

INDIGENOUS PRACTICES REGARDING POSTNATAL CARE AT SIKHUNYANI VILLAGE IN THE LIMPOPO PROVINCE OF SOUTH AFRICA

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ABSTRACT

In South Africa women are discharged from maternity wards 24 hours after normal deliveries. The result is that postnatal care is provided by family members and grandmothers who are often assisted by traditional birth attendants and traditional healers. The purpose of this study was to explore, describe and document the indigenous practices regarding postnatal care. A qualitative, exploratory, descriptive and contextual research approach was used. Study results revealed that traditional birth attendants were concerned about the wellbeing of postnatal women, prevention of complications, maintenance of good nutrition, enhanced wellbeing, exclusion of evil spirits and the resumption of sexual relations. It is recommended that there should be enhanced collaboration between traditional birth attendants and midwives.

Keywords: Indigenous healthcare practices, postnatal care, traditional birth attendants

Introduction

The morbidity and mortality rates among women are high and some of the causes are avoidable (Dennil, King & Swanepoel, 2002:73). A number of serious complications and maternal deaths occur in the postpartum period. Deaths occur during the first week after delivery due to postpartum haemorrhage which occurs within 24 hours after delivery. According to the World Health Organization (WHO 2001) report, it is estimated that reproductive ill health accounts for a third of the total disease burden of women, while postpartum haemorrhage, maternal morbidity and mortality are responsible for a large portion of this figure. The onset of puerperal sepsis is sudden; it often starts a few days after delivery. The temperature rises and the mother becomes seriously ill. With the HIV/AIDS pandemic the risk of postpartum infection has also increased. Many lives are lost during the postpartum period. However, according to the hospital policy in South Africa, patients who have normal deliveries should be discharged within 24 hours after delivery, and those who have delivered through Caesarean section are discharged

on the fifth day after the operation. (Department of Health, 2007:42). There are no follow-up visits by registered midwives to assist the mothers to take care of themselves. Currently, the registered midwives concentrate on in-patients only and discharged postnatal patients are given health education on how to take care of themselves at home. Postnatal women are advised to have adequate rest, avoid lifting heavy objects, and avoid climbing stairs and not to drive a car for up to six weeks post delivery (Sellers, 2005:1576). People who are responsible for the care of these patients at home are family members and grandmothers, often assisted by traditional birth attendants and traditional healers. There is usually conflict of ideas regarding what the grandmothers, traditional birth attendants and traditional healers know about postnatal care. These pose problems and affect the quality of care.

One of the strategies of the implementation of primary health care is a multidisciplinary team approach where the integration of indigenous knowledge and modern health care should take place (Peu, 2001:49). This is also supported by King in Dennil et al. (2002:7), who states that the multidisciplinary team should consist of all people who can assist the community in one way or another towards the improvement of their own health status. The necessity of training traditional birth attendants and traditional healers or integrating them into the health system has been recommended in most studies in South Africa (Peu, 2001:49) but to date no programmes have been put in place. Kyamuhendo (2003:17) states that the clinical causes of maternal deaths are known worldwide. However, less is known about cultural beliefs and practices that are followed during pregnancy, labour and the postpartum period that may also influence the maternal mortality rate in a country.

Traditional birth attendants assisted women in childbirth before the advent of modern medicine. They helped women with pregnancy care, during labour and with postnatal care (Olaleye, 2008:1). They used indigenous practices successfully, preventing postnatal complications such as sepsis and perineal gaping, but there was no documentation of such practices. Based on the fact that postnatal care is rendered at home, the study on which this article is based aimed to explore, describe and document indigenous practices regarding postnatal care to enhance the integration of modern and indigenous health care practices in postnatal care. The maternal mortality rate due to postnatal complications could consequently be reduced. Understanding the methods used by traditional birth attendants and traditional healers would assist midwives to render culturally acceptable and competent care, thus improving quality maternal and child health care services.

The most frequently experienced problems during the postnatal period include perineal pain, puerperal sepsis, postpartum haemorrhage, postpartum blues (depression), fatigue, bowel problems and breast problems (Reid & MacArthur, 2000:25-30; Ngula, 2005:3). Long-term postnatal complications include chronic pain, impaired mobility, damage to the reproductive system and infertility (Nankwanga, 2004:1). This view is supported by Dolea and Stein (2000:3), who assert that "puerperal sepsis is a common pregnancy related condition which can lead to obstetric shock or even death if there are delays in

identifying a rise in temperature”. According to Costello Osrin and Manandhar (2004:3 of 5) postpartum haemorrhage can kill within two hours and there should be community-based interventions to prevent unnecessary postnatal deaths. McIntre, (2003:5 of 11) emphasised that postpartum haemorrhage can be more serious if associated with pre-existing anaemia in HIV- infected women”.

Research design and methods

A qualitative, exploratory, descriptive and contextual research approach was followed. The research was conducted in the context of the people of Sikhunyani village. The population of this study comprised a group of people at Sikhunyani village in the Mopani district who were involved in the care of women during the postnatal period. The inhabitants of Sikhunyani village are people of diverse cultures such as Mozambicans, Sothos, Vendas and Tsonga-speaking people, the latter being the dominant group. The nearest hospital is Nkhensani hospital which is about 15 km from the village. Health care facilities are inadequate since there is no clinic nearby. The nearest clinic is at Ngove, which is about 10 km from Sikhunyani village. The homes of the participants were used as the setting for data collection.

Population

In this study the population of interest comprised the grandmothers, traditional birth attendants and traditional healers who were involved in home deliveries and caring for postnatal patients after discharge from the hospital. Grandmothers were included in this sample as they were the ones who usually sought assistance from the traditional healers and traditional birth attendants.

Sampling method

Snowball sampling was considered a suitable method for this study because no census of the study population existed (Burns & Grove, 2005:350). The researchers started by identifying the grandmothers who, in turn, referred them to the traditional birth attendants and traditional healers who assisted them with the care of postnatal mothers and their babies. In the end a total of six males and 10 females aged between 58 and 70 years were interviewed. Four of the participants were elderly women, six were female traditional birth attendants and six were traditional healers from various cultural backgrounds.

Setting

Data were collected from the participants in their own homes at Sikhunyani village.

Methods of data collection

Unstructured interviews were used to explore and obtain information regarding indigenous practices during postnatal care. The method helped to produce more in-depth information on beliefs, practices and attitudes than could be obtained through

any other data-gathering procedure (Brink, 2002:158). The leading question for the participants during data collection was “what are the indigenous practices regarding postnatal care?” An audiotape was used to record the interviews. The data were collected in Xitsonga and translated into English by the researcher herself who speaks Xitsonga. The translations were later checked by a qualified language practitioner.

Ethical considerations

The researcher presented and verbally defended the research proposal to the Department of Health and Social Development, Limpopo Province. Ethical permission was obtained from the Research Ethics Committee at the University of Pretoria. Permission to conduct the study was obtained from the chief of Sikhunyani village. Written and verbal informed consent was obtained from the participants. The researchers ensured that the participants were not exposed to harm or exploitation by asking questions about their personal views sensitively (Polit & Hungler, 2001:76). The participants decided voluntarily whether to participate in this study or not, without any risk of penalty or prejudicial treatment, to ensure the right to self-determination. The researchers treated all the data provided by the participants confidentially.

Measures to ensure trustworthiness

Credibility

According to Brink (2002) as well as Polit and Beck (2006:332), credibility is achieved when the researcher has enough time to get to know the participants, to build a trusting relationship with them and to set aside deliberately all s/he knows regarding the indigenous practices that are employed during the postnatal care.

In this study, the researchers deliberately set aside all the preconceived ideas they had regarding indigenous practices during postnatal care (Brink, 2002:120). There was a trusting and mutual relationship between the interviewer and the participants during the interview creating an environment in which the participants felt free to express themselves in their own language.

Adequate time was allocated for each participant and the data were collected until there was no more information forthcoming. Peer group review was conducted and feedback on the findings was provided to the participants.

The participants were given information concerning the researcher’s personal particulars, her name and surname, home address, phone numbers (both cell phone and landline) and her qualifications to establish confidence in the researcher’s competence (Polit & Beck, 2006:332).

Dependability

Brink (2002:125) and Polit and Beck (2006:335) define dependability as one of the criteria that are used to establish trustworthiness by having peer researchers perform an audit of the study (Polit & Beck, 2006:335).

Confirmability

According to Brink (2002:125) and Polit and Beck (2006:335), confirmability “guarantees that the findings, conclusions and recommendations are supported by the data and there is an internal agreement between the researcher’s interpretation and the actual evidence”.

To ensure confirmability in this study, the researcher ensured that she, the participants and her peers discussed the collected data and reached agreement that it was meaningful and relevant to the study (Polit & Beck, 2006:336).

Transferability

According to Polit and Beck (2006:336), transferability “is the extent to which the data collected can be generalised or transferred to another setting”. To ensure transferability, the researcher recorded enough information on the audiotape.

Data analysis

As data were in the form of audiotapes, examination of words was conducted instead of numbers (Brink, 2002:192). Data were analysed following the process of data analysis according to Creswell (in De Vos *et al.*; 2002:340).

This method consists of five steps:

The researcher listened to the audiotapes, and transcribed the data from the audiotape. The researcher wrote down any idea that came forward during the transcription. The unstructured interview was used during the analysis of data and thoughts were jotted down as they occurred.

The researcher listed all the topics first; related topics were grouped together in columns and clustered as major topics. Thereafter the topics were coded after referring back to the original transcribed data and coded data according to appropriate segments of the text. After coding, related topics were categorised to reduce the total list.

Discussion of findings

The data were grouped into five main categories (enhanced wellbeing, prevention of complications, maintenance of good nutrition, prohibition of sexual relations, and expertise of traditional birth attendants) and subcategories. Themes were identified and developed to substantiate each category (De Vos *et al.*, 2002:340).

Enhanced wellbeing

It was significant that all the participants were concerned about the physical and emotional wellbeing of the woman during the postnatal period. The participants revealed that during the postnatal period the woman was confined to her room and she

was not allowed to participate in household activities, to enhance her wellbeing. They also emphasised that it was common practice that primigravida were often sent home to recuperate physically under the care of their own mothers and family members. A grandmother said the following:

“I advised the family to isolate the woman and her baby after delivery. The woman is given a chance to rest so that she may regain her energy. Only specified elderly women are allowed to enter the hut. Her sanitary pads must be discarded by herself only, as cruel people can mix them with “muti” before discarding them and as a result she may never fall pregnant again.”

The mother is also restricted from household duties such as washing clothes, cleaning the house and carrying water or wood on her head.

One of the grandmothers said:

“The man’s clothes should be washed properly, so the woman is not allowed to wash her husband’s clothes just after delivery because she is still weak and she will not be able to wash them accordingly.”

She further indicated that:

“The woman is also not allowed to wash her husband’s clothes before she resumes normal menstruation”.

Another grandmother said:

“The woman should not have sex until she stops breastfeeding to avoid killing her husband”.

The mother is also protected from becoming infertile after the birth of the baby. This was indicated by one of the traditional healers as advice to the grandmothers:

“The placenta and the bloodstained cloths and soil, and the soil on which the woman bled are buried behind the hut in a deep pit so that dogs cannot get them as this might result in the woman not conceiving anymore”.

The same findings were reported in studies conducted in Nigeria and Bangladesh where isolating and confining a mother to her room is practised to ensure rest and the emotional well-being of the mother post delivery (Olds, London, Ladewig & Davidson, 2004:1033; Obikeze, 2005:3). On the other hand, Armstrong and Edwards (2004:179) and Cronje and Grobler (2003:108) emphasise that physical activity should be promoted postnatally to enhance good muscle tone. Currie and Develin (in Armstrong & Edwards, 2004:179) also agree with the latter authors by emphasising that exercise is a strategy that can be used to improve blood circulation and the psychological wellbeing of mothers, and that the moods of new mothers are shown to be influenced positively by exercise. However, Olds *et al.* (2004:1033) maintain that in Bangladesh physical activity was believed to

cause problems in uterine involution and healing. It is believed that women who carries heavy loads of wood or buckets of water or do any strenuous work tend to suffer from uterine prolapse. Although postpartum exercise may be recommended it must not be strenuous as the woman is still weak and healing is still taking place.

Prevention of complications

Different methods are used by traditional birth attendants, traditional healers and grandmothers to prevent complications such as postpartum haemorrhage, puerperal sepsis, retention of the placenta, breast problems and pain management.

Postpartum haemorrhage

The traditional birth attendants were able to distinguish between normal postpartum bleeding and postpartum haemorrhage. One of the traditional healers said:

“This bleeding is so severe is like water from a running tap. The cloth or pads used become wet immediately and it starts running down the legs of a woman. This is when you start realising that things are bad”.

Herbal treatments were always ready in case such complications occurred.

Participants indicated that another method that was useful was to use a cloth to tie the woman’s abdomen to prevent bleeding. For example, some traditional birth attendants indicated that:

“I tie a cloth around the woman’s waist; let her lie down on her tummy, and then the womb returns to its normal state and bleeding stops. I then take soil into the hut, ask the woman to sit on it until bleeding stops”.

Another traditional healer said:

“Nowadays we are afraid that women may die, I usually send the woman immediately to the clinic after applying my herbal treatment.”

She further indicated that,

“in order to prevent postpartum haemorrhage I take soil into the hut, order the woman to sit on top of it until bleeding stops”.

To prevent bleeding from the umbilical cord one of the traditional birth attendants said:

“I dress the umbilical cord with an old rag tightly to prevent bleeding”.

Traditional birth attendants knew how to manage haemorrhaging, but needed more education on its dangers to reduce maternal mortality rates. Cooperation between midwives and traditional birth attendants could enable traditional birth attendants

to refer their patients to health-care centres and hospitals if they were experiencing problems, thus reducing the number of maternal deaths.

Puerperal sepsis

Puerperal sepsis is one of the leading causes of maternal deaths in developed and developing countries, although most of the predisposing factors are preventable (Chisele & Say, 2004:3).

In order to prevent puerperal sepsis in indigenous practices, the grandmothers cleaned the hut of the postnatal woman every day. The grandmothers also ensured that the mother had her own basin for bathing, and that the newborn baby was bathed in a separate basin. In that way they were trying to prevent cross infection.

One of the traditional healers said:

“If she is having a sutured episiotomy, I mix salt and water and order the woman to do sitz baths every morning for quick healing of the wound”.

Another traditional healer said:

“If the woman is having a tear, I advise her to clean the wound with warm water and compresses using ‘munywana (young Jew’s mallow)’ for fast healing of the perineal wound”. Munywana is a plant which is boiled, then add salt to form a mixture. Then let it cool a little bit, then dip cloths in the mixture and use it as a warm compresser to the pelvic areas to relieve the afterpains.

One of the grandmothers said:

“I make sure that I clean the hut every morning thoroughly, prepare warm water for the woman to wash herself, on the other hand I will be bathing the infant in a separate basin”.

Another grandmother said:

“I encourage the woman to change the dirty cloth (used pad) regularly so that she does not have bad smell that other postnatal women used to have”.

Another traditional birth attendant said:

“If she had a torn perineum I advise her to sit down and cross her legs for quick healing of the wound. I also advise her to sit on the soil to promote wound healing”.

The Western way of preventing puerperal sepsis includes wearing of masks, scrupulous domestic cleanliness, dust control, and aseptic and antiseptic techniques (Cronje & Grobler, 2003:109).

It is evident that the grandmothers had knowledge and skills for the prevention of sepsis during the postnatal period, but community-based programmes should be put in place to ensure proper supervision of the quality of indigenous postnatal care. The maternal mortality rate due to puerperal sepsis could consequently be reduced (Costello, Osrin & Manandhar, 2004:3 of 5)

Retention of the placenta

Although the birth of the placenta is viewed as part of the third stage of labour in modern medicine, the traditional birth attendants considered it as part of postnatal care. The expertise of traditional birth attendants in managing a retained placenta was described logically. One of the traditional birth attendants expressed the following:

“I encourage the woman to push the placenta out before I cut the cord. If it resists, I boil a slippery green vegetable called ‘dinda’ and give it to her to drink, then the placenta will be expelled”.

Another traditional birth attendant said:

“Once the baby is born I give the woman an empty bottle to blow, this is the quickest method for expulsion of the placenta; she blows continuously until the placenta is expelled”.

Another traditional healer said:

“If the placenta delays to come out, I place the woman on top of the stones used to put the pot when cooking, then I instruct her to cough until the placenta is expelled. If I suspect that the placenta is not complete I use two pieces of reeds as forceps, hold them with two hands and keep saying ‘nqa, nqa. nqa, nqa’ until the retained pieces of placenta are expelled.”

Or *“I prepare herbal treatment called ‘mahurumeje’ (force to push) and give it to the woman to drink, then the placenta will come out”.*

Participants indicated that they waited for the placenta to be expelled before cutting the umbilical cord. In case of a retained placenta they gave medication to induce vomiting. They believed that when the woman vomited the placenta would be expelled automatically. Herbs were also applied externally. Some traditional birth attendants used charms that could be tied around the waist. Other participants indicated that they used manual extraction to remove a retained placenta. In a study conducted in Nigeria traditional birth attendants revealed that methods such as patting the woman’s thighs and hitting at the head and waist of a woman may assist in expelling a retained placenta (Obikeze, 2005:3). According to Olds *et al.* (2004:1023), removal of a retained placenta using fundal pressure is not recommended because it causes discomfort to the woman, damages uterine support and may invert the uterus.

Involution of the uterus

Uterine involution is encouraged by various means, as indicated by the traditional birth attendants:

“I mix salt and ‘munywana (young Jew’s mallow)’ in very warm water and compress the pelvic area until the lochia disappears and the womb goes back inside”.

One of the grandmothers said:

“I tie the woman’s abdomen with an old rag, advise her to lie on her tummy most of the time, until bleeding stops and the uterus returns back to its pregravid state.”

According to Olds *et al.* (2004:1023), in Western postnatal care, the uterus is massaged, the clots are expressed, the woman is advised to lie on her abdomen, and then ergometrine 0, 5 mg is injected intramuscularly.

Management of after-birth pains

On the issue of after-birth pains one of the traditional birth attendants said:

“If she is having after-birth pains, I apply hot compresses to the abdomen.”

“For after-birth pains I boil ‘mukhusu’ (dried indigenous vegetable) and give it to her to drink. This treatment is given until the abdominal pains disappear.”

One of the traditional healers said:

“I use compresses of hot water mixed with salt and ‘munywana (young Jew’s mallow)’ over the pelvic area to reduce after-pains”.

Prevention of breast complications

Breast milk was the only diet given to the newborn baby.

This was evident from the following statements by the grandmother:

“Traditionally the baby should be breastfed until the age of two years”.

She also said that:

“I encourage the woman to express the breast at regular intervals, more especially when the baby is asleep, to prevent formation of breast abscess”.

Breast care was done by providing warm food and drinks. A woman was also encouraged to express her breast. In case of engorged breast, herbs were used. It was indicated that cabbage leaves were also used. They were put on the engorged breast to encourage drainage of milk. Women were also advised to use warm poultices.

The postnatal mother was given special treatment and a special diet to promote lactation and enable her to feed the baby.

The mother was not allowed to have sexual contact while breastfeeding. There was a strong belief that breast milk could be diluted by the seminal fluid. Such breast milk would not have enough nutrients and as a result the baby would suffer from a disease called “lukala”. The description of “lukala” was that it was more or less similar to marasmus (malnourishment) in modern medicine.

Maintenance of good nutrition

The nutritional status of the postnatal woman and her newborn infant was maintained throughout the postnatal period by the indigenous carers, as they prepared special meals, such as “xidlamutana” (warm soft porridge), “murogo” (indigenous vegetable) with ground peanuts, to encourage the production of milk for infant feeding. Maintaining good nutrition was a vital role of the traditional birth attendants and midwives in the management of postnatal women and their newborn babies. The woman was fed with a special meal after giving birth. This was evident from the following statement:

“For breakfast I give her ‘xidlamutana’ (warm finely ground corn soft porridge). For lunch she gets porridge and ‘murogo’ (indigenous vegetable) mixed with ground peanuts and she is not supposed to eat cold food because milk will be decreased and involution will be delayed.”

The grandmother also indicated that:

“The hot soft porridge given to the woman encourages production of milk”, the special diet is given to promote formation of breast milk to feed the newborn baby”.

“It also promotes recovery of the woman after birth.”

The grandmother prepares a special diet when taking care of a postnatal woman to restore blood lost during delivery, to facilitate the healing of wounds, to restore normal bodily functions and to promote milk flow (Obikeze, 2005:2).

This approach is supported by Born and Barron (2005:201-207) who indicate that conditions such as iron deficiency and physiological anaemia, common during the postnatal period, should be treated with dietary modifications such as organ meats, green leafy vegetables, especially kale (type of a cabbage), field greens (Born & Barron, 2005:201-207).

EXPERTISE OF TRADITIONAL BIRTH ATTENDANT

Exclusion of evil spirits.

The traditional birth attendants protected the postnatal woman from evil spirits by isolating the new mother. The isolation usually lasted for four to six weeks. They selected a specific grandmother to take care of the woman during this period. This was evident from the following statements:

“Evil things can come with a crowd of people coming to see the new member of the family.”

“Family members who are sexually active including the father can be too hot for the baby and can cause the umbilical cord to swell and the baby may die”.

“Only the traditional birth attendants and young girls before puberty are allowed to take care of the mother during the postnatal period”.

“I advise the woman not to share the washing basin with the newborn baby. The mother must have her own basin so that the baby’s and her bathing water must never mix. The water is discarded separately”.

The postnatal period was taken as a period of pollution. As a result, the postnatal mother and her newborn baby were isolated to protect them from evil things that might come with a crowd of people. Elderly people and girls before puberty were allowed to enter the hut and take care of the postnatal woman. It was believed that women who were not menstruating were not sexually active; they could therefore not pollute the baby or the mother. The practice of seclusion is supported by Cronje and Grobler (2003:108) who say that the Hindus go to the extent of building a separate temporary hut for delivery and seclusion while Muslims use a kitchen or a separate room. Helman (2002:12) asserts that among the Tamils in Sri Lanka the period lasts thirty days and is accompanied by rituals which purify the house as well as a ritual bath for the mother and the shaving of the child’s head. These practices are threatened by lifestyles, where most people live in nuclear families and the majority of women are working mothers, returning to work after four months. Obikeze (2005:2) and Olds et al. (2004:1032) agree with the practice of isolating the postnatal woman from other family members. However, their view is that isolation of a woman and nursing her in a quiet room may assist in avoiding too many visitors to enable her to have enough time to rest and sleep.

Prohibition of sexual relations

Traditionally, having sex with a breastfeeding woman is forbidden, because it is believed that sexual intercourse could be dangerous to both the baby and the father. The husband is prohibited from sexual relations with the wife before the resumption of her menstruation. This is reflected in the following statements by a grandmother:

*“The man will develop swelling of the testes because he comes into contact with lochia”.
“Sex with a breastfeeding woman causes serious illness to the husband – ‘u werile’
(falling into) - and he can die if he is not treated soon enough.*

“Sexual activity of parents will cause the baby to develop ‘mamerile’ (marasmus)”.

One of the traditional birth attendants said:

*“Sexual intercourse with his wife before the resumption of menstruation is dangerous,
his heat will cause the cord to swell and become septic and the baby will die”.*

When the time comes to resume sexual relations, a traditional healer mixes ‘muti’ which is taken with soft porridge, to prevent pregnancy. In the study conducted by Mulaudzi (2007) among the Vhavhenda it was revealed that postpartum discharges were strongly believed to be infectious. It was widely believed that when a man engaged in sexual intercourse with a woman who had just delivered, he may suffer from weakness and other physical health-related symptoms. To avoid these consequences after delivery, a woman had to move from the main hut and sleep with her mother-in-law who would take care of her. Similarly Olds *et al.* (2004:1035) confirms that “the couples were formerly discouraged from engaging in sexual intercourse until the lochia flow had stopped and the episiotomy had been healed completely”. In a similar study conducted in Ghana by Mill and Anarfi (2002:325), it was revealed that women were encouraged to practise post-delivery sexual abstinence. They further maintained that the practice of separating a woman from the husband was intended to protect men from sexually transmitted infections believed to be caused by lochia (post delivery discharges).

Family planning

Various traditional ways are used to space children, for example the man is encouraged to marry many wives so as to give the breastfeeding wife time to heal and her baby to grow. During this period, the man is at liberty to sleep with his other women where polygamy is practised.

Another traditional healer said:

“Muti (medicine) is wrapped inside the pad with first menstruation after delivery. This is called ‘ximbitana (claypot)’. The woman is advised to bury it in a pit, placing it upside down, and cover the pit with cow dung. The ‘ximbitana (claypot)’ will be kept there until the couple decides to have another baby, when she will dig it out and will fall pregnant.

CONCLUSIONS

This study confirmed that postnatal care was provided effectively at home by the grandmothers, the traditional birth attendants and the traditional healers. The

grandmothers did their best to ensure that the woman was in a good state of health, happy and comfortable during the postnatal period by enhancing her wellbeing. This included keeping her in isolation, discarding sanitary pads properly and not allowing anybody to enter the hut, including the husband, old women and young girls.

They used their expertise, knowledge and skills to enhance the physical and emotional wellbeing of the postnatal woman, to prevent postnatal complications such as postpartum bleeding, to maintain the nutritional status of the postnatal woman and the baby, to delay the resumption of sexual relations and to protect the postnatal woman and the baby by excluding evil spirits.

RECOMMENDATIONS

The Department of Health and Social Development should devise strategies to ensure that there is teamwork between the indigenous and Western postnatal care providers in order to reduce maternal mortality rates caused by avoidable postnatal complications. The midwifery syllabus should be designed in such a way that it also covers the indigenous practices that are employed by traditional birth attendants during the care of postnatal patients. Student midwives should be taught the similarities and differences between indigenous and Western practices when taking care of postnatal patients so that all nurses become familiar with these and to enhance the relationship between traditional birth attendants and registered midwives. The similarities and differences between Western and indigenous practices during the postnatal period should be documented. Registered midwives should provide on-the-job training to traditional birth attendants on a regular basis.

The registered midwives should therefore be familiar with the indigenous practices that are employed during the postnatal period so that they are able to work with the traditional birth attendants as a team to reduce the maternal mortality rate caused by avoidable complications. Nurse educators should be made aware that there is valuable knowledge among traditional birth attendants regarding indigenous practices during the postnatal period, which can be incorporated in the midwifery syllabus for educating student midwives.

Future researchers should further investigate indigenous postnatal practices. Training of traditional birth attendants must be done and midwives must also be trained on cultural practice and methods used by traditional birth attendants and traditional healers to promote collaboration efforts and mutual respect between traditional birth attendants and midwives.

CONCLUDING REMARKS

Traditionally each family has its own traditional healer. The traditional healer is responsible for taking care of family members during crises of illnesses. This is similar to western culture where each family has its own family doctor who is consulted during times of illness.

During preparations for home delivery, the traditional birth attendants ensure that the traditional healer is called so that she assists in case of complications such as retained placenta or post partum haemorrhage. Grandmothers who conduct home deliveries also ensure that they have a traditional healer nearby who assists with the management of complications during and after delivery.

In the case of postnatal women who are discharged from the hospital, they are cared for by specific grandmothers delegated by the family members. They only consult traditional healers when they face challenges or complications.

In South Africa, as a developing country, most women still choose to deliver at home despite the accessibility of hospital services. Ishikawa, Simon and Porter (2002:55-57), confirm that “in developing countries there is poor utilization of hospital services and women are still delivering at home with the help of the traditional birth attendants”. Nevertheless, as indicated earlier, even those who deliver at the hospital are discharged early.

In this study, it was revealed that the grandmothers are responsible for taking care of the postnatal woman immediately after discharge from the hospital. Where there are complications the grandmothers consult the traditional healers for assistance. The traditional birth attendants are responsible for delivering women who still choose an indigenous type of delivery. They also consult the traditional healers if they experience complications before, during or after delivery.

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