The mothers' view of child-bearing according to midwives**

According to the midwives, the mothers held the following views regarding child-birth.

TABLE 4.1 : VIEW OF CHILD-BEARING

MOTHERS' VIEWS AS PERCEIVED BY MIDWIVES	PERCENTAGE
Normal physiological event	27,5
A wellness experience	9
A time of vulnerability	19,5
A time of risk	21
A state of illness	23

The results set out in Table 4.1 show that 36% of midwives preceived the mother's view of child-bearing to be a normal and wellness event while 63,5% perceived it to be a time of vulnerability, a risky event or a state of illness.

- **The midwives view of the perceived needs of the patients**

According to the midwives, the mothers prefer the following persons as support person as set out in Table 4.2 (on page 76).

Table 4.2 shows that 60.7% of midwives stated that most patients preferred their mothers as a support person, while 0,3% mentioned children as support persons.

TABLE 4.2 : THE VIEW OF MIDWIVES WITH REGARD TO THE PATIENTS' PREFERRED SUPPORT PERSON(S)

THE VIEW OF MIDWIVES REGARDING THE PATIENTS' PREFERRED SUPPORT PERSON(S)	PERCENTAGE
Husbands	27,9
Mothers	60,7
Mothers-in-law	3,3
Traditional birth attendants	1,6
Others : (not specified)	6,5
Sisters	3
Nurses	2,6
Sisters-in-law	0,3
Doctors	0,3
Children	0,3

- **Midwives' view of traditional taboos/restrictions**

Traditional taboos/restrictions are practices to be honoured or avoided in order to prevent negative consequences or complications of pregnancy and childbirth. Pregnant women wear protective bands to prevent evil spirits from entering their bodies or harming them, and to prevent complications of labour. Table 4.3, 4.4 and 4.5 (on page 77) shows the midwives are aware of traditional taboos or restrictions honoured by patients during the antenatal, intranatal and postnatal periods.

TABLE 4.3 MIDWIVES VIEWS OF DIETARY TABOOS

MIDWIVES VIEW OF DIETARY TABOOS	PERCENTAGE
Avoid eating whilst standing	30
Avoid drinking whilst standing	29
Avoid eating uncrushed/boiled eggs	30
Avoid eating tendons	0
Avoid eating traditional spinach	9
Others - Avoid eating red meat Avoid drinking milk	2 1 1

TABLE 4.4 : MIDWIVES VIEW OF BEHAVIOURAL TABOOS

MIDWIVES VIEW OF BEHAVIOURAL TABOOS	PERCENTAGE
Do not become angry during pregnancy	19
Avoid certain pathways that may harbour evil spirits or wizards/witches	26
Don't plait hair during pregnancy	35
Refrain from sleeping during the day	20

TABLE 4.5 : THE WEARING OF PROTECTIVE BANDS

THE MIDWIVES VIEW OF THE WEARING OF PROTECTIVE BANDS	PERCENTAGE
Neck	18
Wrists	18
Abdomen	50
Ankle	14

Tables 4.3, 4.4 and 4.5 show that less than 50% of midwives knew what traditional taboos or restrictions pregnant and lactating mothers adhere to and wearing of protective bands.

- **The knowledge of and the allowing of the use of herbal medicine by midwives**

Many black patients use herbal medicines which are not prescribed by doctors or nurses. As midwives must give pregnant/lactating mothers advice on medicines, they must not only be knowledgeable about herbal medicines used by their patients but must also decide whether or not to allow the mothers to use them during pregnancy/childbirth/postnatal periods.

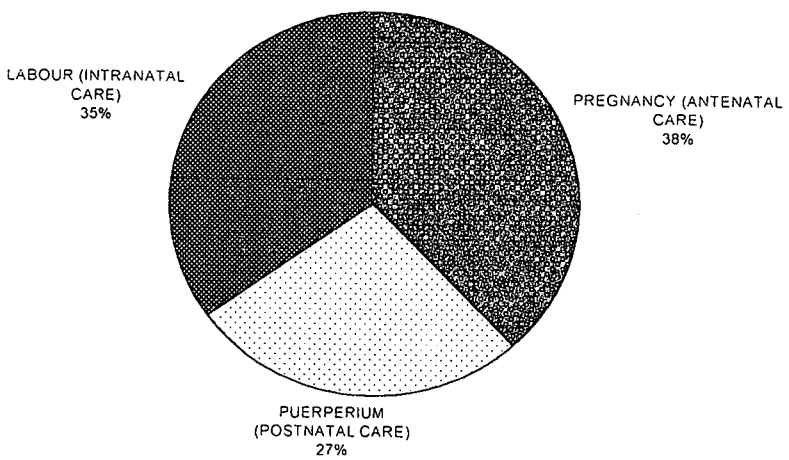

FIGURE 4.8 : ALLOWING THE USE OF HERBAL MEDICINES BY MIDWIVES

According to the responses in Figure 4.8, the minority of midwives (fewer than 50%) allowed their patients to use herbal medicines throughout pregnancy, childbirth and the postnatal period; 38% of the midwives allowed their use during antenatal care (pregnancy), 35% in intra natal care (childbirth) and 27% in postnatal care (puerperium).

The reasons why midwives allowed or refused the use of herbal medicines are reflected in Tables 4.6 and 4.7.

TABLE 4.6 REASONS FOR ALLOWING USE OF HERBAL MEDICINE

REASONS FOR ALLOWING USE OF HERBAL MEDICINE	PERCENTAGE
Patient's choice	11
Ease labour	9,4
Preserve pregnancy	7,7
Protect from evil spirit	7,7
Cannot harm the unborn baby	4,5
Doctor/pharmacist approval	4,5
Cleanse the uterus	2,7

TABLE 4.7: REASONS FOR NOT ALLOWING USE OF HERBAL MEDICINE

REASONS FOR NOT ALLOWING USE OF HERBAL MEDICINE	PERCENTAGE
Inadequate knowledge of these medicines	21,3
Hospital policy does not allow use of these medicines	9,5
Side effects of these medicines	6,8
Patients do not report using them	5,2
Medicines are harmful	4,8
Not enough research material available to refer to	4,9

Although nurses knew of herbal medicines (21,3%) they did not allow patients to use them as they were uncertain about them or because they followed hospital policies.

The knowledge of nurses with regard to the commonly used herbal medicines are reflected in Table 4.8.

TABLE 4.8 : THE VIEW OF MIDWIVES OF COMMONLY USED HERBAL MEDICINE

THE VIEW OF MIDWIVES OF COMMONLY USED HERBAL MEDICINE	PERCENTAGE
Isihlambezo	0
Imbelekisane	11,5
Kgaba	11,5
Pitsa	13,6
Caster Oil	31
Garlic	17
Others (Holy waters only)	15,4

Table 4.8 shows that midwives know about the commonly used herbal medicines like castor oil, garlic, holy waters, *pitsa, kgaba* and *imbelekisane*. No midwives knew whether patients were using *isihlambezo*.

- **The mothers preferred method of pain intervention as perceived by midwives**

Pain relief differs from person to person and from one cultural orientation to another because the perception of pain is embedded in the patient's own experiences and her cultural view of pain and intervention.

Figure 4.9 shows how the midwives perceived the patients' preferred method of pain intervention.

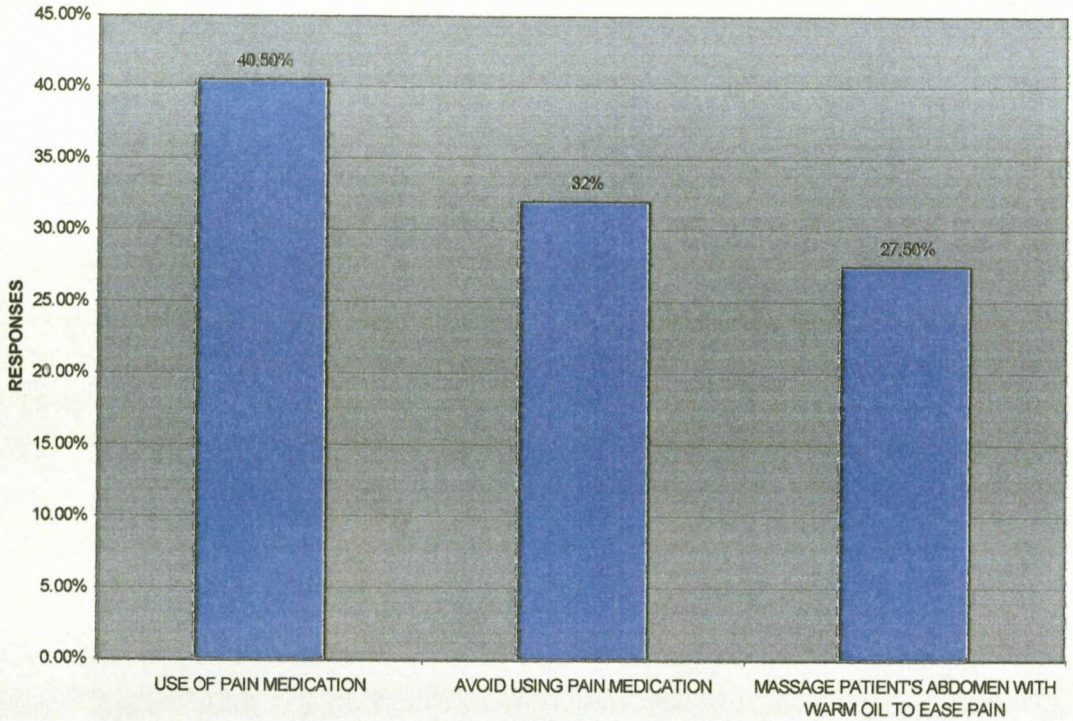

FIGURE 4.9 : THE MOTHERS' PREFERRED METHOD OF PAIN INTERVENTION AS PERCEIVED BY MIDWIVES

According to Figure 4.9, 40,5% of midwives declared that mothers preferred analgesics while 59,5% stated that mothers usually prefer not to us analgesics.

- **The mothers' preferred position during labour as perceived by midwives**

Because different positions can be assumed during labour, it is of the utmost importance for the midwife to position the mother in the position she prefers. Figure 4.10 (on page 82) sets out the preferred positions of mothers as perceived by midwives.

Figure 4.10 shows that 49,2% of midwives stated that the mothers' preferred position was squatting while 21,3% declared it was supine.

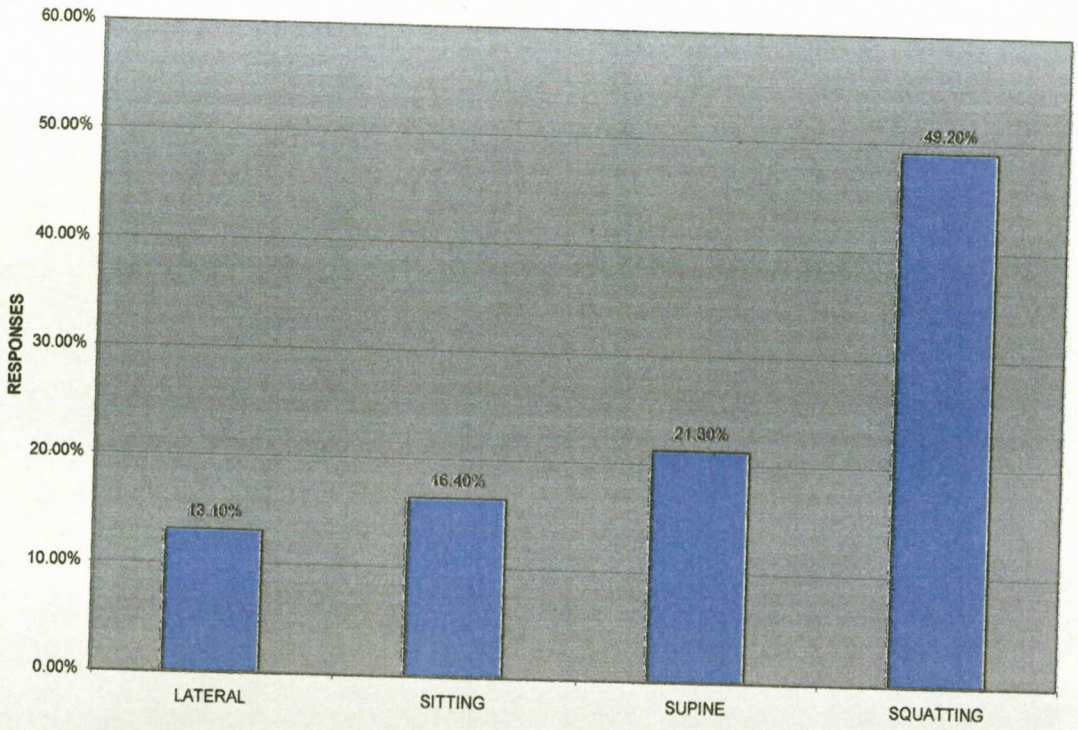

FIGURE 4.10 : THE MOTHERS' PREFERRED POSITION DURING LABOUR AS PERCEIVED BY MIDWIVES

- **The mothers' preference regarding episiotomy as perceived by midwives**

Episiotomy is performed for a specific reason; it must be discussed with the mother and she must indicate whether she wants it. Figure 4.11 (on page 83) reflects the midwives' perception of what the mothers preferred regarding episiotomy.

Figure 4.11 shows that 34,9% of midwives stated that mothers do choose to have an episiotomy while 65,1% declared that they do not prefer to have one.

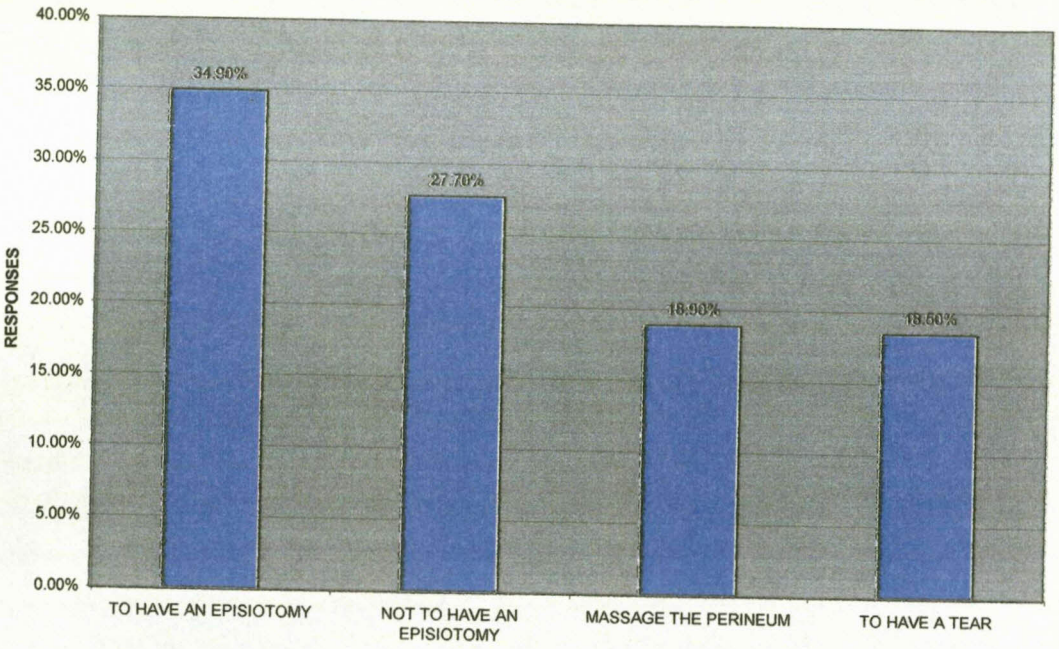

FIGURE 4.11 : THE MOTHERS PREFERENCE REGARDING EPISIOTOMY AS PERCEIVED BY MIDWIVES

- **The mothers preferred method of disposing of the placenta as perceived by midwives**

The placenta can be disposed of according to hospital policy or according to the traditional health practice of the patient. Therefore it is important for midwives to know what their patients prefer. The results were as follows: 24,2% of midwives stated that mothers preferred the placenta to be disposed of according to hospital policy while 75,8% of them declared that mothers preferred to take the placenta home and dispose of it according to their culture.

- **The cultural practices to be followed by mothers and babies before, during and after the delivery**

Many traditional African patients still follow their traditional cultural practices which must be performed by/for the mothers and their babies.

According to the survey, no midwives had knowledge of such practices; especially not regarding the cleansing and protective rituals.

- **Comfort measures provided by midwives to mothers during ante-, intra- and post-natal periods**

The comfort measures provided by midwives during ante-, intra-, natal- and post-natal periods are reflected in Table 4.9.

TABLE 4.9 : TYPES OF COMFORT MEASURES PROVIDED BY MIDWIVES

TYPE OF COMFORT MEASURES PROVIDED BY MIDWIVES	PERCENTAGE
Allowing visitors of the patients' choice at any time	27,4
Reassurance	24,4
Sedation	17,4
Talking to the patient	11,3
Not leaving the patient alone	9,9
Massaging the patient's back	9,6

According to Table 4.9 the comfort measures most commonly provided by midwives are allowing patients visitors and reassurance.

- **Health education given by midwives**

Midwives must give patients health education to prepare families for childbirth and child-rearing, reduce anxiety and to help them to cope with modern childbirth procedures. Figure 4.12 reflects the data regarding health education topics that nurses regard as important.

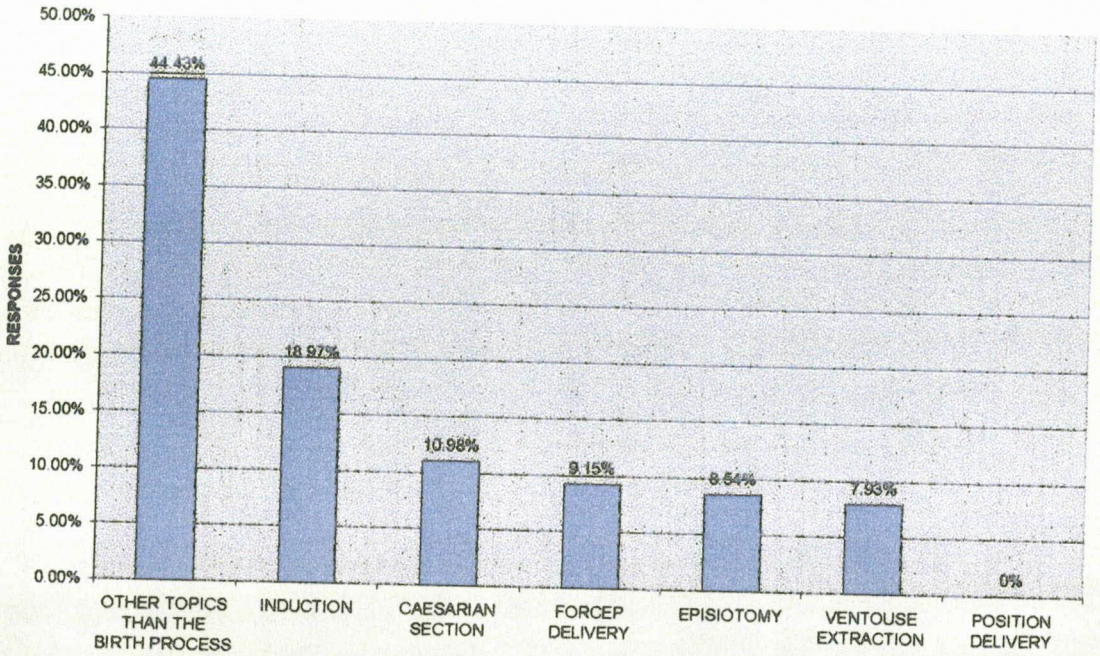

FIGURE 4.12: TOPICS IN THE HEALTH EDUCATION THAT ARE GIVEN BY MIDWIVES

Topics other than the birth process included:

*	Advice on diet, medicines, exercises and rest	18,97%
*	Onset of labour	12,06%
*	Breast feeding	7,70%
*	Complications of pregnancy	4,50%
*	Craniotomy	0,60%
*	Decapitation	0,60%

The responses in Figure 4.12 show that mothers were given health education mainly on the topic of abnormal delivery and antenatal are as viewed by the western health care model.

4.3.2.4 SECTION D : EVALUATION OF THE NURSING CARE THAT WERE RENDERED BY MIDWIVES

- **The process of evaluation of nursing care that were rendered**

Evaluation on an ongoing basis is implicit in the nursing process. Nursing care must be evaluated to ascertain the quality of care given. An evaluation of cultural congruent nursing care must also be done to ensure that the cultural health needs of the patient are met. According to the survey, 78,7% of midwives declared that nursing care are not evaluated. No evaluation of cultural congruent nursing care are also ever made.

- **Resource person(s) with regard to cultural childbirth practices consulted by midwives**

Midwives are expected to consult resource persons regarding cultural health practices if they are not able to render congruent nursing care themselve. The following persons were named by nurses as resource persons (Table 4.10 on page 87):

The responses in Table 4.10 show that most (73%) midwives indicated that patients and their families are principal resources (i.e.38% indicated that the patients and 35% of midwives indicated that their family members are the principal resources) for providing information regarding cultural health practices.

- **The involvement of mothers in the planning (decision-making) of their nursing care**

Patients must be involved in the planning and execution of nursing care so that they may take ownership of their care. The survey reflected that only 47,8% of mothers were involved by midwives in the planning and execution of their nursing care.

TABLE 4.10 : RESOURCE PERSON(S) CONSULTED

RESOURCE PERSON(S) CONSULTED	PERCENTAGE
Patient/client	38
Family member	35
Community member	7,1
Traditional birth attendant	5,4
Colleague	8
Nurse administrator	1,6
Nurse educator	4,9

- **The involvement of the traditional birth attendant as a multi-disciplinary team member**

Traditional pregnant/lactating women also use traditional birth attendants and these persons must be included as members of the multi-disciplinary team.

According to the survey, 75,4% of midwives indicated that traditional birth attendants must be involved as multi-disciplinary team members (although it seldom happens that they are consulted or included).

- **The experiences of midwives in caring for patients across the cultural border**

Midwives have to deal with different experiences when caring for patients across the cultural border.

The experiences as reflected in Table 4.11.

TABLE 4.11 : THE MIDWIVES' EXPERIENCE REGARDING TRANS-CULTURAL NURSING

THE MIDWIVES' EXPERIENCES REGARDING TRANSCULTURAL NURSING	PERCENTAGE
No problems experienced	28
Midwives experienced difficulties	26,4
Midwives felt that some cultural practices were impossible	18
Midwives felt frustrated	16,4
Midwives experienced communication problems	9
Midwives found it challenging	2,2

According to the responses in Table 4.11, 72% of midwives had negative experiences when caring for patients who are not of their own cultural orientation.

- **The need of midwives for further information regarding cultural congruent nursing care**

Midwives need further information to enable them to cope with the changes and challenges of cultural congruent nursing care.

Table 4.12 (on page 89) shows the need of midwives for further information on cultural congruent nursing care.

According to Table 4.12 it is evident that most midwives (85,2%) do need further information on cultural congruent nursing care while 14,8% do not require any further information.

TABLE 4.12 : THE NEED OF MIDWIVES FOR FURTHER INFORMATION ON CULTURAL CONGRUENT NURSING CARE

THE NEED OF MIDWIVES FOR FURTHER INFORMATION ON CULTURAL CONGRUENT NURSING CARE	PERCENTAGE
Midwives needed further information	85,2
Midwives did not need further information	11,5
Midwives not sure whether they needed information	3,3

4.3.3 EXPOSITION OF DATA COLLECTED BY THE STRUCTURED INTERVIEW CONDUCTED WITH PREGNANT OR LACTATING WOMEN

The data obtained from the structured interview will be presented as follows:

- Biographical data (Section A)
- Meeting the patients' cultural health needs (Section B)
- Patients' experiences (Section C)

Each section will be set out separately.

4.3.3.1 SECTION A : BIOGRAPHICAL DATA

The biographical data of the child-bearing mothers included their age, ethnicity, languages spoken and their need of an interpreter.

- **Age**

The ages of the mothers in the maternity section ranged from early adulthood to late middle adulthood.

The data is set out in Figure 4.13.

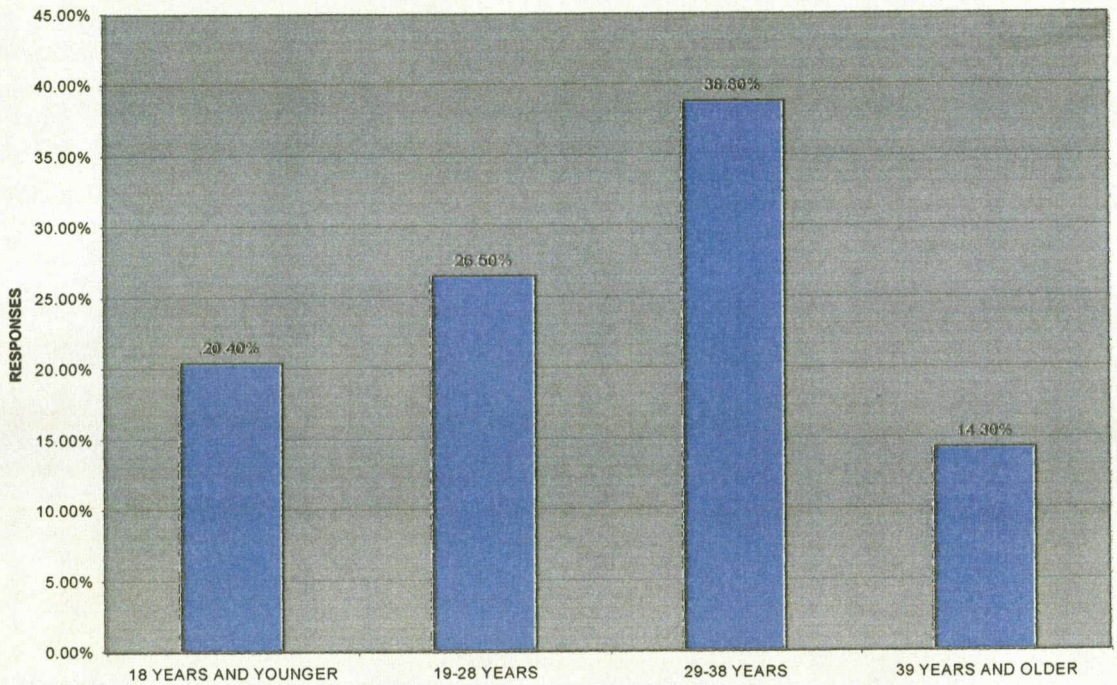

FIGURE 4.13 : THE AGES OF THE MOTHERS

According to Figure 4.13, 46,9% of mothers were below the age of 29 years. The rest of the patients were 29 years and above.

- **The mothers' ethnicity**

Within the black culture there exist different cultural groups whose cultural orientation may be similar or totally different.

The data is set out in Figure 4.14.

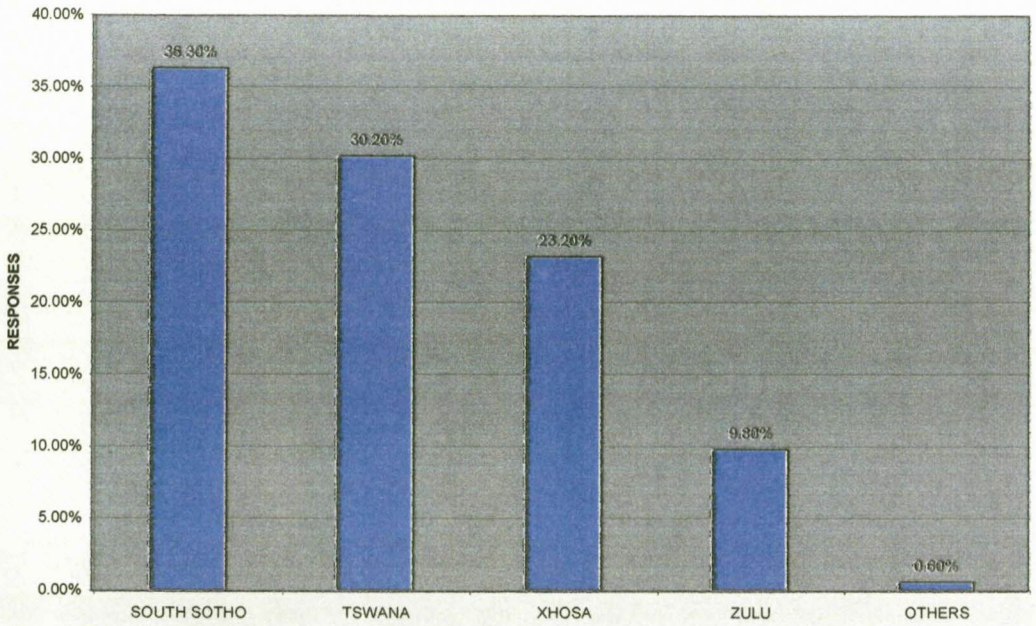

FIGURE 4.14 : ETHNICITY OF THE MOTHERS

According to Figure 4.14 most of the mothers were South Sotho's while Zulu's made up 9,8% of the total. Other orientations included Northern Sotho (0,6%).

- **Languages spoken by mothers**

The languages the mothers were able to converse in are shown in Figure 4.15 (on page 92).

According to Figure 4.15 most mothers were able to speak South Sotho (35%) while only 18% could speak English and 11,8% could speak Afrikaans.

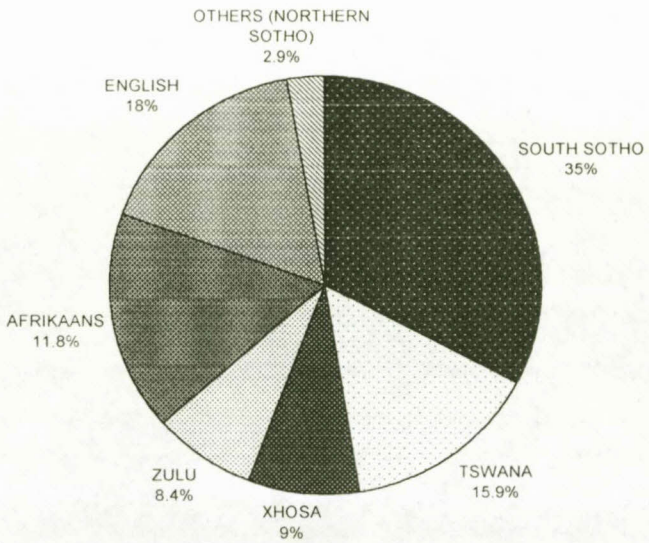

FIGURE 4.15 : LANGUAGES SPOKEN BY MOTHERS

- **Using the services of an interpreter**

In a transcultural setting patients use an interpreter if they do not understand the language spoken by the health care practitioners

The data is set out in Figure 4.16 (on page 93).

According to Figure 4.16; forty-nine comma seven percent (49,7%) of all mothers used an interpreter because they could not understand the midwives.

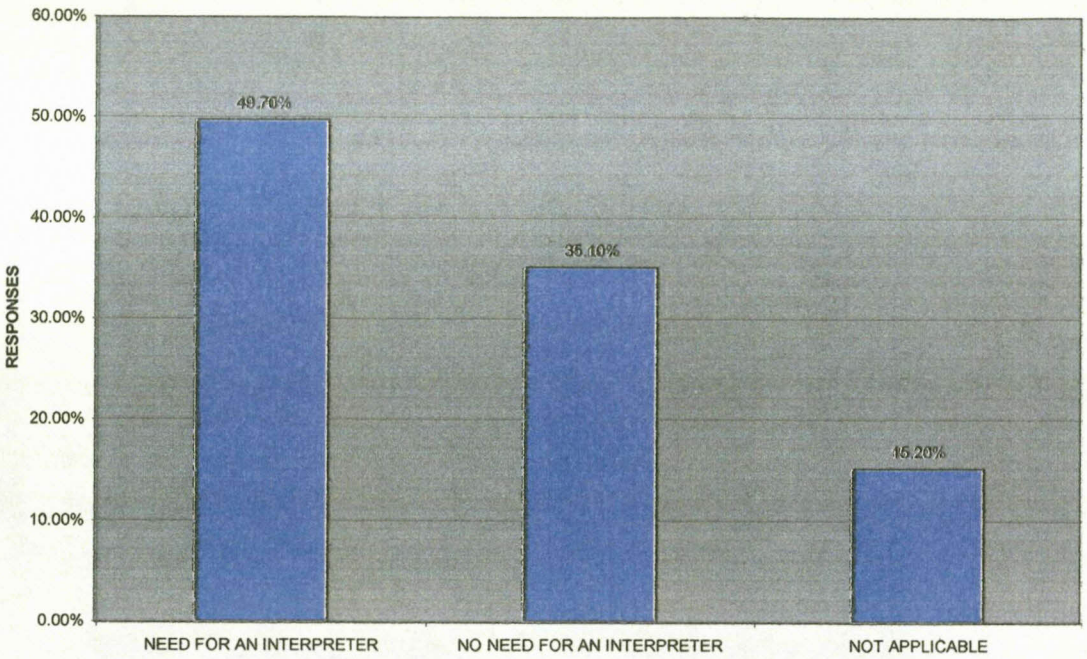

FIGURE 4.16 : THE USE OF AN INTERPRETER BY THE PREGNANT/LACTATING MOTHERS

4.3.3.2 SECTION B : MEETING THE CULTURAL HEALTH NEEDS OF THE MOTHER

This section included the mothers' view of child-bearing, the mothers' cultural health needs and the mothers' experience of the nursing care rendered by midwives.

- **The mothers' view of child-bearing**

The mothers' view of child-bearing is embedded in her cultural orientation. Midwives need to have knowledge of the different views of child-bearing to render quality care. The different views of the mothers are featured in Table 4.13.

TABLE 4.13 : THE MOTHERS' VIEWS OF CHILD-BEARING

THE MOTHERS' VIEWS OF CHILD-BEARING	PERCENTAGE
Normal physiological event	62,5
A wellness experience	2,0
A time of vulnerability	0,3
A time of risk	25
A state of illness	10,2

The results in Table 4.13 show that 87,5% of mothers viewed child-bearing as normal and a wellness event.

4.3.3.3 THE CULTURAL NURSING NEEDS OF THE MOTHERS

Meeting the patients' cultural health needs based on the information obtained from their initial and subsequent assessment interview(s) by nurses. The following data was collected:

- **The mothers' preferred support persons during hospitalization**

The persons the mothers preferred to support them are reflected in Table 4.14 (on page 95).

According to Table 4.14 most mothers respondents (60%) preferred their husbands to be their support person.

TABLE 4.14 : MOTHERS PREFERRED SUPPORT PERSON(S)

MOTHERS PREFERRED SUPPORT PERSON(S)	PERCENTAGE
Husband	60
Mother	20
Mother-in-law	8
Traditional birth attendant	2
Others :	10
Sister	3
Sister-in-law	2
Cousin	1,6
Aunt	1,6
Brother	0,6
Uncle	0,3
Father	0,3
Neighbour	0,3
Friend	0,3

- **Traditional taboos/restrictions honoured by mothers**

Persons from different cultures or cultural groups honour certain taboos during the antenatal, intra natal and postnatal periods, they also wear protective bands. The taboos/restrictions the mothers honoured are shown in Table 4.15, 4.16 and 4.17 (on page 96).

- **Herbal medicine used by pregnant and lactating women**

Pregnant and lactating mothers make use of herbal medicines prescribed by the traditional birth attendants as well as those bought over the counter. The use of herbal medicines by pregnant and lactating women is reflected in Figure 4.17 (on page 97).

TABLE 4.15 : DIETARY TABOOS THAT ARE HONOURED

DIETARY TABOOS HONOURED BY MOTHERS	PERCENTAGE
Avoid eating whilst standing	25,5
Avoid drinking water whilst standing	20,8
Avoid eating uncrushed/boiled eggs	15,4
Avoid eating tendons	13,9
Avoid eating traditional spinach	13,5
Others: Not eating red meat Not drinking milk	10,9 4,9 6,0

TABLE 4.16 : BEHAVIOURAL TABOOS THAT ARE HONOURED

BEHAVIOURAL TABOOS HONOURED BY MOTHERS	PERCENTAGE
Do not become angry during pregnancy	14,5
Avoid certain pathways that may harbour evil spirits of wizards or witches	23,5
Don't plait hair during pregnancy	42
Refrain from sleeping during the day	20

TABLE 4.17 : WEARING OF PROTECTIVE BANDS BY MOTHERS

WEARING OF PROTECTIVE BANDS	PERCENTAGE
Neck	20
Wrist	8,7
Abdomen	55,3
Ankle	16

According to tables 4.15, 4.16 and 4.17 mothers honoured different dietary and behavioural taboos. Most mothers (50%) used abdominal protective bands.

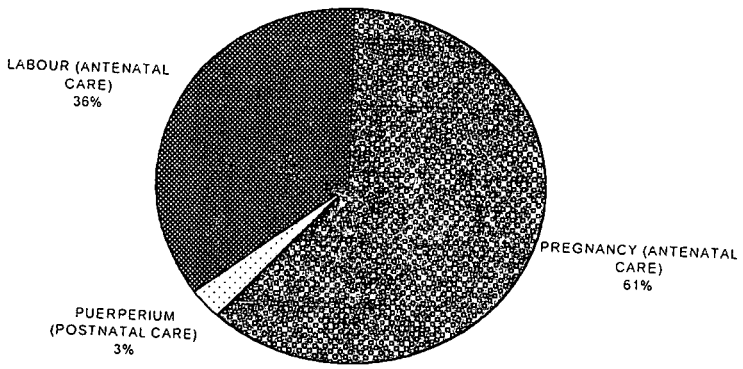

FIGURE 4.17 : THE USE OF HERBAL MEDICINES BY PREGNANT AND LACTATING WOMEN.

Although 69,4% of pregnant and lactating mothers indicated that they used herbal medicines, only few pregnant and lactating mothers (4,3%) who reported the use to professional midwives stated that all the midwives discouraged them from using herbal medicines without giving them reasons. Most of the mothers (42%) did not report the use of herbal medicine to midwives for cultural reasons while 30,6% of mothers did not use herbal medicines at all. Some mothers (27,4%) refused to report the use of herbal medicines for personal reasons.

- **Types of herbal medicines commonly used**

Table 4.18 reflects the herbal medicines commonly used by pregnant and lactating women (in hospital or in the community).

TABLE 4.18 : HERBAL MEDICINES USED BY PREGNANT AND LACTATING WOMEN

HERBAL MEDICINE USED	PERCENTAGE
Isihlambezo	0
Imbelekisane	0
Kgaba	10
Pitsa	40,5
Castor Oil	10,6
Garlic	11,2
Other	27,7
Holy waters	14
Vimbella	11,2
Haarlemensis	2,5

According to Table 4.18 most pregant and lactating women (40,5%) used *pitsa*. *Isihlambezo* and *imbelekisane* are very seldom if ever used by mothers.

- **The child-bearing mothers' preferred method of pain relief**

Child-bearing mothers' use of pain relief methods differed from person to person. The preferred method of pain relief depends on the mother's perception of pain as well as her cultural background and orientation. The pain relief methods preferred by child-bearing mothers are shown in Figure 4.18.

According to Figure 4.18, most mothers (46,5%) did not want any pain medication (whether analgesics or other types of pain relieves), 20,5% wanted pain intervention other than analgesics while 33% wanted to use analgesics as a method of pain relief.

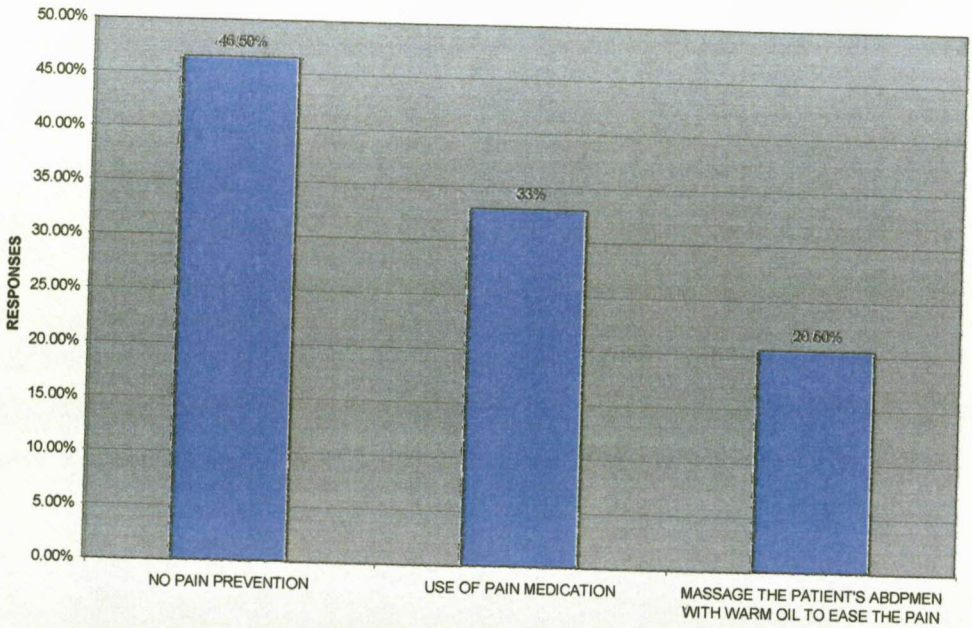

FIGURE 4.18 : THE CHILD-BEARING MOTHERS' PREFERRED METHOD OF PAIN INTERVENTION

- **The mothers' preferred position during labour**

Because different positions may be adopted during the first and second stages of labour, the mother must be given a choice to adopt the position in which she feels most comfortable. The positions mothers preferred are reflected in Table 4.19.

TABLE 4.19 : THE MOTHERS' PREFERRED POSITION DURING LABOUR

THE MOTHERS' PREFERRED POSITION	PERCENTAGE
Lateral position	0
Sitting	25,3
Supine	70,5
Squatting	4,2

Table 4.19 shows that most mothers (70,5%) preferred the supine position; 25,3% wished to sit while 4,2% of mothers preferred squatting.

- **Choosing an episiotomy to prevent complications**

Nurses must inform and discuss episiotomy with pregnant/child-bearing women in order to enable them to make an informed decision. The decision of the mothers is reflected in Table 4.20.

TABLE 4.20 : THE DECISION OF MOTHERS REGARDING EPISIOTOMY

MOTHERS' DECISION REGARDING EPISIOTOMY	PERCENTAGE
To have an episiotomy	27,1
Not to have an episiotomy	33,0
To have a tear rather than an episiotomy	13,0
Had an episiotomy	26,9

According to Table 4.20, 46% of mothers preferred not to have an episiotomy and 13% would rather have a tear than be surgically incised, but twenty-six comma nine percent (26,9%) had an episiotomy.

- **The patients' preferred method of disposing of the placenta**

Nurses must inform and discuss the options regarding the disposal of the placenta with the pregnant woman, especially if she wishes to dispose of it in a traditional manner. The mothers' preferred method of disposing of the placenta are shown in Table 4.21.

TABLE 4.21 : MOTHERS' PREFERRED METHOD OF DISPOSING OF THE PLACENTA

MOTHERS' PREFERRED METHOD OF DISPOSING OF THE PLACENTA	PERCENTAGE
According to hospital policy	8
Take it home and dispose of it in the traditional/cultural manner	20
Relied on the nurses' decision	72

According to Table 4.21 most mothers (72%) did not make a choice but relied on the decision of the midwife on how to dispose of the placenta.

- **The cultural practice mothers and babies have to adhere to after the delivery**

The data collected shows that 99% of mothers did not request any traditional cultural practices (that is cleansing/protective rituals) they would like for themselves and their babies. Only one mother asked that her traditional birth attendant, to carry out traditional cultural practice for her baby, this was granted. Most of the mothers did not request these because they were afraid that nurses won't respond positively, nurses do not believe in such practices while others did not make any request because they (mothers) do not believe in such practices.

- **The comfort measures preferred by child-bearing women**

The comfort measures provided by midwives must help the patients to cope with the process of childbirth. According to the survey, all the mothers indicated that they did not received enough emotional care from midwives.

The reason for this negative emotional experience was that they were left alone when they needed someone and when they were anxious. Most mothers reported that the physical care (for instance, being washed if they could not wash themselves; sedation given for pain or massage on request) was excellent.

- **The allowing of the preferred support person to be present during the second stage of labour and delivery**

Allowing the preferred support person of the mother into the delivery room during the second stage of labour is the most important emotional care-giving act of the midwife. The support persons allowed by the midwife during the second stage of labour and delivery according to the mothers, are reflected in Table 4.22.

TABLE 4.22 : THE SUPPORT PERSON ALLOWED BY MIDWIFE DURING THE SECOND STAGE OF LABOUR AND DELIVERY

THE SUPPORT PERSON ALLOWED BY MIDWIFE DURING SECOND STAGE OF LABOUR AND DELIVERY	PERCENTAGE
Husband	100
Mother	0
Mother-in-law	0
Others	0

According to Table 4.22 the only person (whether preferred or not) allowed in the delivery room was the husband of the patient.

- **Reasons given by mothers why their preferred support person was not allowed/unable to attend the delivery**

Men do not form part of the cultural practices during pregnancy, labour and child-bearing.

Most of the mothers (67%), claimed that their husbands did not want to attend the delivery because men are not allowed into the delivery room - a very sacred cultural practice. Thirteen percent of the mothers said their husbands could not attend the delivery because they were at work. Twenty percent of mothers indicated that they wanted a support person (e.g., mother, mother-in-law, sister, sister-in-law) other than their husbands but they thought it would be against hospital policies and felt uncomfortable to discuss the issue with the midwives. The midwives did not discuss the matter during health education sessions, nor during the assessment phase of the nursing process.

- **Health education received by pregnant and lactating women**

The health education given by midwives in preparation of childbirth as stated by mothers is reflected in Figure 4.19.

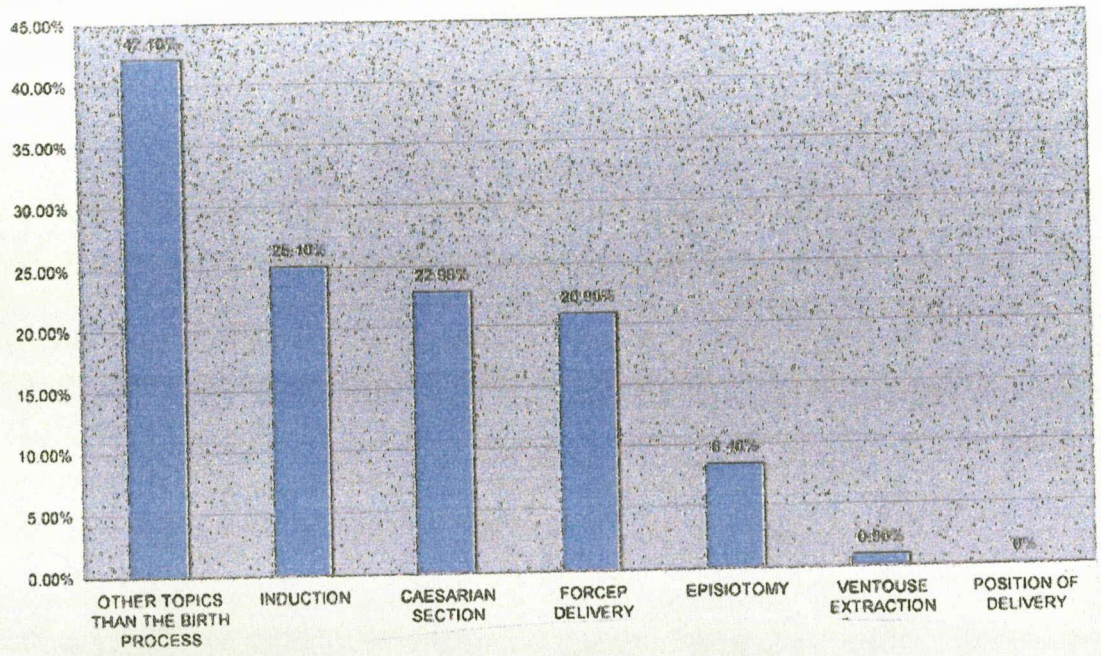

FIGURE 4.19 HEALTH EDUCATION TOPICS GIVEN BY MID-WIVES AS STATED BY MOTHERS

Topics other than the birth process included:

- Onset of labour (1,6%)
- Advice on diet, medicines, exercises and rest (13,6%)
- Complications of pregnancy and labour (5%)
- Breast feeding (0,6%)
- Decapitation (0%)

According to Figure 4.19 the most important topics midwives educated mothers about were Induction, Caesarean Section, Forceps Delivery and Onset of Labour.

- **Information given by midwives regarding medical grounds for other forms of delivery than a normal vaginal delivery**

Not all women are able to have a normal vaginal delivery. Many medical grounds exist for this situation. Thus it is of the utmost importance that midwives should explain the reasons for other forms of delivery to the pregnant woman and she should be helped to accept the situation.

Information received by mothers regarding the medical grounds for other forms of delivery are reflected in Table 4.23.

TABLE 4.23 : INFORMATION RECEIVED REGARDING MEDICAL GROUNDS FOR OTHER FORMS OF DELIVERY

INFORMATION RECEIVED REGARDING MEDICAL GROUNDS FOR OTHER FORMS OF DELIVERY	PERCENTAGE
Reasons where explained to the mothers	21
Reasons where not explained to the mothers	37
The mothers found it unnecessary to be given explanation as they had a normal vaginal delivery	42

Table 4.23 showed that only 21% of child-bearing women were given an explanation as to why a vaginal delivery was not possible; 19% of the 21% said they understood the indication(s) as explained.

4.3.3.4 INFORMATION ABOUT THE MOTHERS' EXPERIENCES OF THE RENDERED NURSING CARE

Section C of the structured interview focused on the mothers own experiences of the nursing care they received. This information is of a subjective nature as it is based on the "lived experience" of the patients and differs from patient to patient.

- **Involvement of mothers in their own care**

The data revealed that most of the pregnant/lactating women (99,7%) said they were not involved in their own care as they were never asked how they would like their nursing care to be rendered. A few patients (0.3%) said they would rather not comment on this issue. All the patients (100%) said they would welcome being involved in their own nursing care.

- **Consulting a traditional birth attendant while in hospital**

Very few mothers (6,4%) indicated that they wished to consult their traditional birth attendant whilst in the hospital. This was not allowed as neither the multidisciplinary team nor the nursing team responded to their request. Most of the patients said they would consult their own traditional birth attendant after being discharged. The reasons given by the mothers were that the traditional birth attendants are very busy and as they live far from the hospital, it is impossible to consult them while in hospital. A few mothers (0,1%) said that the traditional birth attendants are not members of the disciplinary team and therefore can not be consulted.

- **The mothers' experiences of being cared for by midwives of other cultural orientations**

Most of the mothers (50%) indicated that they were satisfied with the care they received. The following comments indicated the mothers' satisfaction:

- Ten percent of mothers felt safe being in the hospital for their care and did not concentrate on the midwives cultural orientation.

- A minority mothers (17%) relied on the midwives decisions about their care, as they knew that they were trained to give proper care.

- Almost a quarter mothers (23%) did not experience any problems as they were sedated and were checked from time to time to ascertain whether they needed care.

A third, of the pregnant/lactating mothers (33,7%) indicated that they were not satisfied with the care they received for the following reasons:

- A few mothers (9,3%) reported that some midwives scolded them or joked about them and called other midwives to listen if they voiced their cultural health needs.

- Some mothers (12%) stated that midwives indicated that they did not know what decision to take when they voiced their cultural health needs.

- Others (12,4%) did not feel free to express their need for cultural congruent nursing care as they were afraid of being ill-treated.

- Some mothers (16,3%) indicated that it did not matter to them whether their cultural health needs were met as long as they received the necessary care.

4.3.4 COMPARISON OF CORRELATED INFORMATION CATEGORIES IN THE QUESTIONNAIRE, STRUCTURED INTERVIEW AND NURSING RECORDS

- **Language used by nurses and mothers for communication.**

The preferred language spoken by midwives and mothers are indicated in Table 4.24.

TABLE 4.24 : PREFERRED LANGUAGE SPOKEN BY MIDWIVES AND MOTHERS

LANGUAGE	MIDWIVES	MOTHERS
English	37,0%	18,0%
South Sotho	35,4%	35,0%
Tswana	14,1%	15,9%
Afrikaans	10,8%	10,8%
Xhosa	1,6%	9,0%
Zulu	0,8%	8,4%
Northern Sotho	0,3%	2,9%

According to the responses in Table 4.24 most midwives and mothers could understand one another as both spoke or understood South Sotho. Tswana and Afrikaans also did not pose problems with regard to communication between midwives and mothers.

- **The use of the services of an interpreter**

The use of the services of an interpreter by either the midwife or the mother are shown in Table 4.25.

TABLE 4.25 : THE USE OF AN INTERPRETER

THE USE OF THE SERVICES OF AN INTERPRETER	MIDWIVES	MOTHERS
Made use of an interpreter	54,1%	49,7%
Did not make use of an interpreter	44,3%	35,1%
Not applicable	1,6%	15,2%

Both midwives and mothers made use of an interpreter when necessary. However, the nursing records did not reflected that the mother needed the services of an interpreter and/or that the service of an interpreter was incorporated in the nursing care rendered by the midwives.

- **Child-bearing as viewed by midwives and mothers**

Child-bearing as viewed by midwives and mothers are shown in Table 4.26 (on page 110).

According to the above Table, the midwives' perception of how mothers view pregnancy/labour and child-bearing differs from that of the mothers. Mothers tended to view pregnancy/labour and child-bearing as a wellness-normal physiological state (64,3%) while midwives accentuated (63,5%) the negative aspects (illness, risk, unhappy) of this life event.

TABLE 4.26 : DIFFERENT VIEWS OF CHILD-BEARING

DIFFERENT VIEWS OF CHILD-BEARING	MIDWIVES	MOTHERS
Normal physiological event	27,5%	62,5%
A state of illness	23,0%	10,2%
A time of risk	21%	25%
An unhappy event	19,5%	0,3%
A wellness experience	9	2%

- **The preferred support person as viewed by midwives and mothers**

The preferred support person as viewed by midwives and mothers are shown in Table 4.27 (on page 111).

According to Table 4.27, 60,7% of midwives indicated that mothers preferred their own mothers as support person rather than their husband. The mothers' responses showed that they preferred their husband (60%) rather than their mothers (20%) although the mothers indicated that the cultural taboo of "no men allowed at birth place" is still honoured. Other mothers (1,2%) indicated brother, uncle and father as support person during hospitalization and midwives did not indicate this.
The midwives' view differed from the mothers' view as indicated above and 3,2% of midwives indicated doctors, nurses and children as other support persons; but mothers did not indicate that instead 3,8% of mothers indicated cousin, aunt, neighbour and friend as other support persons.

- **The traditional taboos/restrictions honoured by mothers during the ante-natal, intra- natal and postnatal periods**

Both the midwives and the mothers responses are reflected below:

Taboos/restrictions honoured are shown in Table 4.28 (on page 112).

TABLE 4.27 : THE PREFERRED SUPPORT PERSON AS VIEWED BY MIDWIVES AND MOTHERS

THE PATIENTS' PREFERRED SUPPORT PERSON	MIDWIVES	MOTHERS
Husband	27,9%	60,0%
Mother	60,7%	20,0%
Mother-in-law	3,3%	8,0%
Traditional birth attendant	1,6%	2,0%
Others		
Sister	3	3%
Sister-in-law	0,3	2%
Cousin	0	1,6%
Aunt	0	1,6%
Brother	0	0,6%
Uncle	0	0,3%
Father	0	0,3%
Neighbour	0	0,3%
Friend	0	0,3%
Doctor	0,3%	0
Nurses	2,6%	0
Children	0,3%	0

TABLE 4.28 : TABOOS/RESTRICTIONS HONOURED

TABOOS/RESTRICTIONS HONOURED	MIDWIVES	MOTHERS
DIETARY TABOOS Commonly used traditional African diet avoided during pregnancy, labour and puerperium are uncrushed/boiled eggs, tendons spinach, red meat and milk	41%	53,7%
BEHAVIOURAL TABOOS Commonly avoided during pregnancy Don't plait hair during pregnancy	35%	42%
WEARING PROTECTIVE BANDS Abdominal protective bands	50%	55,3%

The responses from Table 4.28 show that midwives and mothers agree more or less to one another with midwives on taboos/restrictions honoured by mothers and wearing of protective bands.

- **The use of herbal medicines during the antenatal, intra natal and postnatal periods**

The use of herbal medicines as reported by midwives and mothers are shown in Table 4.29.

TABLE 4.29 : THE USE OF HERBAL MEDICINES AS REPORTED BY MIDWIVES AND MOTHERS

HERBAL MEDICINES USED	MIDWIVES	MOTHERS
Antenatal period	38%	61%
Intra natal period	35%	36%
Postnatal period	27%	3%

Most mothers indicated that they used herbal medicines during the antenatal period. This was more than the midwives believed. Midwives (27%) also shown that they thought mothers used herbal medicines during postnatal period; but only 3% of mothers indicated that they used herbal medicines during postnatal period.

The actual use of different herbal medicines by mothers differed vastly from what the midwives indicated as reflected in Table 4.30 below.

- **Childbirth preparation through health education given by midwives**

The health education topics (other than birth process) indicated by midwives differed vastly from what the mothers indicated they were taught by the midwsives (Figure 4.20 on page 115).

TABLE 4.30 : THE HERBAL MEDICINE USED

HERBAL MEDICINE USED	MIDWIVES	MOTHERS
Castor Oil	31,0%	10,6%
Garlic	17,0%	11,2%
Holy waters	15,4%	14,0%
Pitsa	13,6%	40,5%
Kgaba	11,5%	10,0%
Imbelekisane	11,5%	0%
Isihlambezo	0%	0%
Vimbella	0%	11,2%
Haarlemensis	0%	2,5%

According to Figure 4.20 health education topics importance rated differently but both midwives and mothers indicated that position of delivery was excluded in health education

Table 4.31 (on page 115) which showed topics other than birth process. Most midwives (18,97%) indicated "advice on diet, medicines, excercises and rest, this was confirmed by most mothers (13,6%). It also showed that 1,2% of midwives reported topics like "craniotomy" and "decapitation", but mothers reported those topics not included in the health education; whereas 24,26% of midwives reported topics like "onset of labour", "breastfeeding" and "complications of pregnancy and labour" but only 7,2%of mothers confirmed this.

- **Pain intervention**

The mothers' and midwives' beliefs regarding pain intervention are set out in Table 4.32 (on page 116).

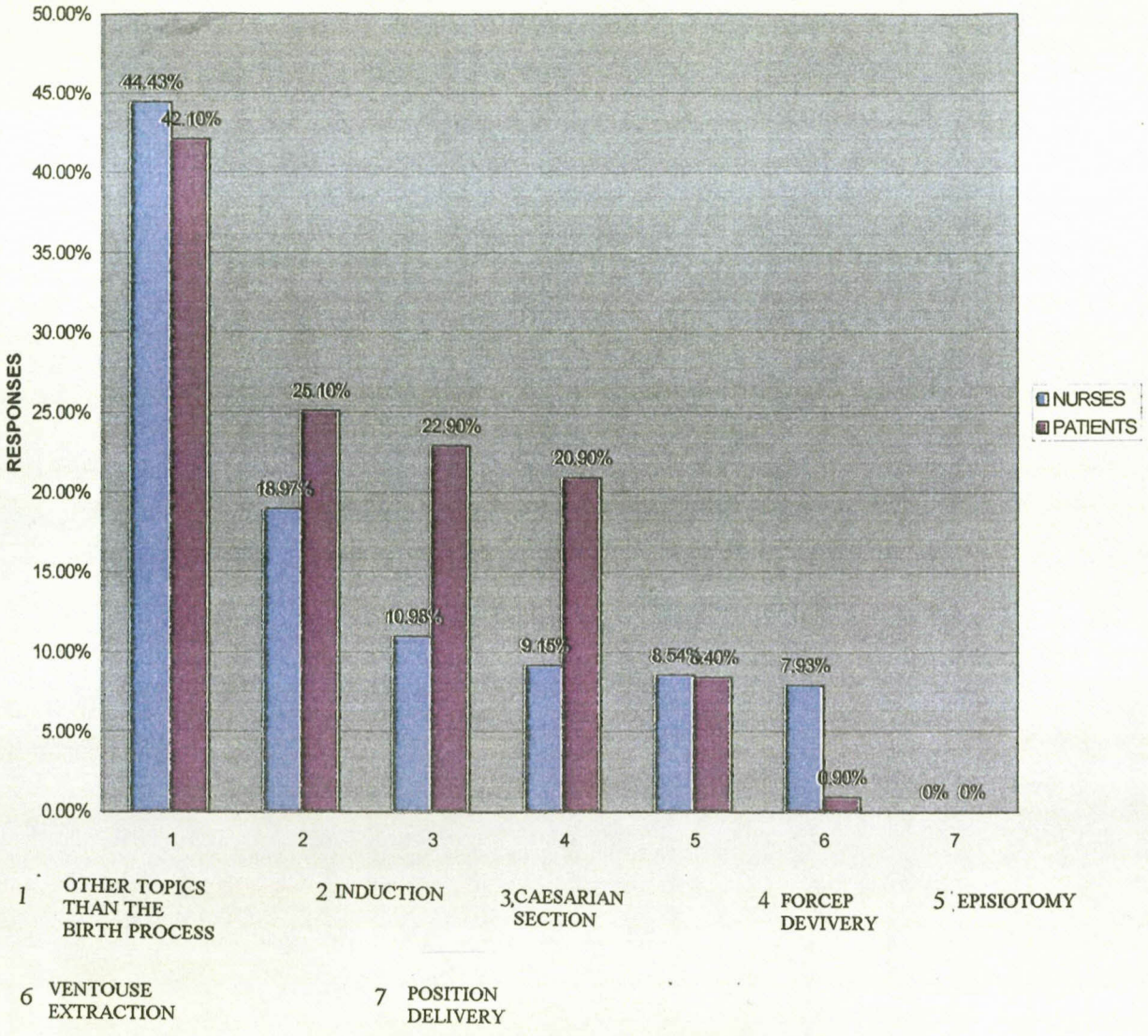

FIGURE 4.20 : TOPICS OTHER THAN THE BIRTH PROCESS

TABLE 4.31: TOPICS OTHER THAN BIRTH PROCESS

TOPICS OTHER THAN BIRTH PROCESS	MIDWIVES	MOTHERS
Advice on diet, medicines, exercises and rest	18,97%	13,6%
Onset of labour	12,06%	1,6%
Breast feeding	7,70%	0,6%
Complications of pregnancy and labour	4,50%	5%
Craniotomy	0,60%	0%
Decapitation	0,60%	0%

TABLE 4.32 : PAIN INTERVENTION

PAIN INTERVENTION	MIDWIVES	MOTHERS
Use of analgesics	40,5%	33%
Avoided using analgesics	32%	46,5%
Massage the abdomen with warm oil to ease pains	27,5%	20,5%

According to Table 4.32, 40,5% of midwives indicated that mothers did want analgesics to relieve labour pains while the mothers themselves (46,5%) indicated that they did not want analgesics. Both midwives (27,5%) and mothers (20,5%) also indicated that the mothers preferred to be "massaged the abdomen with warm oil to ease pains."

- **The patients' preferred birth position**

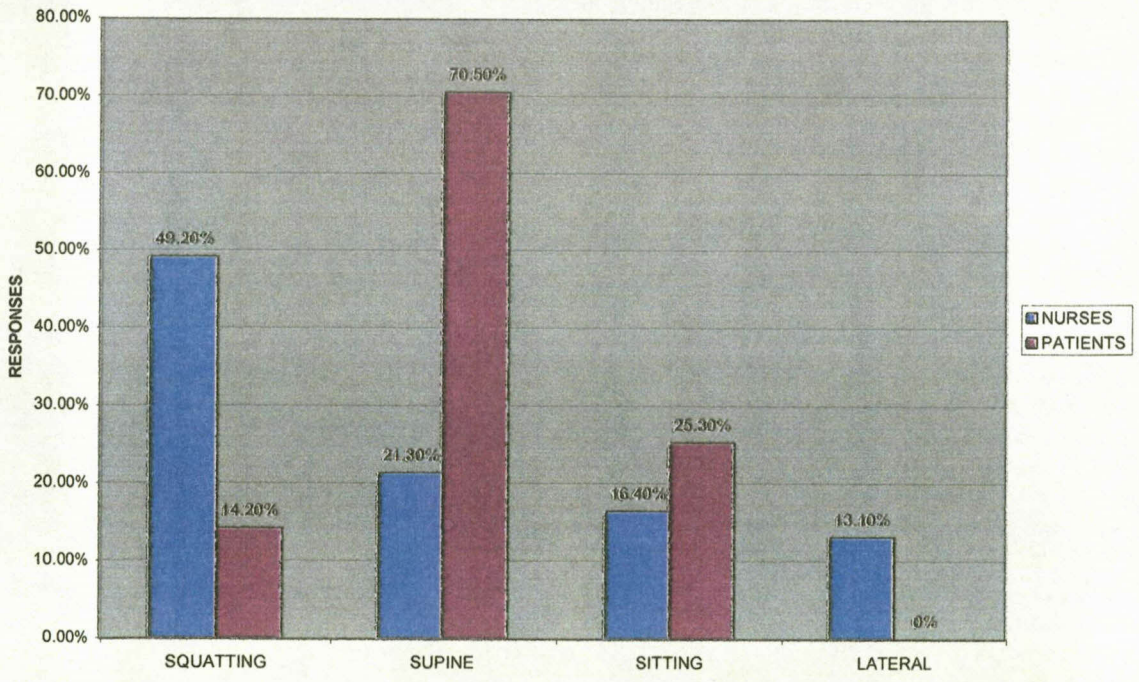

FIGURE 4.21: THE MOTHERS' PREFERRED BIRHT POSITION

The midwives responses show that all positions were represented in the mothers choices. Squatting rated as the highest by midwives. However, the mothers' responses differ as they indicate the supine position.

- **Episiotomy - mothers' choice**

The mothers' choices to have an episiotomy or not as indicated by the midwives and mothers are exposed in Table 4.33.

TABLE 4.33: THE CHOICE OF PATIENTS RE: EPISIOTOMY

MOTHERS' CHOICES ON EPISIOTOMY	MIDWIVES	MOTHERS
To have an episiotomy	34,90%	27,1%
Not to have an episiotomy	27,7%	33%
To have a tear rather than an episiotomy	18,5%	13%
To be massaged	18,9	0%
Had an episiotomy	0%	26,9%

According to the midwives (34,9%), most mothers wanted an episiotomy; but (26,9%) of the mothers indicated that they had an episiotomy; even if 33% of mothers said they did not want to have an episiotomy as shown in Table 4.33.

- **Preferred way of disposing of the placenta**

The preferred way of disposing of the placenta are shown in Table 4.34.

TABLE 4.34 : PREFERRED WAY OF DISPOSING OF THE PLACENTA

PREFERRED WAY OF DISPOSING OF THE PLACENTA	MIDWIVES	MOTHERS
According to hospital policy	24,2%	8%
Took it home and disposed of it in the traditional/cultural manner	75,8%	20%
Relied on the nurses' decision	0%	72%

According to Table 4.34 the midwives indicated that most mothers wished to dispose of the placenta in the traditional/cultural way. Most mothers (80%) relied on the midwives' decisions and hospital policy as they were not involved in the decision-making process with regard to disposing of the placenta. Therefore the mothers were unable to disucss their preferred way when they had the delivery at hospital.

- **Child-bearing cultural practice/rituals for mother and baby**

The mothers' requests for cultural practices/rituals for themselves and their babies as reflected in Table 4.35 (on page 119).

According to Table 4.35 all midwives responded that not one mother requested cultural practices they wished to be carried out for themselves and/or their babies. The mothers' responses were similar as only one mother requested a cultural practice to be carried out for her baby in hospital (this was granted by the health care team). Most mothers also declared that they felt too uncomfortable to request such cultural practices from professional nurses/midwives others felt it will be inconveniencing in the hospital to carry them out; as they were afraid that nurses

won't respond positively, nurses do not believe in such practices while midwives thought they do not ask because they do not use them.

TABLE 4.35 : CHILD-BEARING CULTURAL PRACTICE/RITUALS FOR MOTHER AND BABY

CHILD-BEARING CULTURAL PRACTICE/RITUALS FOR MOTHER AND BABY	MIDWIVES	MOTHERS
Cultural practices/rituals not requested by mothers	100	99
Cultural practices/rituals requested by mothers	0	1

- **Involvement in decision-making**

Table 4.36 shows the involvement in decision-making.

TABLE 4.36 INVOLVEMENT IN DECISION-MAKING

INVOLVEMENT IN DECISION-MAKING	MIDWIVES	MOTHERS
Involved	47,8	0
Not involved	52,2	100

According to Table 4.36, 47,8% of midwives indicated that they did involve mothers in decision-making and planning of their care; on the other hand, all mothers (100%) said they were not asked to make any decisions regarding their care or to give input in the planning and rendering of nursing care.

4.4 CONCLUSION

This chapter has covered the data collected by the auditing the relevant documents and the reduction of the completed questionnaire and structured interview. A comparison of the data was made in which the differences and similarities of responses given by midwives and pregnant or lactating women were reflected. The findings will discussed in Chapter Five.

CHAPTER FIVE

FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

5.1 INTRODUCTION

As the purpose of the study was to ascertain whether midwives render cultural congruent nursing care to traditional African pregnant or lactating women, the importance of this chapter lies in the discussion of the findings of the study and in making recommendations.

5.2 THE FINDINGS OF THE STUDY

Based on the exposition of the data in the previous chapter, the following findings were made:

- It showed that in most incidences nurses/midwives opinions differed from patients preferences. This finding correlates with that of Uys (1989:16) who states that when patients enter a system dominated by nursing staff from a cultural group different from theirs experience the difference.

- Most midwives (65,6%) declared that their nursing education had prepared them sufficiently to render cultural congruent nursing care. But Zeelie (1996:7) stated that even if cultural congruent nursing care is taught the content is insufficient, uncoordinated and that nursing lectures are unpre-

pared to present and evaluate cultural congruent nursing care content. This is experienced when nurses are working in the clinical field; as indicated in the study that 57,4% of nurses said they were not giving inservice training regarding cultural congruent nursing care and 85,2% nurses stated that they needed further information on cultural congruent nursing care.

- Hospital and ward policies do not endorse cultural congruent nursing care. This tendency was also reflected in the nursing care documents as cultural congruent nursing care was recorded only in a very few documents. Only the preferred language and support person(s) were mentioned.

- Mothers and midwives view of life events as pregnancy, labour and child-rearing vastly different as 63,5% midwives view them as a health risk a time of illness and a time of vulnerability while 64,5% mothers view them as a normal life event and a wellness experience. This finding correlates with that of Groat (1992:28) who states that people from different cultural groups have very distinct and varying views of the childbirth event.

- Although midwives (47,8%) indicated that patients were involved in decision-making regarding their own care, most mothers (99,7%) denied this. This finding stresses Anderson's (1990:137-139) point that it is important for nurses and patients to arrive at a mutually acceptable intervention by nurses discovering the patients' viewpoint related to care, health, illness and cultural beliefs.

- Midwives concentrated on health issues such as diet medicines, exercises and rest when giving health education. Cultural taboos/practices that should be included in health education were not touched on while cultural practices were not included in nursing care programmes in the maternity setting.

- The following culturally specific issues related to cultural congruent maternity nursing care require more attention:

Taboos/Restrictions

* Most mothers (53,7%) indicated that uncrushed/boiled eggs, tendons, spinach, red meat and milk are traditional diet to be avoided during pregnancy and 41% of midwives indicated all abovementioned diet; except tendons. But these mothers did not report them to midwives and midwives did not make a note of them in any nursing care records/documents. This finding supports that of Mokoena (1991:30) that it is not common for traditional African patients to express their food likes and dislikes or even their cultural practices. As a result midwives tend to forget to ask patients about these.

* Some mothers and midwives indicated that they have knowledge about behavioural taboos to be honoured during pregnancy. Thirty-five percent (35%) of mothers had to avoid plaiting their hair during pregnancy and 42% midwives also indicated that mothers avoided to plait their hair during pregnancy but this was not recorded in the nursing care records. This finding correlates with the statement of Chalmers (1992:89) that members of traditional African cultures must honour behavioural taboos to prevent complications of pregnancy and labour, but that most nurses do not consider them when giving care.

* Fifty-five comma three percent (55,3%) of mothers reported that they were wearing protective bands; especially over the abdomen and 50% of midwives knew about this practice. This supports the finding of Lupuwana (1991:14) that women wear protective bands when pregnant or lactating to prevent evil spiritis from entering the body.

Herbalism

* Ninty-seven percent (97%) of mothers used herbal medicines during pregnancy and labour. The majority of midwives (52,5%) did not allow their patients to use herbal medicines during pregnancy and labour, because they were afraid of side-effects or had little knowledge of these medicines. Other reason given by midwives was that the mothers did not inform them that they were using these medicines. This correlates with the finding of Veale, Furman and Oliver (1992:186) that many traditional African women in South Africa use herbal remedies but little research is being done regarding the potential value of these medicines. Traditional African women are also afraid to inform the professional health care personnel that they use herbal medicines because they are afraid of being scolded.

Health education to prepare women for childbirth

* Only nineteen percent of mothers who had not a normal vaginal delivery were well prepared for labour and understood the indication for the surgical intervention. This finding shows that few midwives measured up to Bluff's (1993:30) requirement that the midwife must be a childbirth educator who possesses the skills to assist women and their families (their support persons) to cope with pregnancy, labour, the postpartum period and early parenthood. Most midwives failed to give health education to help mothers to make informed choices regarding maternity practices.

Preferred support person(s)

* Sixty percent (60%) of mothers reported that their husbands were their support persons during hospitalisation but 60,7% midwives indicated differently that mothers preferred support person was their mothers. But the mothers' preferred person (husband) could not attend during labour and delivery because of cultural reason they also indicated they wanted other preferred person(s) like mother, mother-in-law or even sister. This finding correlates with Sengane (1996:6) statement that cultural norms were one of the stumbling blocks that prevent the husband of traditional African woman from attending the birth of their child. Beside cultural norms fathers stated they do not attend the delivery of the child because they think the policy of the hospital does not allow it. The presence of a support person is one of the topics not included in the health education programme.

Pain Relief

* Although most mothers (67,5%) did not prefer analgesics most of the midwives (40,5%) thought that they did. In this study the midwives only gave advice on medicines - other methods of pain relief were not included in the health education programme.

Position during labour

* Most mothers (70,5%) preferred the supine position because they thought that it was the only position allowed in the hospital delivery room. Forty-nine percent of midwives stated that mothers preferred the squatting position; but did not allow them to assume it. This fin-

ding correlates with that of De Jong (1994:5) that the supine position is common practice in the health care setting as it is the most convenient position for both midwives and doctors. None of the mothers in this study indicated that they were given health education on the position for delivery.

Episiotomy

* Seventy-two comma nine percent (72,9%) mothers indicated not preferring to have episitomy as they preferred (not to have an episiotomy and to have a tear) and 65,1% midwives indicated that mothers did not prefer an episitomy (27,7% midwives reported that mothers did not prefer an episiotomy, 18,9% midwives reported that mothers prefer to have their perineum massaged and 18,5% midwives indicated that mothers preferred to have a tear) never the less 26,9% had an episiotomy. Benn (1993:12) found that episiotomies were sometimes performed unnecessarily because the perineum does not always tear. Most midwives are concerned that if an episiotomy is not performed the pelvic floor muscle of the patient may weaken and this leads to a prolapse and incontinence problems later. Information about episitomy is given to a very minimal scale as 8,4% of mothers indicated that they were given information during antenatal period and this was confirmed by 8,54% midwives.

Protective/cleansing practices for mother and child and traditional birth attendants

* Ninety-nine percent of mothers felt uneasy about reporting the need for cleansing or protective cultural practices for them and their babies

after delivery (the only one mother who made such a request had her request granted). Cultural practices for childbirth are not included in the health education programme either because midwives are not conversant with them or know very little about them. Most midwives (75,4%) indicated that there is a need for a traditional birth attendant to be included in the maternity multi-disciplinary team. This finding correlates with Chalmers' (1990:51) statement that traditional birth attendants should be included in the multi-disciplinary team as they provide continuity of care which is often lacking in the western system of maternity care.

5.3 DISCUSSION OF THE CONCLUSIONS

Based on the findings, the following conclusions will be discussed:

5.3.1 THE HEALTH CARE MODEL PRACTISED AND THE TRADITIONAL CULTURAL HEALTH NEEDS OF THE PATIENTS

The dominating health care model practised in South Africa is ethnocentric to western beliefs, values and practices and does not include traditioanl African cultural health care needs of patients. In the light of this and based on the findings of this study that this model does not include the assessment, planning for and fulfilment of the patient's and her family's cultural health needs, it may be assumed that not only professional nurses but most professional health care practitioners negate the most fundamental health care need of the patient and her or his family - namely their cultural values, beliefs and practices. Villarruel (1995:427) states that there are critical gaps to be bridged regarding the effects of culture on patients' and nurses' perceptions in the designing of culturally competent and effective nursing care for members of diverse racial and ethnic groups. Thus, to render holistic care also to

patients with a traditional African orientation, the two health models (western and traditional African) must be combined in all health care settings to fulfill the patients' and their families' cultural health needs.

5.3.2 THE HEALTH CARE MODEL PRACTISED AND THE EDUCATION OF HEALTH CARE PRACTITIONERS

The dominating health care model in South Africa is the western one based on science and technology. The education of all health practitioners (nurses, doctors and all other team members) is based on this model This fact and the findings of this study that the education of midwives regarding cultural congruent nursing care is insufficient, show that it may be assumed that not all professional health care practitioners are sufficiently knowledgeable about the cultural health care their patients need. This situation must be remedied very soon in so far that the education curricula must be changed to include cultural congruent health care. If this is not done, traditional African patients and their families will not receive quality holistic health care now or in the future and professional health care practitioners will remain ignorant about the importance of rendering cultural congruent care.

5.3.3 THE HEALTH CARE MODEL PRACTISED AND LIFE EVENTS SUCH AS PREGNANCY, BIRTH AND CHILD CARE

According to Du Toit and Van Staden (1994:54) the health care models of the western, African and eastern cultures differ vastly. Western medicines emphasises a scientific approach with regard to diagnosis, treatment and rehabilitation. The African and eastern health care model is based on the cultural and religious beliefs and values of the people themselves. Because the western health care model is based on scientific principles and objective data of illness the beliefs/values/norms/views/-practices of people regarding life events such as pregnancy, birth and child care but

the socio-cultural care is excluded. Based on this and the finding that the views of midwives regarding child-bearing differ vastly from those of their patients and that the education of midwives does not include cultural norms/beliefs/values/practices of life events, it may be assumed that goals of care that health practitioners set for patients and the goals patients and their families set for their care also differ. Because of these different goals professional health care practitioners and traditional African patients (including their families) seldom enter into the healthy health practitioner-patient relationship and health care thus becomes dehumanized.

The nursing process is a model of problem-solving and is based on the scientific principles of collecting data regarding the problem (assessment) stating strategies to solve the problem (diagnosing and planning for care), implementation of the strategies and evaluation of the care rendered to establish whether the implemented strategies solved the problem (whether needs were fulfilled). The cultural health care needs of patients are not problems, but beliefs/practices that are congruent in everyday life for all people of the same cultural orientation. In the light of the above and based on the findings that the assessment phase of the nursing process does not cater for the assessment of traditional African health needs it may be assumed that professional health care practitioners - especially professional nurses - will go on negating the cultural health care needs of traditional African patients because the nursing records (forms) accentuate biophysical needs as based on the western health care model of individual patients. In conclusion it may also be said that the nursing care documents will reflect this tendency.

5.3.4 NURSE-PATIENT RELATIONSHIP AND THE CULTURAL WORLD-VIEW OF THE NURSE AND PATIENT

As both the patient and the nurse are human beings, they bring their own cultural world-view to the nurse-patient relationship (Moyle, 1990:14). The nurses' world-

view, according to Smith, Colling, Elander and Latham (1993:205), is a blend of their own cultural orientation and the health/illness orientation prescribed by the dominating health care model underlying nursing education. According to Ntoane (1988:21) nurses tend to negate their own cultural world-view in favour of a cold scientific world-view lacking in humanity at the end of their educational programme. In the light of this and based on the finding that both professional nurses and traditional African patients differ in number of health practices carried out when care is rendered across the cultural orientation borderline; it may be assumed that nurses tend not to enter into the nurse-patient relationship with patients from a different cultural background from their own, keep the patient at arm's length and only meet those needs that can be solved scientifically. To render holistic care to all patients, the two health care models (western and traditional African) must be combined in all health care settings to fulfil the patients' and their families' cultural health needs.

5.4 RECOMMENDATIONS

Based on the discussion of the findings and conclusions, the following recommendations are made:

- The hospital and maternity section policy documents must be reviewed to endorse cultural congruent nursing care. These documents must be revised at least annually or biennially. Cultural practices must also be included in the instruments of the quality assurance programme in nursing care settings (hospitals, clinics and community care programmes). These policies must emphasize the importance of recording of such practices in all nursing care documents.

- The nursing care assessment form must be comprehensive in the sense that it should cover both the physical/biomedical and socio-cultural health needs of the pregnant or lactating mother and her family. All cultural congruent nursing care rendered must be recorded in the nursing care documents.

- The following guide-lines must be followed to enhance cultural congruent nursing care in education and practice:

  * Primary health care must according to Herbst (1996:38) be adopted by the South African Nursing Council as the model to deliver health care in South Africa, as this model includes the varied cultural groups in South Africa and alternative health care approaches.

  * Cultural congruent nursing care must form one of the pillars of the nursing process. By including this particular model, it may be assumed that the cultural health needs of the patients and their families will be assessed, planned for, fulfilled and recorded. It is recommended that the sunrise model of Leininger (See Figure 5.1 on page 132), which depicts how cultural congruent nursing care may be delivered, be accommodated in nursing education and practice as the basic framework for this purpose.

Based on the above, nursing education , nursing practice, and the nurse-patient-relationship need attention to include cultural congruent nursing care.

Nursing education

- All basic and post-basic nursing education curricula must include cultural congruent nrusing practices (theory and practice).

- Nursing education institutions must ascertain that all nursing curricula include comparative cultural congruent nursing care values and practices. The values and practices must focus on both "western" and "non-western/-traditional" cultures and nursing care based on these cultures. All examinations and assignments must include cultural congruent nursing care.

- One of the basic nursing educational goals should be to assist students to accommodate the cultural congruent nursing care model into their own ethnic world-view. This will help them to meet the diverse socio-cultural health needs of their patients and their families.

- Research must be carried out to determine the degree of realization of cultural congruent nursing care in all courses that lead to registration/enrolment as a registered nurse, enrolled nurse and enrolled auxiliary nurse.

Nursing Practice

- All nursing care must be rendered according to the nursing process and a holistic approach must be followed when assessing the patient as patients view health and illness uniquely because of their different beliefs, values, practices and cultural orientations. The rendered nursing care must be reflected in the written nursing care document.

Nurses should not only adhere to the standardized assessment forms/nursing care plans but must also ask patients what they really want. Cultural health care areas must be explored with the patient and his or her family because they will not raise the subject themselves. The nursing care planned and rendered must be in congruence with the patient's health care expectations. When assessing the patient's and family's cultural health needs the following questions should be asked:

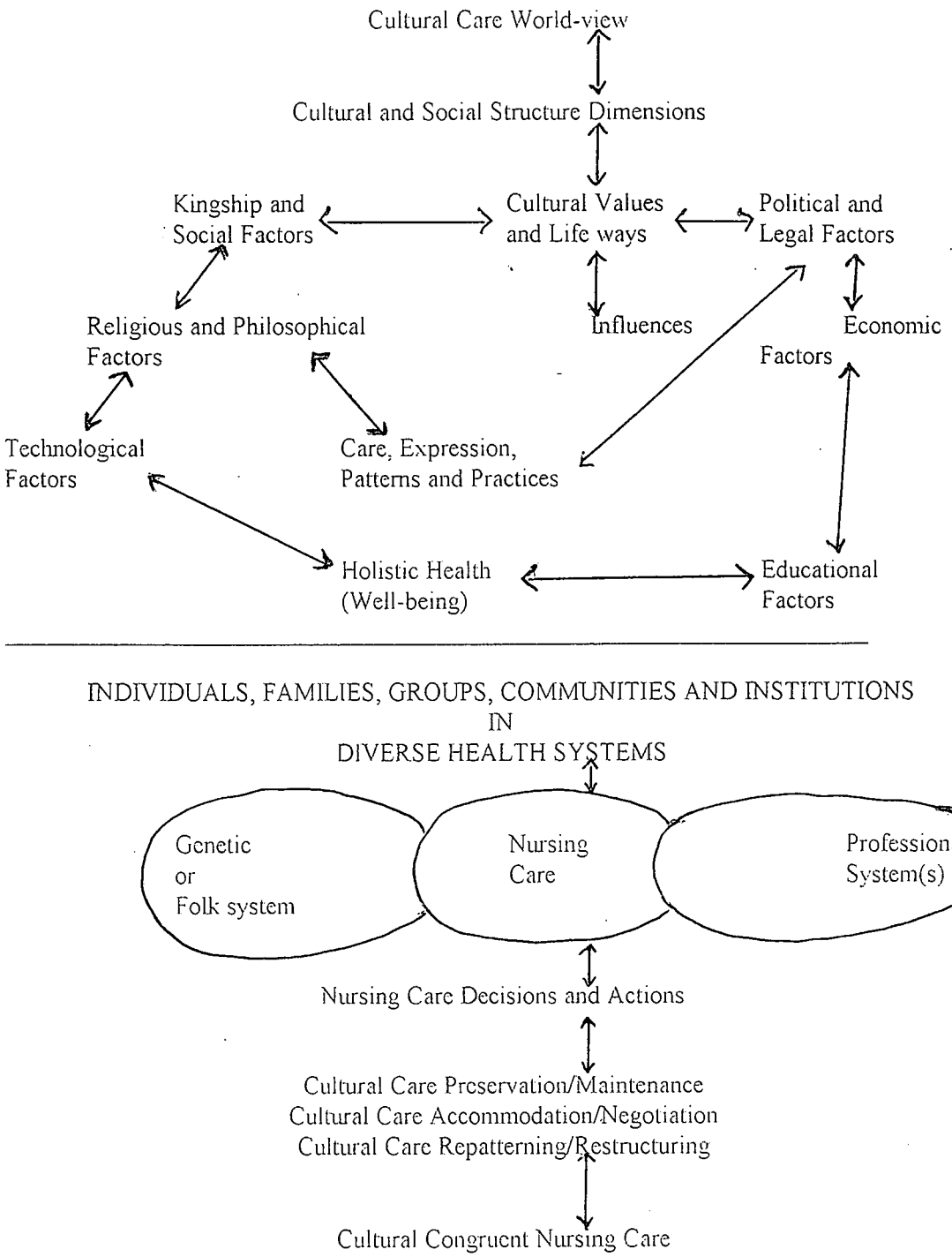

FIGURE 5.1 : LEININGER'S SUNRISE MODEL TO DEPICT THEORY OF CULTURAL CARE DIVERSITY AND UNIVERSALITY

* the patient and family's view of health, illness and treatment according to their cultural orientation;
* who must be involved in the care of the patient (is it a private intimate experience or a societal event); to whom do they turn for help to cope;
* who are the support person(s) during hospitalization;
* what dietary, behavioural restrictions/taboos and/or prescribed protective bands must be included in the nursing care plan;
* what support should be given by the nursing personnel during hospitalization;
* what expectations do the patients and their families have regarding nursing care and what decisions must be abided with by health care practitioners;
* how should pain intervention be handled;
* which comfortable position the patient wishes to adopt during the different stages of labour, and treatment by persons other than the nursing personnel;
* the procedures to be carried out if the patient and the family wish to consult traditional healers, traditional birth attendants and/or traditional healers such as a herbal doctor; and
* the cultural practices to be observed in the health care setting.

The nurse-patient relationship

- The patient's cultural orientation and cultural health needs must be blended with the professional practice of the nurse in order to establish a trusting nurse-patient relationship.

- Nurses must be enabled by their education program to deal with cultural conflict, differences and misunderstanding in the clinical settings when nur-

ses and patients from different cultural orientations meet to enable them to understand one another.

- Patients must be cared for as members of families and communities not as individuals on an island. The family of the patient must therefore be part of the nurse-patient relationship.

In the light of these points it is clear that nurses must be knowledgeable about the patients', the family's and community's language, beliefs, values and cultural practices. Biomedical terminology and procedures must be explained in simple language to patients and there families to avoid misunderstanding and confusion. Patients must be respected by addressing them appropriately and nurses must render holistic nursing care and be available to the patient and her or his family when needed. Nurses and patients must enter into the nurse-patient relationship with the freedom to end the relationship and enter into another relationship with a new nurse/new patient with whom they can bond.

5.5 SUMMARY

In this chapter the findings of the study were highlighted and the conclusions were discussed. Recommendations regarding basic education, clinical practice and the nurse-patient relationship were made to enhance cultural congruent nursing care. The last chapter, will be the conclusion of the whole study.

CHAPTER SIX

THE CONCLUSION OF THE STUDY

The inhabitants of the Republic of South Africa form a multicultural society. The care given in health care institutions is based on the western health care model. This model does not cater for African people who adhere to traditional African culture. Cultural conflict and misunderstanding between patients and nursing staff are common, with uncooperativeness and non-compliance behaviours by patients and stereotyping of patients by nurses.

The purpose of this study was to assess whether professional midwives are knowledgeable and sensitive to the traditional African mothers cultural needs when rendering nursing care. The design was non-experimental and descriptive and exploratory in nature. The survey method was used. The data were obtained by a questionnaire which midwives completed; by conducting a structured interview with pregnant or lactating women and by the auditing of the relevant health care documents (policies and nursing care records). The data of all open-ended questions was analysed according to the method described by Tesch. All data was analysed on a nominal descriptive level.

The study showed that the professional midwives' knowledge and application of cultural orientation practices do not correlate with the care the traditional African mothers expected. This tendency was also reflected in the records as cultural congruent nursing care was not recorded. The problem of the lack of cultural congruent nursing can only be solved if health care educators and managers ensure that cul-

tural congruent care is endorsed in health care education and practice. Nurses (including midwives) and all health care practitioners must be knowledgeable about and sensitive to the cultural health needs of our multicultural society - individuals, their families and communities. Guide-lines for nurse educators, nurse managers and practising nurses were also set. These guide-lines must be followed to prevent the deterioration of the quality of nursing care.

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ADDENDUM A

LETTER FOR PERMISSION FROM THE HEAD OF HEALTH DEPARTMENT

198 Koedoe Road
Fauna
9325 BLOEMFONTEIN
Tel. (051) 421-3051

The Head of Health Department
Lebohang Building
P.O. Box 517
BLOEMFONTEIN

ATTENTION; DR. C. HOUSEHAM

Sir

RESEARCH CONCERNING CULTURAL CONGRUENT NURSING CARE OF BLACK PATIENTS IN THE MATERNITY SECTION OF PUBLIC HOSPITALS IN BLOEMFONTEIN

I am a Masters Social Science (Nursing) degree student at the University of the Free State. To comply with the degree requirements, I have to do a research project. The research project tile is as stated above. This entails questionnaires to be completed by professional nurses and midwives, a structured interview will be conducted with patients and auditing of documents (policy and patients' nursing care documents) at public hospitals in Bloemfontein.

I will have include a copy of the research proposal as well as questionnaire and checklist (data-collecting tools).

I am hereby requesting permission to do the research project at the maternity sections of Pelonomiu and Universitas hospitals.

Hoping my request will receive your favourable attention.

Yours sincerely

A.S. SESING
REGISTERED NURSE

Date:

CONSENT FORM FROM HE HEAD OF HEALTH DEPARTMENT

RESEARCH CONCERNING CULTURAL CONGRUENT NURSING CARE OF BLACK PATIENTS IN THE MATERNITY SECTION OF PUBLIC HOSPITALS IN BLOEMFONTEIN

I hereby declare, with my signature, that I grant permission to researcher as requested, to perform her research in needed capacity required.

Signed in Bloemfontein _____ day of _____ 199....

Hand Signature : _____

Name and Surname : _____

Title holder of signature : _____

Witnesesses : 1. _____

2. _____

ADDENDUM B

LETTER FOR PERMISSION FROM NECESSARY AUTHORITIES OF PUBLIC HOSPITALS IN BLOEMFONTEIN

198 Koedoe Road
Fauna
9325 BLOEMFONTEIN
Tel. (051) 421-3051

Public Hospital
9301 BLOEMFONTEIN

ATTENTION: DEPUTY DIRECTOR: NURSING

Sir/Madam

RESEARCH CONCERNING CULTURAL CONGRUENT NURSING CARE OF BLACK PATIENTS IN THE MATERNITY SECTION OF PUBLIC HOSPITALS IN BLOEMFONTEIN

I am a Masters Social Science (Nursing) degree student at the University of the Free State. To comply with the degree requirements I have to do a research project. The research project title is as stated above. This entails questionnaires to be completed by professional nurses and midwives, a structural interview will be conducted with patients and auditing of documents (policy and patients' nursing care documents) at public hospitals in Bloemfontein.

I have included a copy of the research proposal as well as data collecting tools (questionnaire and checklist).

I hereby request permission to do the research project at the maternity section of your hospital.

Hoping my request will receive your favourable consideration.

Your sincerely

A.S. SESING
REGISTERED NURSE

Date:

CONSENT FORM FROM THE DEPUTY DIRECTOR: NURSING (PUBLIC HOSPITAL)

RESEARCH CONCERNING CULTURAL CONGRUENT NURSING CARE OF BLACK PATIENTS IN THE MATERNITY SECTION OF PUBLIC HOSPITALS IN BLOEMFONTEIN

I hereby declare, with my signature, that I grant permission to researcher as requested, to perform her research in needed capacity required.

Signed in Bloemfontein _____ day of _____199...

Hand Signature : _____

Name and Surname : _____

Title holder of signature : _____

Witnesses : 1. _____

2. _____

ADDENDUM C

LETTER FOR PERMISSION FROM NECESSARY AUTHORITIES OF PUBLIC HOSPITALS IN BLOEMFONTEIN

198 Koedoe Road
Fauna
9325 BLOEMFONTEIN
Tel. (051) 421-3051

Public Hospital
9301 BLOEMFONTEIN

ATTENTION; MATERNITY SECTION'S IN CHARGE

Sir/Madam

RESEARCH CONCERNING CULTURAL CONGRUENT NURSING CARE OF BLACK PATIENTS IN THE MATERNITY SECTION OF PUBLIC HOSPITALS IN BLOEMFONTEIN

I hereby request permission to do research project at your maternity section to use nurses and patients as subjects of my research. I will also like to audit documents (policy and patient nursing care documents).

Privacy, confidentiality and anonymity is guaranteed to the patient, so as the choice of participants. Informed consent will be obtained by letter and researcher's personal with the patient.

Hoping my request will receive your favourable consideration.

Yours sincerely

A.S. SESING
REGISTERED NURSE

Date:

CONSENT FORM FROM THE MATERNITY SECTION'S IN-CHARGE OF THE PUBLIC HOSPITAL IN BLOEMFONTEIN

RESEARCH CONCERNING CULTURAL CONGRUENT NURSING CARE OF BLACK PATIENTS IN THE MATERNITY SECTION OF PUBLIC HOSPITALS IN BLOEMFONTEIN

I hereby declare, with my signature, that I grant permission to researcher as requested, to o perform her research in needed capacity required.

Signed in Bloemfontein _____ day of _____199...

Hand Signature : _____

Name and Surname : _____

Title holder of signature : _____

Witnesses : 1. _____

2. _____

ADDENDUM D

LETTER TO REGISTERED NURSE OR MIDWIFE

198 Koedoe Road
Fauna
9325 BLOEMFONTEIN
Tel. (051) 421-3051

Dear Colleague

I am doing a research project concerning "**Cultural Congruent Nursing Care of Black Patients in the Maternity Section Public Hospitals in Bloemfontein**" to find out the knowledge of registered nurses and midwives concerning the patients' cultural health needs and how are cultural issues incorporated in the nursing care process in the maternity sections. This is to help nurses to create cultural awareness and cultural sensitiveness in their working environment in order to improve nursing care.

As a registered nurse or midwife working in the maternity ward, you are requested to participate in this research project. I would like you to share with me your knowledge of your patients' cultural health needs and how you incorporate cultural health issues in the nursing care you render. I guarantee that as a subject of my research, you will remain at all times totally anonymous i.e., no name or identity required.

A questionnaire will be sent to you so that you can attend to it in the privacy of your own time to ensure confidentiality. Together with the questionnaire there will be an envelope to put a completed questionnaire in and seal it. Please do not discuss your responses with your colleagues because it might influence their responses. Your participation is voluntary and your consent is requested.

Your cooperation is highly appreciated as this is aimed at improving nursing care rendered to patients from multicultural society.

Yours sincerely

_____

A.S. SESING (Miss)
REGISTERED NURSE

Date:

CONSENT FORM FROM THE NURSES IN MATERNITY SECTIONS

RESEARCH CONCERNING CULTURAL CONGRUENT NURSING CARE OF BLACK PATIENTS IN THE MATERNITY SECTION OF PUBLIC HOSPITALS IN BLOEMFONTEIN

I hereby declare, with my signature, that I grant permission to researcher as requested, to perform her research in needed capacity required.

Signed in Bloemfontein _____ day of _____1999...

Hand Signature : _____

Name and Surname : _____

Title holder of signature : _____

Witnesses: 1. _____

2. _____

ADDENDUM E

LETTER TO PATIENTS

198 Koedoe Road
Fauna
9325 BLOEMFONTEIN
Tel: (051) 421-3051

Dear Patient

I am doing a research project concerning "**Cultural Congruent Nursing Care of Black Patients in the Maternity Section Public Hospitals in Bloemfontein**" to find out whether patients' cultural orientations are taken into consideration when care is rendered in the maternity sections. This is done to help nursing personnel to improve the nursing care rendered.

As a patient admitted at maternity ward of one of the public hospitals in Bloemfontein, I would like you to share your experience with me for my research. I guarantee that as a subject of my research, you will remain at all times totally anonymous i.e., no name or identity required. The interview will be conducted in privacy to ensure confidentiality. The participation is voluntary.

Your cooperation will be highly appreciated as it will benefit your and other patients who are cared for across the cultural barrier.

Yours sincerely

_____

A.S. SESING (Miss)

Date:

CONSENT FROM THE PATIENT

I hereby declare my willingness to take part in the research study as has been explained to me.

Signed in Bloemfontein on the _____ day of _____199..

Signature of the patient : _____

Full name and surname : _____

Date : _____

ADDENDUM F

LETTER OF PERMISSION FROM THE ETHICAL COMMITTEE OF THE FACULTY OF HEALTH SCIENES OF THE UNIVERSITY OF THE ORANGE FREE STATE

THE UNIVERSITY OF THE ORANGE FREE STATE

Office of the Director : Administration
Faculty of Health Sciences

✉ 339 BLOEMFONTEIN 9300
☎ (051) 405-3013 / 401-2847
Mrs G Niemand

REPUBLIC OF SOUTH AFRICA
TELEFAX: (051) 4480-967 SA
Tel 4053004

23rd February 1999

Enquiries:

ME AS SESING
198 KOEDOE ROAD
FAUNA
BLOEMFONTEIN
9325

Dear Me Sesing

STUD PROJECT NR. 83/97
PROJECT TITLE: "CULTURAL CONGRUENT NURSING CARE OF BLACK PATIENTS IN THE MATERNITY SECTION OF PUBLIC HOSPITALS IN BLOEMFONTEIN".

During their meeting held on the 23rd February 1999 the Ethics Committee took notice with approval that the title of the project have changed.

Please note that the student project number, i.e. 83/97 have to be quoted in correspondence in the future.

Yours faithfully

for DIRECTOR: MEDICINE ADMINISTRATION.

ADDENDUM G

QUESTIONNAIRE

NURSES

INSTRUCTION

1. Please make a tick (✓) or a cross (X) in the appropriate square ☐ or give a written or typed answer where applicable.

2. Your are requested to please answer all questions honestly. You may answer in English or Afrikaans.

3. The Questionnaire will be delivered to the person in charge of the section/ward and would be collected within seven days.

4. Please be reassured that all information you give in this questionnaire will be treated with strictest confidentiality.

5. Your identity will not be needed in anyway.

6. Your contribution to this project is highly appreciated.

QUESTIONNAIRE - NURSES

SECTION A: BIOGRAPHICAL DATA

1.1 In which Section are you working presently?

Antenatal Clinic	
Antenatal Unit	
Labour Ward	
Postnatal Unit	

1.2 How long have you been working in this Section?

Less than one year	
Two - Three years	
Four - Five years	
More than Five years	

1.3 In what Languages can you communicate with patients at ease?, You can tick more than one.

S.Sotho	
Tswana	
Xhosa	
Zulu	
Other (Specify)	

1.4 For those patients that you cannot communicate with at ease, do you use an interpreter?

Yes	
No	
N/A	

SECTION B: PROFESSIONAL AND NURSING PRACTICE DATA

2.1 During your midwifery training was cultural congruent nursing care taught so that you can care for patients from multicultural society. (Patients with different cultural orientation)

Yes	
No	
Uncertain	

2.2 Is cultural congruent nursing care practiced in your Ward/Section?

Yes	
No	
Uncertain	

2.3 Did you receive any in service education with regard to cultural congruent nursing care after basic nursing education?

Yes	
No	
Uncertain	

2.4 Do the assessment of patients include the patient's cultural nursing care needs?

Yes	
No	
Uncertain	

2.5 Can any traditional practices be incorporated into the nursing care according to patients cultural and time orientations?

Yes	
No	
Uncertain	

2.6 Is the nursing care rendered evaluated to ensure that traditional/cultural practices are incorporated in the nursing process considered?

Yes	
No	
Uncertain	

SECTION C : NURSING CARE RENDERED DURING PREGNANCY, LABOUR AND POSTPARTUM PERIOD (MIDWIFERY PRACTICES)

3.1 How is childbearing viewed by traditional African pregnant/lactating mothers from cultural orientations point of view?

	Yes	No
Normal Physiological Event		
A Wellness Experience		
A Time of Vulnerability		
A Time of Risk		
A State of Illness		

3.2 DOES THE FOLLOWING CULTURAL INFORMATION DURING THE PATIENTS INITIAL AND SUBSEQUENT ASSESSMENT INTERVIEWS COLLECTED?

3.2.1 Who is/are the patients preferred persons during the patients hospitalization and during labour?

	Most	Often	Seldom	Never
Husband				
Mother				
Mother in Law				
Traditional Birth Attendant				
Other (Specify)				

3.2.2 During Antenatal, Labour and Postnatal periods are there any traditional taboos/restrictions like the following reported?

3.2.2.1 Dietary:

Avoid Eating Whilst Standing	
Avoid Drinking Water Whilst Standing	
Avoid Eating Uncrushed Eggs/Boiled Eggs	
Avoid Eating Tendons	
Avoid Eating Traditional Spinach	
Other (Specify	

3.2.2.2 Behavioural:

Don't have to be Angry During Pregnancy	
Avoid Certain Pathways that may Harbour Evil Spirits of Wizards/Witches	
Don't Plait Hair During Pregnancy	
Refrain from Sleeping during the Day	

3.2.2.3 Wearing Protective Bands on the:

Neck	
Wrist	
Abdomen	
Ankle	

3.2.3 Are mothers allowed to use herbal medicines during the following periods?

	Yes	No	Never
Pregnancy			
Labour			
Postpartum			

3.2.4 Motivate your answer? _____

_____

3.2.5 Are mothers given health education about herbal medicines as being used by mothers during pregnancy, labour and postpartum periods?

	Yes	No
Isihlambezo		
Imbelekisane		
Kgaba		
Pitsa		
Castro Oil		
Garlic		
Others (specify)		

3.2.6 Motivate your answer _____

_____

3.2.7 The patients' preferred way of pain intervention

	Yes	No
Use Pain Medication		
Avoid Using Pain Medication		
Massage the Patients Abdomen Warm Oil to Ease the Pain		

3.2.8 The patients' preferred position during labour

	Yes	No
Lateral Position		
Sitting		
Supine		
Squatting		

3.2.9 To make a choice about episiotomy

	Yes	No
Whether to have an Episiotomy		
Not to have an Episiotomy		
Massage the Perineum with Warmed Oil to make it less Liable for Tears		
To have a Tear Rather than an Episiotomy		

3.2.10 The patients' preferred way of disposing a placenta

	Yes	No
According to Hospital Policy		
Take it home and Dispose it according to Traditional/Cultural way (Burial)		

3.2.11 Are mothers allowed any cultural practices they prefer for themselves and their babies to be fulfilled like cleaning/protective rituals?

Yes	
No	

3.2.12 What types of comfort measures were provided during the patient hospitalization, during labour and delivery?

_____

_____

3.3 During childbirth planning/preparation is health education given to mothers according to their cultural beliefs?

Topics	Yes	No	Uncertain
Position of delivery			
Caesarian Section			
Vacuum Extraction			
Forceps Delivery			
Induction			
Episiotomy			

Others (Specify) _____

SECTION D: EVALUATION OF NURSING CARE RENDERED

4.1 Is evaluation done of cultural congruent nursing care rendered in your ward?

Yes	
No	

4.2 Whom do you consult as a resourceful person for cultural knowledge regarding childbirth cultural practices?

Patient/Client	
Family Member	
Community Member	
Traditional Birth Attendant	
Colleagues (Unit Nurses)	
Nurse Administration	
Nurse Educators	
Other Professionals (not Nurse)	

4.3 Are patients involved in the decision making of their nursing care?

Yes	
No	
Uncertain	

4.4 Do you think traditional birth attendant must be involved as a multidisciplinary team member?

Yes	
No	

4.5 How do you experience caring for patient across cultural border?

_____

_____

4.6 Do you think further information is necessary with regard to cultural congruent nursing care to improve your maternity cultural congruent nursing care?

Yes	
No	
Uncertain	

THE END

THANK YOU FOR YOUR PARTICIPATION

ADDENDUM H

QUESTIONNAIRE

PATIENT

SECTION A: PERSONAL DATA

1.1 Present age group (in years)

18 Years and Below	
19 - 28 Years	
29 - 38 Years	
39 Years and Above	

1.2 Subcultural group

South Sotho	
Tswana	
Xhosa	
Zulu	

Other (Specify) _____

1.3 Which other languages are you able to communicate in with ease?

South Sotho	
Tswana	
Xhosa	
Zulu	
English	
Asfrikaans	

Other (Specify) _____

1.4 For languages that you cannot communicate with ease in do you used an interpreter?

Yes	
No	
N/A	

SECTION B: NURSING CARE DURING PREGNANCY, LABOUR AND POSTPARTUM PERIODS

2.1 How do you view childbearing according to your cultural orientation?

A normal life event	
A wellness experience	
A time of vulnerability	
A state of illness	

2.2 WERE YOU ABLE TO GIVE THE UNDERMENTIONED CULTURAL INFORMATION OR ASKED FOR IT DURING THE INITIAL AND SUB-SEQUENT ASSESSMENT INTERVIEW?

2.2.1 Your preferred support person/s during your hospitalization, labour and delivery.

Husband	
Mother	
Mother in Law	
Traditional Birth Attendant	
Other (Specify)	

2.2.2 During antenatal, labour and postnatal periods are there any traditional taboos/restrictions that you have to honour?

2.2.2.1 Dietary

Avoid Eating Whilst Standing	
Avoid Drinking Water Whilst Standing	
Avoid Eating Uncrushed Eggs/Boiled Eggs	
Avoid Eating Tendons	
Avoid Eating Traditional Spinach	
Other (Specify)	

2.2.2.2 How was this respected and incorporated in the care?

_____

_____

2.2.2.3 Behavioural

Don't have to get angry during Pregnancy	
Avoid Certain Pathways that may Harbour Evil Spirit of Wizards/Witches	
Don't Plait Hair during Pregnancy	
Refrain from Sleeping during the Day	

2.2.2.4 Wearing Protective Bands on the:

Neck	
Wrist	
Abdomen	
Ankle	

2.2.2.5 How was this respected and incorporated in the care?

_____

_____

2.2.3 Did you report use of herbal medicines to nurses during:

	Yes	No
Pregnancy		
Labour		
Postpartum		

2.2.4 Herbal Medicines Like:

	Yes	No
Isihlambezo		
Imbelekisane		
Kgaba		
Pitsa		
Castor Oil		
Garlic		
Other (Specify)		

2.2.5 If any of the above mentioned answers in 2.2.3 and 2.2.4 is "Yes" have you reported it to the nurses.

Yes	
No	

2.2.6 If you have not reported to the nurses why?

_____

_____

2.2.7 If you have reported how was it handled and incorporated in the care?

_____

_____

2.2.8 Your preferred way of pain intervention:

	Yes	No
No pain intervention to be used		
Use of pain medication		
Massage the patient's abdomen with warm oil to ease pains		

2.2.9 If you relied on the nurses/doctors what position did you adopt?

2.2.10 Your preferred position during labour?

	Yes	No
Lateral position		
Sitting		
Supine		
Squatting		

2.2.11 Were you able to decide for yourself about?

	Yes	No
Whether to have an Episiotomy		
Not to have episiotomy		
To have a tear than an episiotomy		
Did you have an episiotomy		

2.2.12 Your preferred way of disposing a placenta

	Yes	No
According to Hospital Policy		
Takes it Home and Disposes it According to Traditional/Cultural way (Burial)		
Relied on the nurses decision		

2.2.13 Were you able to request any traditional cultural practices you preferred for yourself and the baby to fulfill?

	Yes	No
Cleansing Rituals		
Protective Rituals		

2.2.14 Motivate your answer

_____

_____

2.2.15 What types of comfort measures were provided during hospitalization, labour and delivery?

_____

_____

2.2.16 Who were allowed at your attendance during second stage of labour and delivery as a support person/s?

Husband	
Mother	
Mother in Law	
Other (Specify)	

2.2.17 If the preferred person could not attend what was the reason, please state:

_____

_____

2.3 During childbirth preparation were you given information according to your cultural orientation about the following?

Position of delivery	Yes	No
Caesarian Section		
Vacuum Extraction		
Forceps Delivery		
Induction		
Episiotomy		
Other (Specify)		

2.4 If you did not have normal delivery were you told indication of the type of delivery you had.

Yes	
No	
N/A	

2.5 If "Yes" did you understand it?

Yes	
No	

SECTION C: PATIENT EXPERIENCE

3.1 Were you asked how would you like your care to be rendered?

Yes	
No	

3.2 Did you like to consult traditional birth attendant during your hospital stay?

Yes	
No	

3.3 If "Yes" how was this handled and incorporated in the nursing care?

_____

_____

3.4 How does it feel to be cared for by an nurse of other cultural orientation than you?

_____

_____

THE END

ADDENDUM I

CHEKCLIST FOR DOCUMENTS

SECTION A: POLICY DOCUMENT

1.1 Does the policy document of the hospital include cultural health issues?

Yes	
No	

1.2 Are the following cultural health issues included in maternity Nursing Care Policy?

	Yes	No
Language preferred by patient for Better Communication		
The Use of Interpreter when Necessary		
The Importance of Preferred Support Person		
The Incorporation of Traditional Taboos in the Nursing Process		
How to Handle Herbalism		
The Incorporation of Traditional Midwifery Practices (Traditional rituals and manipulations)		
Consultation of traditional birth attendants		

1.3 Are the childbirth topics in the policy document communicated to staff member or made available to them? DURING:

	Yes	No
Ward/Section Policy Manual		
In-Service Training		
Ward Meetings		
Professional Meetings		
Other (Specify)		

1.4 Does the ward/section policy accommodate the involvement of the following people in the decision-making in the nursing care plan of the patients:

	Yes	No
Patient herself		
Patient's family members		
Community members		
Traditional birth attendants		
Other (Specify)		

1.5 How often is the policy manual reviewed according to the patient's cultural orientation and time perspective?

	Yes	No
Once a Year		
When Necessary per Request		
Both of the Above		
Not Reviewed at All		

SECTION B: NURSING CARE DOCUMENT

2.1 INFORMATION REGARDING THE PATIENT CULTURAL HEALTH ISSUES AS COLLECTED FROM THE PATIENT DURING ASSESSMENT, BIRTH PLANNING, CARING AND EVALUATION PHASES AND RECORDED IN THE NURSING CARE DOCUMENTS.

2.1.1 The patient's preferred language for communication is recorded in the patient's file.

Yes	
No	

2.1.2 The use of an interpreter when necessary is recorded.

Yes	
No	

2.1.3 The identified support person and her/his particulars are recorded in the patient's file

Husband	
Mother	
Mother-in-Law	
Traditional Birth Attendant	
Other (specify)	

2.1.4 During antenatal, labour and postnatal periods, are there any traditional taboos/restrictions recorded, like:

2.1.4.1 Dietary

	Yes	No
Avoid Eating Whilst Standing		
Avoid Drinking Water Whilst Standing		
Avoid Eating Uncrushed Eggs/Boiled Eggs		
Avoid Eating Tendons		
Avoid Eating Traditional Spinach		
Other (Specify)		

2.1.4.2 Behavioural

Did the patient mention the following and were they recorded?

	Yes	No
Don't plait Hair during Pregnancy		
Don't have to get Angry during Pregnancy		
Avoid certain pathways that may harbour evil spirit of wizards/witches		
Refrain from sleeping during the day		

2.1.4.3 Wearing protective bands on the following is recorded

	Yes	No
Neck		
Wrist		
Abdomen		
Ankle		

2.1.4.4 Was the above-mentioned (2.1.4) taken into consideration during nursing care and how was it recorded?

_____

_____

2.1.5 Is usage of any herbal medicines reported and recorded during pregnancy, labour and postpartum periods like

	Yes	No
Isihlambezo		
Imbelekisane		
Kgaba		
Pitsa		
Castor Oil		
Garlic		
Others (specify)		

2.16 How was this handled and incorporated in the nursing care?

_____

_____

2.1.7 Is the patient preferred way of pain intervention reported and recorded?

	Yes	No
Use pain medication		
Avoid using pain medication		
Massage the patient's abdomen with warm oil to ease pain		

2.1.8 Is the patient's preferred position during labour reported and recorded?

	Yes	No
Lateral position		
Sitting		
Supine		
Squatting		

2.1.9 Are the patient's preferred ways of disposing the placenta documented e.g:

	Yes	No
According to Hospital Policy		
Takes it Home and Disposes it According to Traditional/Cultural way (burial)		

2.1.10 Did mothers report any cultural practices they are to honour during antenatal, intra natal and postnatal periods, and are they recorded?

	Yes	No
Cleansing Rituals		
Protective Rituals		

2.1.11 Is there any record that the mothers liked to consult the traditional birth attendants during antenatal, intra natal and postnatal periods?

Yes	
No	

2.2 Is evaluation done of cultural congruent nursing care rendered:

Yes	
Nó	

THE END

ADDENDUM J

SUMMARY OF THE RESPONSES GIVEN TO OPEN-ENDED QUESTIONS

QUESTIONNAIRE GIVEN TO CONDUCTED MIDWIVES

DIRECT RESPONSES FROM PARTICIPANTS

1. **Why midwives allowed mothers to use herbal medicines during pregnancy, labour and peurperium.**

They gave following reasons:

- to preserve pregnancy to term
- kan nie deur plasenta gaan nie
- it's natural and don't move over the placenta
- to fulfil the wishes of the patient and to protect her from evil events
- to prevent miscarriages
- ease labour
- give a reason that according to their cultural beliefs these medicines (herbs) help the uterus to contract quicker than expected
- they are effective in shortening the period of labour
- bevorder algemene gesondheid, versnel kraamproses en vir geringe ongesteldhede
- hierdie medikasie is gewoontlik deur meeste aptekers goedgekeur bv. Vitaforce ens.
- they prevent evil spirit from befalling the patients and protect them throughout till postpartum period
  they do not interfer with normal development of the foetus and normal labour process
- die moeder kry 'n keuse t.o.v. pynverligting
- daar is geen chemiese middels in nie. Nie alles word toegelaat nie. Kontroleer met apteker of dokter
- to control bleeding and expell clots
- patients believe that after delivery they use herbal medicines in order to clean their inside eg. retained products etc.

2. **Why midwives do not allow mothers to use herbal medicines and not able to give health education regarding herbal medicines.**

Reasons given:

- they are harmful
- I don't have much knowledge of such herbal medicines and their effects during antenatal care
- will interfere with the normal development of the foetus
- they are not good as they are laxatives
- because they (patients) tend not to know how much to take and if they exceed the dosage that may cause problems to both the mother and the baby
- I warned patients during pregnancy, labour and delivery not to use herbal medicines because they hasten labour. If taken during first trimeser they cause foetal abnormalities as they are teratogenic
- Ek ken nie bogenoemde "herbal medicines" maar Garlic is aanvaarbaar asook al die ander natuurlike bnv. Practica Rx
- we actually do not encourage herbals medicines since - Its not part of our daily routine and procedures and we are not well vested in such practices - but the patient has a right to make a choice
- They become dangerous to black people because they use too much strength for one dose
- I never know they existed - Never heard of them!
- Patients never informed me that they are using them. I have never thought of asking about them
- hulle het nie gevra nie!
- Does not have enough knowledge about these to give advice and health education
- to avoid uncalled for complications
- because herbal medicines may counteract with treatment from hospital
- not been treated obstetrically regarding the teratogenic effects they might have on the fetus
- "Herbal medicines" is nie aan my bekend nie, so ek kan nie voorligting gee nie
- medicines not prescribed by doctors can be dangeorus to both mother and foetus
- ons weet nie dat hulle dit wil gebruik nie. Hulle vra nooit uit daaroor nie

- patients are taught to take medication per prescriptions which do not include herbal medicines

3. What are comfort measures provided by midwives during the patient hospitalization, during labour and delivery.

Types of comfort measures

- Reassurance
- Being reassured without specific comfort
- reassurance of the patient by never left alone to relieve tension and anxiety
- massaging and sedation
- massaging the patients bag and administration of sedatives
- rubbing of the back during labour
- health education on mechanism of labour so as to alleviate pain and promote progress of labour
- patient be with close relatives eg. mother or husband
- pyn verlig, pasiënt keuses laat maak, gesels oor baba en haar gevoelens
- they are never left alone when there is enough staff
- empty the bladder and rectum
- support
- allow visitors at all times. Allowed to were their own attire as long as it will not interfere with rendering of nursing care
- non other than bedrest and relaxation programmes during hospitalization. During labour tranquilizers
- inform a patient with each procedure done and her nurse-patient relationship
- well-balanced dieet, infection control prior and post to delivery including the baby
- holding the patient's hand during contractions
- most of the time there is no time for extra comfort measures except routine observations
- comfortable position
- according to patients needs
- physical care
- encouragement, giving prescribed treatment, allaying anxiety, good handling
- during labour - moral support by remaining with the patient throughout labour - offering pain relief medications, massaging the back etc.

- warm bath
- exercises and rest
- docotr's decision eg. pain injection, epidural etc.
- comforting talks
- dit word gedoen in kraamsaal
- empathy
- full bath (warm) post delivery
- care for human

4. Midwives' experiences when caring for patients across cultural border

Expierences expressed:

- It is very difficult and sometimes frustrating, if there is a big cultural gap betweeen yourself and the patient. Some of traditional practices clash with health practices.
- Difficult because hosptial policies were made most by White people.
- It is sometimes impossible and difficult. As some cultures are dangerous and infection is introduced eg. substances applied to cord after delivery cause Tetanus in the newborn
- difficult, because our training didn't include cultural aspects
- it is sometimes difficult to gain cooperation from other patients
- its difficult at times since the patient does not understand some of the procedure eg. in position during labour supine position instead of squatting
- Baie moeilik en soms verstrerend, omdat pasiënte nie wil kommunikeer nie al kan hulle
- Difficult because I am not acquinted to their cultures and beliefs and not understanding them. At times patients deny necessary proceudre
- Soms moeilik a.g.v. verskeidenheid kulture en min kennis van kulture
- More information required to equip personnel
- I learn a lot about cultural matters and other racial cultures other than yourself and broaden your knowledge
- It is challenging though sometimes boring
- Quiet interesting since cultures are so different and you learn a lot from dealing with such experiences
- kulturele aspekte word in ag geneem in verpleegkundige hantering
- Not yet seriously attendant; but it would be nice to treat each accordingly

- It proves to us the importance of uniqueness of an individual
- that enables me to understand othe better and to nurse patient in totality. It enables us to consider patients do's and dont's as long as it does not put the life of the mother and baby in danger
- health education during antenatal care visits builds understanding between the patient and the nurse therefore making the experience an easy task
- nie te moeilik nie ons probeer sover moontlik om hulle te akomodeer
- I have not been exposed to it, but I feel could feel ill at ease
- enables me to be in the best position for quality patient care
- it helps us to adapt to any situation as it arises, improving communication by consulting people with knowledge
- it is a bit difficult as sometimes becasuse of respect to one's culture you find yourself dutybound to abide by some of the patients cultural demands as long as they are not detrimental to both mother and the unborn child's life - but in cases where there is danger to them one has got to sit down and counsel the patient so as to gain her cooperation
- Different, but excited
- Nothing different from other patients, very well, no problems unless I cannot talk the patients language
- It would not be a problem if traditional attenders could be more involved with professionals such that a difference in understanding can be minimized
- I feel very comfortable but it would be helpful if traditional birth attendants are involved they wil be able to refer to health care team and complications can be avoided
- As long as the practice are save for both mother and baby, different ideas are acceptable

STRUCTURED INTERVIEW WITH PREGNANT AND LACTATING WOMEN

1. **Why mothers did not report the use of herbal medicines to midwives**

- I did not report because I was not using them
- I was advised by my family not to say anything to midwives about them (herbal mediciens) they will react badly
- I was afraid I will embarrans myself because not all believe in the use of herbal medicines
- I was of the experience that nurses do not accept the use of herbal medicines
- I did not report because when I reported with the first baby nurses scolded at me and past unnecessary and unacceptable remarks
- Because during health talks regarding medicines expressed a negative attitude toward the use of herbal medicine and strongly discouraged it
- I thought it was not acceptable to hospital and it did not make any differences whether they are reported or not
- I discontinued their use when I was admitted to hospital and thought I will continue with them when discharged
- Not free to discuss with midwives except what they asked
- I was afraid to tell White nurses
- I was not free to tell strangers about my use of herbal medicines as I did not know their cultural background and how will they react
- Nurses did not have same understanding as I did because they just said they are harmful and not beneficial during health talks
- I thought it did not make any difference as I used them without their (midwives) knowledge
- When I talked about the use of herbal medicines midwives did not want listen and they said they knew nothing about those things
- I felt shy to talk about them
- If you have reported how was the nurses discouraged the use of them.

2. **If the mothers have reported the use of herbal medicines how was it handled**

- the nurses said they are harmful not to be taken

- the nurses discouraged their use and said only medicines prescribed by doctors to be used
- some nurses said they have never seen them helping anybody
- nurses said they were used in olden days and they are not to be taken now
- some nurses said if they are to be used, they are rather be used at home not in the hospital.

3. Why mothers preferred support person could not attend during second stage of labour and delivery

- My husband said it was against his culture (African culture)
- My husband said labour ward is not a place for men; but sacred women
- My husband wanted to attend; but he was discouraged by my mother-in-law
- Could not attend because I had an operation nobody (outsider) could attend
- Did not understand the policy how to arrange
- I felt comfortable with (nurses) midwives only
- My husband was away with work duties on the day of delivery
- My husband was not interested
- My boyfriend was not keen for attending reason unknown
- I was not keen for my husband to attend because of cultural background
- I wanted traditional birth attendant I thought she was more relevant, but I understood as if only husbands were allowed
- My boyfriend said it was good for White people
- My sister-in-law was agasint her brother witnessing saying is not a woman
- My mother discouraged me from the idea that my husband should attend saying it is culturally not right. My husband said is good when professionals are there, they know what to do is not necessary for him
- My neighbour discouraged my husband offering herself to come on his behalf (is a place for women trusted by the family)
- My boyfriend was not available during delivery
- I did not arrange as I thougth that preferred support person for midwives was husband only and my husband was not available as we separated
- I wanted my friend to attend; but I thought she won't be allowed
- My husband was discouraged by his friends; as they were laughing about him saying he is no more a Black man
- My husband had his personal reservations and did not attend after arrangements

- My husband wanted to attend; but the baby was premature and he could not take leave that time

4. The comfort measured provided by midwives to mothers during hospitalization

- I saw a nurse when coming to check blood-pressure
- I was given water to bath in the morning then medicines and checked from time to time
- I was checked during intervals when the babies heart was checked
- I was with the nurse when I had storng contractions but after they subsided I was left alone
- I was given bath, meals, water, medicines then checked blood-pressure from time to time
- I was prepared for an operation and the nurse explained why it was done, then I was given an injection
- I was massaged at the back during my second stage of labour
- I was taught how to exercise antenatally and postnatally
- I was allowed visitors of my choice up to first stage of labour only

5. How the mothers felt when cared for by midwives of other cultural orientation than themselves

- satisfied and safe
- comfortable
- restful
- respected
- reassuared
- not satisfied because some midwives were harsh, rude and unfriendly
- not satisfied because I was left alone during labour oftenly and attended only when I called
- I did not know how to express cultural needs because when mentioning these to midwives they laughed at me
- I did not understand instructions given by other midwives
- I felt threatened to call nurses during the night as they did not have time to listen to any stories
- I felt neglected as midwives did not have time to chat and I did not feel free to disucss anything except what they asked

SUMMARY

The inhabitants of the Republic of South Africa form a multicultural society. The care given in health care institutions is based on the western health care model. This model does not cater for traditioanl African people's cultural health care needs. Cultural conflict and misundestanding between patients and nursing staff are common, with uncooperativeness and non-compliance behaviours by patients and stereotyping of patients by nurses.

The purpose of this study was to assess whether midwives are nowledgeable and sensitive to the mothers cultural needs when rendering nursing care. The design was non-experimental and descriptive and exploratory in nature. The survey method was used. The data were obtained by a questionnaire which midwives completed; by conducting a structured interview with pregnant or lactating women and by the auditing of the relevant health care documents (policies and nursing care records). The data of all open-ended questions was analysed according to the method described by Tesch. All data was analysed on a nominal descriptive level.

The study showed that the midwives knowledge and application of cultural orientation practices do not correlate with the care the mothers expected. This tendency was also reflected in the records as cultural congruent nursing care was not recorded. The problem of the lack of cultural congruent nursing can only be solved if health care educators and managers ensure that cultural congruent care is endorsed in health care education and practice. Nurses (including midwives) and all health care practitioners must be knowledgeable about and sensitive to the cultural health needs of our multicultural society - individuals, their families and communities. Guide-lines for nurse educators, nurse manages and pactising nurses were also set. These guide-lines must be followed to prevent the deterioration of the quality of nursing care.

OPSOMMING

Die inwoners van die Republiek van Suid-Afrika is vanaf verskeie kulture afkomstig en toon 'n multikulturele aard. Die gesondheidsorg wat in alle gesondheidsorginstansies gelewer word, is op die westerse gesondheidsorgmodel geskoei. Die westerse gesondheidsorgmodel sluit geen kulturele gesondheidsbehoeftes, soos geopenbaar deur Afrika-etnosentriese bevolkings, in nie. Kulturele konflik en wanbegrip wat gekenmerk word deur geen samewerking tussen pasiënte en praktisyns, die nienakoming van die sorgplan deur pasiënte en die stereotipering van pasiënte deur verpleegkundiges, kom algemeen tussen pasiënte en gesondheidsorg praktisyns voor.

Die doel van die studie was om vas te stel of vroedvroue oor die nodige kennis beskik rakende en sensitief is vir die kulturele gesondheidsbehoeftes van swanger- en lakterende vroue wanneer verpleegsorg verleen word. Die navorsingsontwerp is nie-eksperimenteel met 'n beskrywende en verkennende aard. Die opname-metode is gebruik om die data mee in te samel. Die volgende navorsingstegnieke is gebruik: 'n vraelys is deur die verpleegkundiges voltooi; 'n gestruktureerde onderhoud is met die moeders gevoer en die nodige gesondheidsorgdokumente (beleide en verpleegsorgverslae) is geouditeer. Die verwerking van alle oop-einde vrae is volgens die metode soos deur Tesch beskryf, gedoen. Alle data is op die nominale beskrywende vlak geanaliseer.

Die resultate toon dat daar geen verband bestaan tussen kennis oor verpleegsorgpraktyke rakende kultuur-kongruente verpleging en die verpleegsorg wat pasiënte verwag en kry. Hierdie tendens word ook in die gesondheidsorgdokumente vergestalt daar kultuur-kongruente verpleegsorg nie onderskryf word nie en ook nie aangeteken word nie.

Die problematiek rondom die nie-lewering van kultuur-kongruente verpleegsorg kan slegs opgelos word indien verpleegopvoedkundiges en -bestuurders, kultuur-kongruente verpleging onderskryf en dit in alle verpleegsorg-praktyke en verpleegopvoedingsprogramme inbou en toepas. Derhalwe is die nodige riglyne vir verpleegopvoedkundiges, verpleegbestuurders en verpleegpraktisyns daargestel. Hierdeur is verseker dat alle verpleegkundiges oor die nodige kennis sal beskik en sensitief vir die kulturele gesondheidsorgbehoeftes van ons multi-kulturele samelewing, individue, gesinne en gemeenskappe sal wees. Hierdeur kan verhoed word dat die kwaliteit van verpleegsorg wat verleen word, van 'n swak gehalte sal wees.