



Experiences of women receiving maternal care regarding cultural practices in selected public hospitals in the North West Province, South Africa

Khumoetsile Daphney Shopo^{a,*}, Tinda Rabie^b, Antoinette Du Preez^b, Petra Bester^c

^a North-West University, Potchefstroom Campus, NuMIQ Focus Area, South Africa

^b North-West University, Potchefstroom Campus, School of Nursing Science, NuMIQ Focus Area, South Africa

^c Africa Unit for Transdisciplinary Research, North-West University, Potchefstroom Campus, South Africa

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ABSTRACT

Background: Midwives providing care to a culturally diverse society must know and understand the important cultural practices for women receiving maternal care. On the part of the midwives, balancing an act of respecting cultural beliefs and practices while maintaining the professional standard of care is an art.

Objective: To explore and describe the experiences of women receiving maternal care regarding cultural practices and their perception about midwives providing maternal care.

Method: A phenomenological, qualitative and descriptive design approach was chosen for this study. Women receiving maternal care (antenatal and postpartum) within five public hospitals in the North West Province of South Africa, were purposively sampled. A total of fifty (n = 50) in-depth individual interviews, guided by an interview guide, were conducted in English or Setswana. The interviews were digitally audio-recorded and transcribed verbatim followed by thematic analysis. The independent co-coder also conducted data analysis to enhance rigour.

Findings: Participants described specific self-care practices which are essential to them during the antenatal period. These included restricting movement and social activities, wearing loose clothing, not smoking and attending the antenatal clinic. Important cultural practices included consulting traditional healers for protection against evil spirits throughout the pregnancy journey. The cultural practices in the postnatal period involved using traditional medicines to protect the newborn as well.

Conclusion: The objective of this study was achieved as the women receiving maternal care were able to share their important cultural practices during antenatal care until postnatal period, they further revealed that their cultural practices are not allowed.

1. Introduction

Since the 1980s, there has been extensive research about cultural competence in midwifery, nursing care and education in developed countries, such as the United States of America and Europe, to address racial and ethnic inequities (Prosen, 2015; Shen, 2015; Callister et al., 2011; Vaughn, 2008). The authors are of the opinion that a midwife might have different cultural beliefs and practices to that of the patient. To prevent cultural disagreements, midwives need to be culturally competent and use the culturally based knowledge and skills to benefit the patient. According to Chauke et al. (2015), nurses should listen to their clients, explore and learn about their beliefs and folk practices

regarding childbearing.

It is impossible to ignore the role of Indigenous Knowledge (IK) when exploring the cultural competency of midwives in the South African context. Indigenous knowledge refers to cultural practices and knowledge passed on from generation to generation. Mothiba et al. (2015) define indigenous knowledge as a *set of experiences generated by people living in a specific community, expressed in stories, songs, folklore, proverbs, dances, myths, cultural values, beliefs, rituals, community laws, local language, agricultural practices and curing of diseases by herbs*. Several studies have been conducted about pregnant women's indigenous practices (Mogawane et al., 2015; Ngunyulu, 2014; Ngomane & Mulaudzi, 2012), which supports the role of indigenous knowledge as an alternative to the

* Corresponding author.

E-mail addresses: 16470087@nwu.ac.za (K. Daphney Shopo), Tinda.Rabie@nwu.ac.za (T. Rabie), Antoinette.DuPreez@nwu.ac.za (A. Du Preez), Petra.Bester@nwu.ac.za (P. Bester).

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Western approach to address health problems during pregnancy. A study by Mogawane et al. (2015) conducted in Limpopo Province highlighted the cultural practices that women follow from the antenatal period through delivery and recommended the acknowledgement, respect, and protection of indigenous practices in South Africa (SA). Ngunyulu (2014) supported this sentiment and indicated that indigenous postnatal care practices need to be incorporated into the midwifery healthcare system to improve healthcare quality.

According to the Department of Health (South Africa) (2015), the challenges of the healthcare system, failure of pregnant women to use healthcare facilities, inadequacies of the services and substandard care related to knowledge and skills were identified as the leading causes of maternal deaths. Furthermore, as outlined by Department of Health (South Africa) (2015), home deliveries were discouraged to prevent maternal deaths, regardless of that delivery being carried out by a skilled birth attendant. The AmaSwati women prefer home births to facility-based births as they can practice the squatting position, which they believe enables quicker delivery. Moyer et al. (2013) conducted a literature review on facility-based delivery and maternal, and early neonatal mortality in Sub-Saharan Africa and found that throughout many countries, cultural beliefs and norms may oppose a facility-based delivery. This statement confirms there is no accommodation of cultural beliefs and practices of the women receiving maternal care. Ogu et al. (2016) conducted a study in Nigeria and emphasised that socio-cultural factors are the determinant of whether women will make use of the offered maternal health services. Therefore, disconnection exists between the indigenous and Western approach to maternal healthcare.

The health system in SA focuses on the Western approach to deal with illness and disease, while the indigenous communities define illness and disease based on their cultural and spiritual beliefs (Naidu & Nqila, 2013). These authors also stated that the Western view of health divides illness into somatic, psychological, and psychosomatic categories, which are dissimilar from the indigenous communities' beliefs. While people from Western cultures perceive pregnancy and birth as events to celebrate, this is not the case in the African culture. Naidu and Nqila (2013) confirmed in their study that pregnancy and birth is regarded as highly personal and secret event among the Mpondo ethnic group in the Eastern Cape Province of SA. The cultural beliefs of the Mpondos and other indigenous communities attribute anything that can happen to the pregnancy or the newborn to a spiritual or social causative reason other than to a physiological or biological cause. A midwife working in Eastern Cape, who has a different cultural background, must be culturally sensitive and aware of such beliefs to understand why the patients want to take the placentas home to perform specific rituals after the baby's birth.

Chauke et al. (2015) explored cultural childbearing practices by women from six ethnic groups. Although their sample was not representative of the SA population, the study confirmed the need for midwives to be aware of the beneficial cultural practices and incorporate those into their care. In another study, Mulaudzi et al., (2016) cited an example about pregnant women whose cultural belief was to delay attending antenatal clinics in the first trimester due to fear of being "bewitched," contributing to late bookings and unidentified maternal problems. Consequently, these events patterns could negatively affect patient outcomes. With an overall aim of improving maternal outcomes, this study aimed to explore and describe the experiences of women receiving maternal care regarding the cultural practices and their perception about midwives providing maternal care. The research question posed for the study was – What are the experiences of women receiving maternal care regarding the cultural practices and their perceptions about midwives providing maternal care?

2. Materials and methods

2.1. Study design

This study followed a phenomenological approach using a qualitative descriptive design, which assisted the authors in getting an in-depth and rich understanding of the research topic (Gray et al., 2017).

2.2. Study setting and population

The study setting was public hospitals in North West Province. The population included women in the antenatal and postpartum wards of these hospitals.

2.3. Sample size and selection of sample

Purposive sampling (Bradshaw et al., 2017) was used for both the hospitals and the participants. Five hospitals (N = 19; n = 5) in the North West Province was included, being a combination of large district, regional and tertiary hospitals.

There were fifty (n = 50) participants included in the study. The inclusion criteria were women receiving maternal care must be admitted for more than one day in the maternity units; multigravida because they had knowledge and experience from previous pregnancies; English, Setswana, Afrikaans and/or isiXhosa speaking; willing to give informed consent to participate; 18 years and older. The exclusion criteria included primigravida women because they had no prior experience to explain culturally appropriate care, therefore in the author's opinion not able to provide rich data and women in pain or in active labour.

2.4. Data collection

Data collection occurred between November 2018 and June 2019, it was commenced after ethics approval and approval from provincial DoH and facilities. Informed consent was obtained from participants prior to data collection. A quiet, unoccupied and access controlled room was used to conduct interviews. A digital audio-recorder was used to capture interviews which was later transcribed verbatim as data. The in-depth interviews were in Setswana with most participants, except for two who spoke English. Participants were encouraged to explain their responses further, thus providing clarity on the questions asked. After conducting fifty (n = 50) interviews, data saturation was declared. The interviews lasted for approximately 30 min (see Table 1 for interview guide used).

2.5. Data analysis

The audio recordings were transcribed verbatim immediately after the interviews by an independent transcriptionist; codes were used to indicate participants. Thematic analysis was done using Creswell's generic qualitative analysis approach combined with Tesch's eight steps in the coding process (Creswell, 2014). These included organisation and preparation of data for analysis, developing a general sense, coding all the data, describe and identify themes, representation and interpretation of the data. An independent qualitative researcher, fluent in Setswana, accepted an invitation to be a co-coder. After completing data analysis, there was a consensus discussion to confirm a true reflection of the findings.

2.6. Ethical consideration

The Health Research Ethics Committee at North-West University, South Africa, granted ethical approval (ethical approval number NWU-00067018-S1), and thereafter all the relevant authorities. The North West Provincial Department of Health (NWPDoH) further granted permission for research, and the hospital management of the five

Table 1
Interview guide.

Interview guide
Tell me about your cultural practices that are important when you receive maternal care (antenatal, intrapartum and postpartum)?
How did you experience the care provided by midwives in the hospital in relation to your cultural practices?

hospitals granted permission to access the hospital premises to commence with recruitment. Participation was voluntary, and participants gave both verbal and written consent before conducting the in-depth interviews. Each ward's unit manager provided the researcher with unoccupied, access controlled and quiet rooms to conduct interviews in. No participant gave their name, thereby enhancing anonymity, confidentiality, and privacy. Participants were free to withdraw their participation in interviews at any stage.

To ensure trustworthiness in this study, the researchers applied the five strategies, which include truth-value, applicability, consistency, neutrality and authenticity (Lincoln and Guba in Botma et al., 2010). Bias in this study was prevented by being truthful from conceptualisation phase until report writing.

2.7. Study limitations

The phenomenological approach applied to this study provided experiences of women receiving maternal care in the North West province regarding their important cultural practices and how they perceive the maternal care provided by midwives and their cultural competency. The limitation of the study is that it lacks the generalizability to hospitals outside the province including private hospitals as the contexts are different. Furthermore, the findings of this study cannot be generalized to the entire population in the country, but the study can be replicated in different context by other researchers.

3. Results

3.1. Demographic characteristics

The majority of the participants (n = 26; 52 %) were in the age range of 20–29 years, followed by 21 (n = 21, 42 %) in the age range 30–39 years, two (n = 2; 4 %) were within the age group of 40–49 years, and the youngest participant was 18 years old (n = 1; 2 %). Total number of pregnancies referred to as gravida (Vaidya et al., 2014) indicated most participants were gravida 2 (n = 27; 54 %), followed by gravida 3 (n = 13; 26 %), gravida 4 (n = 6; 12 %), with gravida 5 and 6 having equal representation (n = 2; 4 %). In terms of culture, most of the participants were Batswana (n = 31; 62 %), Basotho and Xhosa culture had equal representation of six (n = 6; 12 %), followed by Zulu (n = 2, 4 %), Afrikaans (n = 1; 2 %) and lastly other cultures (Griqua, Shona, Uganda, Ghana) (n = 4; 8 %).

3.2. Themes and subthemes identified from the participants' data

Four main themes and 15 sub-themes emerged. The four main themes were self-care by a pregnant woman, important cultural practices for diverse women, cultural care of the newborn and perception about maternal care provided (see Table 2).

3.2.1. Theme 1. Self-care by a pregnant woman

The first main theme identified in this study was self-care by pregnant women. The participants confirmed that they were advised to look after themselves and their unborn babies by not drinking alcohol and not smoking, wearing loose clothing, restricting their movements and social activities, and attending antenatal care. The sub-themes are discussed below.

Table 2
Themes and subthemes arising from the participants' data.

Themes	Sub-themes
1. Self-care by a pregnant woman	1.1 Pregnant woman does not drink alcohol and smoke 1.2 Pregnant woman must wear loose clothing 1.3 Restricted movement and social activities 1.4 Attending antenatal clinic
2. Important cultural practices for diverse women	2.1 Protection of pregnancy by traditional healers 2.2 Preventing bad spirits 2.3 Use of herbal medicines 2.4 Abdominal massage during pregnancy 2.5 Lying-in during postnatal period to protect the newborn
3. Cultural care of the newborn	3.1 Isolation until umbilical stump falls off 3.2 Cleaning the umbilical cord 3.3 Prevention of dehydration 3.4 Strengthening the newborn to prevent sickness
4. Perception about maternal care provided	4.1 Cultural practice is not allowed 4.2 Midwives have different approaches to care

3.2.1.1. Subtheme 1.1. Pregnant woman does not drink alcohol and smoke. Participants revealed that they are not supposed to drink alcohol when they are pregnant; they were provided with health education during antenatal clinic visits about the risks of alcohol and smoking to the unborn baby.

When you are pregnant what I believe is that you must take care of yourself. Don't drink, don't smoke, that is very important for the baby's health [Participant 4, 27 years old, Afrikaans].

You don't have to smoke; you don't have to drink alcohol. These are for the beginning [Participant 7, 35 years old, Xhosa].

3.2.1.2. Subtheme 1.2. Pregnant woman must wear loose clothing. Participants expressed how a pregnant woman should dress, as dress code attributed partly to the cultural belief that people will be able to “read” how far the pregnancy is if a woman is wearing tight fitting clothes.

Like the elders say you don't wear tight fitting clothes, like jeans (trouser), t-shirt let's say 'crop top'... I won't wear a crop top while pregnant, isn't it they say those things make you 'exposed'... Again, we grow up being told that these tight things the elders would say....in our culture they believe that people read you, isn't it? [Participant 17, 35 years old, Motswana].

You don't wear trousers because we grow up with the elders teaching us that they (trousers) affect the baby. You must wear loose clothing [Participant 42, 24 years old, Motswana].

You must not wear trousers, wear dresses that are loose so that you are well and the baby comes being alright. [Participant 17, 35 years old, Motswana].

3.2.1.3. Subtheme 1.3. Restricted movement and social activities. Restriction in attendance of social activities during pregnancy, specifically funerals. Some participants, depending on their culture, indicated that when pregnant they should not walk around due to fear that evil spirits will befall them and negatively affect them and their unborn baby.

We don't attend funerals, you don't attend funerals of babies, especially, it is said that you collect bad spirits [Participant 17, 35 years old, Motswana].

They say if you attend funerals when pregnant this affects the baby; it is possible that your baby is stillborn or is born with a disability [Participant 37, 18 years old, Motswana].

They say the danger is that the baby is affected, at the end of the day the baby will have an ulcer called 'seroma' [Participant 2, 38 years old, Motswana].

3.2.1.4. Subtheme 1.4. Attending antenatal clinic. Although participants had cultural practices, such as consulting traditional practitioners in their pregnancy journey, they still viewed antenatal care as an important source of pregnancy-related care.

When you are pregnant you are not supposed to just sit. You must also go and check yourself at the doctors (traditional practitioners), you mustn't only drink pills from the clinic [Participant 48, 28 years old, Motswana].

I start attending clinic, I drink pills, I consult the doctor. Sometimes if there is a problem I go to the traditional practitioner because other things are not the same [Participant 38, 28 years old, Griqua culture].

3.2.2. Theme 2. Important cultural practices for diverse women

The second theme relates to the objective of this study, that was to explore and describe important cultural practices for women receiving maternal care. The analysis of the data revealed five sub-themes – protection of pregnancy by traditional healers, preventing bad spirits, use of herbal medicines, abdominal massage during pregnancy, and lying-in during the postnatal period to protect the newborn. The next section discusses the sub-themes in detail.

3.2.2.1. Subtheme 2.1. Protection of pregnancy by traditional healers.

Some participants mentioned that they consult the traditional practitioners to protect them and their unborn babies during pregnancy until labour.

In the Batswana culture we believe that there are things like 'dikgaba' [bad spirits] and so forth, so you consult someone, or the traditional [Participant 2, 38 years old, Motswana].

The cultural practices I use in antenatal period, there is water, this water is prayed for. The water binds and protect a pregnant woman so that she doesn't get a miscarriage [Participant 29, 29 years old, Motswana].

I put 'sewasho' in the water. There is one that you put in the water and the one you put directly in the mouth; they are different. They serve to prevent evil spirits, so that the baby is always well [Participant 35, 25 years old, Mosotho].

She pours her things in the water; I don't know what. But normally the father of my baby is the one who brings it [water] [Participant 33, 26 years old, Shona].

3.2.2.2. Subtheme 2.2. Preventing bad spirits. Some participants mentioned that during pregnancy there are beliefs that people who do not like them or have grudges against them can wish them and their unborn babies' harm. Participants also attribute this to witchcraft, with the consequences being that one experiences either a miscarriage, prolonged or difficult labour. Others mentioned that having 'dikgaba,' in other words 'bad spirits,' might lead to a woman being post-dated until 10 months and end up giving birth through caesarian section. Participants used the term 'dikgaba' because of evil spirits cast by other people who have ill-wishes for the pregnancy.

Kgaba is...in most instances people can hold grudges, yes, that is what causes kgaba. You'll find that you were not supposed to give birth through operation, but you'll end up giving birth by operation because of kgaba [Participant 1, 35 years old, Motswana].

There is this thing...In Setswana culture there is something called witchcraft or 'dikgaba'. When a person has cast 'dikgaba' on you it means there is an evil spirit and you end up having miscarriage or they do something which will make you have miscarriage [Participant 29, 29 years old, Motswana].

I don't know how to explain it... Kgaba is like when a person wishes bad things for your pregnancy, that you don't get help in time [Participant 3, 28

years old, Motswana].

3.2.2.3. Subtheme 2.3. Use of herbal medicines. Participants revealed they use herbal medicines as part of their cultural practices to protect themselves and the unborn babies, and to ensure they have an uncomplicated labour. Several types of traditional medicines used during pregnancy and labour include 'kgaba,' ostrich egg (lee la nchwe), baboons' urine (Moroto wa tshwene) and Vimbela, which is an ointment bought from muthi shops. The participants use these in conjunction with attending the antenatal clinic.

In our country like the culture, we are using when we are there, that means when you are pregnant they are giving you medicine, herbal medicine... [Participant 28, 34 years old, Uganda].

Yes, they prepare it for you with water, you drink it and throw the cup away behind you. You don't look back after drinking it [Participant 19, 23 years old, Motswana].

That is when you take that 'kgaba' (medicine) and throw it behind you and don't look back.... Yes, it means that according to our belief if you look back then you are taking it back again [Participant 29, 29 years old, Motswana].

3.2.2.4. Subtheme 2.4. Abdominal massage during pregnancy. The importance of massaging around the abdomen during pregnancy is another cultural practice reported by some participants. They believed there was a specific period when the baby must turn so that the head is the presenting part. The traditional healers or elderly experienced women (traditional birth attendants) massage the abdomen to assist the baby to assume a 'normal' birthing position, to prevent a woman from having to give birth through an operation, attributed to the babies who are breech presentations or transverse lie who are born by caesarian section.

There is someone who knows how to massage pregnant women, like...in the village or elders know her. A person knows that with a pregnant woman you can touch which areas and not touch which areas is the one you ask to come and massage you. Not everyone can massage a pregnant woman [Participant 21, 23 years old, Motswana].

Yes, the baby would have shifted in position, that's why some people end up having operations, it is because they were not massaged [Participant 24, 24 years old, Motswana].

I had a problem of... like when I'm pregnant I vomit too much. So, people believed that the baby is not positioned correctly. So, when these women massage you, they place him in a correct position [Participant 31, 36 years old, Motswana].

3.2.2.5. Subtheme 2.5. Lying-in during postnatal period to protect the newborn. Importance of lying-in during postnatal period emerged, lying-in varies from 10 days to 3 months (or longer) for both the mother and newborn baby. Staying in the house with the newborn baby was to protect the baby from bad spirits, which have potential to make them ill. The mother is expected to stay in the house and sleep in a prone position after having a vaginal delivery, because this position helps the woman's uterus to return to a pre-pregnancy state; however, women who gave birth via caesarean section are not expected to sleep in a prone position. The baby's isolation is to prevent infections and due to their vulnerability, they are strictly isolated until the umbilical cord falls off.

After giving birth there is lying-in whereby, we are taught to respect that period. You just remain indoors; you are kept there [Participant 42, 24 years old, Motswana].

10 days is for staying in the bedroom you don't go outside, that 10 days is for you. The baby will stay for 3 months [Participant 12, 33 years old, Motswana].

3.2.3. Theme 3: Cultural care of the newborn

Cultural care of the newborn emerged as the third theme in this study. The theme was supported by four sub-themes – isolation until the

umbilical stump falls off, cleaning the umbilical cord, prevention of dehydration and strengthening the newborn to prevent sickness. The participants revealed that an important cultural practice is how they care for the newborn to prevent bad spirits as well as illnesses relating to a newborn being around too many people. These discussion of these sub-themes follows.

3.2.3.1. Subtheme 3.1. Isolation until umbilical stump falls off. The newborn is vulnerable to infections and the most important preventive measure they use is isolation of the mother and newborn. Young girls who are having menstrual periods or who engage in sexual intercourse apparently delays the baby's umbilical cord from falling and thus not allowed in the bedroom. Therefore, elderly women, such as mothers-in-law or grandmothers, take care of the woman and newborn during the postpartum period.

Its' just that we are fearing for them or we respect them I don't know. Not everyone comes into the house until a certain time the parent would have said maybe for a month no one must enter the house or that bedroom [Participant 21, 23 years old, Motswana].

So, if someone is looking after you during confinement period, and they are menstruating, they don't just hold the baby [Participant 41, 38 years old, Zulu].

3.2.3.2. Subtheme 3.2 Cleaning the umbilical cord. Participants receive health education on care of the umbilical cord and encouraged to use surgical spirit to clean it. Some participants only use surgical spirit to clean the umbilical cord, while others revealed they follow cultural practices, as advised by the elders. These substances included ashes mixed with Vaseline ointment (called mogato in Setswana), snuff (tobacco product, in dry or moist form, inhaled or put between the cheek and the gums).

For the baby on the umbilical cord, you apply the spirit that they give you at the clinic [Participant 1, 35 years old, Motswana].

Yes, it (snuff) dries up the baby's umbilical cord, after drying up it falls off. Spirit also works, yes? But the snuff is fast [Participant 46, 25 years old, Motswana].

Mogato is said to be something like ashes, you mix with Vaseline and then apply on the umbilical cord so that it can fall off [Participant 30, 30 years old, Motswana].

Mogato is like on the pots when you have cooked outside in a black pot they take the soot on the outside of the pot, they mix that with sunlight and makes it watery and apply on the umbilicus, it doesn't take long to fall off [Participant 23, 38 years old, Motswana].

3.2.3.3. Subtheme 3.3 Prevention of dehydration. Some, not all participants revealed that some newborn illnesses are not treatable at hospital, and they immediately take the newborn to the traditional healers. The most common illness was dehydration, which the participants referred to as 'phogwana' ritual.

I don't use cultural things like I said at the beginning. After.... I don't believe in doing a ritual for 'phogwana' for my baby [Participant 21, 23 years old, Motswana].

After giving birth, according to Setswana culture, my mother took my firstborn baby to a traditional healer for 'phogwana' ritual [Participant 9, 26 years old, Motswana].

Phogwana in western they say it is dehydration in Setswana, the baby's eyes are sunken, and the fontanelle is sunken [Participant 2, 38 years old, Motswana].

3.2.3.4. Subtheme 3.4 Strengthening the newborn to prevent sickness. Some participants mentioned that the traditional healers give the newborn certain herbal medicines to take for a few days to months to strengthen and prevent illnesses. The medicines are used to prevent bad spirits from affecting the newborn.

There is a belief that newborn babies have certain parts of their bodies that

are not strong enough like the fontanelles. So, it is (giving herbal medicines) to make those body parts strong, like sometimes the baby's neck takes long to balance...So it is to improve growth of the baby and make him strong [Participant 3, 28 years, Motswana].

There is 'ditantanyane', something that is dug out called ditantanyane. That medicine is given to the baby [Participant 17, 35 years old, Motswana].

Ditantanyane is the medicine that helps the baby to be strong [Participant 25, 37 years, Motswana].

3.2.4. Theme 4. Perception about maternal care provided

Participants shared their perception regarding the maternal care provided and this was identified as the last theme. Childbirth is a very special period for women and they have specific expectations in terms of the care provided by midwives. Two sub-themes emerged, namely, participants indicated that cultural practice is not allowed, and secondly midwives have different approaches to care. The sub-themes are discussed in the following sections.

3.2.4.1. Subtheme 4.1 Cultural practice is not allowed. Some participants explained that the hospitals do not allow cultural practices because they only support a western approach. Participants believed that because their cultural practices were not accommodated, they decided not to inform the midwives that they had taken some traditional medicines before coming to the hospital.

It is not right because sometimes when you give birth, you must explain to the nurse that "nurse I must do 123 before giving birth", she doesn't listen. "Hey come, come", you see? And even when you see that here I am going to give birth normally, if you can explain to the nurse that I must do 123 so that I can give birth, she will say come and give birth, and you end up going for c/section. The reason being the things that you must use before [Participant 44, 23 years old, Mosotho].

... I can say according to me they don't take it [cultural practices] serious that much. They are just focus on Western things than cultural [Participant 3, 28 years old, Motswana].

We really don't use our culture in hospital, they don't allow it [Participant 25, 37 years old, Motswana].

3.2.4.2. Subtheme 4.2 Midwives have different approaches to care. Participants mentioned that midwives assisted them with good and caring maternal care, and although midwives do not condone the use of certain cultural practices in the hospital, they were caring.

It is not the same, but their care is good [Participant 19, 23 years old, Motswana].

I didn't experience any problem, they were good to me [Participant 32, 41 years old, Xhosa].

4. Discussion

This study aimed to explore and describe the experiences of women receiving maternal care regarding the cultural practices and their perception about midwives providing maternal care in public hospitals in the NWP. Participants mentioned they must look after themselves by not drinking alcohol, wearing loose clothing, restricting their movements including attending funerals, and the importance of attending antenatal clinics. Several studies supported that women should abstain from using alcohol while pregnant (Peltzer & Pengpid, 2019; Watt et al., 2017; Williams et al., 2014). The importance of wearing loose clothing during pregnancy was because other people might bewitch them; the belief was that people can estimate a women's gestational age when wearing tight clothes and can thus cause harm to their unborn baby. Other studies supported this finding that jealous people could affect others by using witchcraft (Chimatiro et al., 2018; M'soka et al., 2015; Ngomane & Mulaudzi, 2012).

Restriction on the attendance of funerals is due to a cultural belief

that the woman is exposed to bad spirits and that have a potential to cause prolonged labour, miscarriage, and/or foetal death; Liamputtong et al. (2005) and Lau (2012) support this finding in the literature. Other cultural practices found included the protection of pregnancy by traditional healers, preventing 'dikgaba' (bad spirits), use of herbal medicines, abdominal massage during pregnancy and lying-in postnatal to protect the newborn. Few participants indicated a strong religious belief and consultation of religious healers for holy water, and there is a shared sentiment of protecting the pregnancy. There was no literature found regarding the benefits of pregnancy for women who received an abdominal massage in their antenatal period, which is a unique finding considering that literature is very limited in terms of abdominal massage during pregnancy. Adokiye et al. (2016) concluded that practices with no statistical evidence-based benefits to the mother and unborn baby should be discouraged and health education provided.

There should be respect and acknowledgement of the women's cultural beliefs by midwives when rendering maternal care, as well as understanding that consulting traditional healers during pregnancy, labour and postpartum is still part of their cultural practices (Mothiba et al., 2015; Chauke et al., 2015; Van der Kooi & Theobald, 2006; Ngomane & Mulaudzi, 2012). Musie et al. (2022) concluded in their study that culturally appropriate care is not rendered in maternity units due to organisational culture and midwives' personal beliefs. However, there is limited knowledge about how cultural beliefs and practices can influence maternal morbidity and mortality in South Africa (Ngunyulu & Mulaudzi, 2009). Cultural care of the newborn important to women in this current study included isolation until the umbilical cord falls off, application of surgical spirit and/or substances such as 'mogato' (ashes mixed with Vaseline ointment) and/or snuff and prevention of dehydration through the 'phogwana' ritual and 'ditantanyane', a herbal medication to strengthen the newborn. Mashile et al. (2019) explored the use of herbal plants for maternal-health problems and confirmed that Mapulana babies receive traditional medicine for sunken fontanelle, known as 'phogwana' in the Batswana culture. However, a unique finding in this study is the strengthening of newborn babies against sickness by using 'ditantanyane.' However, it is important to note that the use of 'ditantanyane,' with regard to its safety and efficacy, should be explored.

After discharge from hospital, elderly women or grandmothers usually care for the newborn and mother, which is known as the cultural practice of lying-in during postnatal period. Reshma and Sujatha (2014) are of the opinion that reduction in neonatal mortality may depend greatly on the interventions involving promotion or adaptation of traditional care behaviours at home. The practice of lying-in and isolating the newborn and woman is an important cultural intervention, as it serves to isolate a vulnerable newborn from infection.

This study found that midwives did not allow women's cultural practices and different approaches to care, as the public hospitals in the NWP in South Africa supported a western, biomedical approach. As a result, there is a perception that midwives providing maternal care are lacking cultural competency. Recent study conducted by Mantula et al. (2023) also found that women in Zimbabwe perceived the midwives to be lacking cultural competence during intrapartum care. However, it is important that cultural competence in healthcare includes sensitivity to the role traditional medicine plays in a client's life (Chauke et al., 2015). The hospitals as employer as well as the Department of Health need to provide midwives with the tools to accommodate the safe cultural practices that are important to women receiving maternal care, as this practice is not generally known; this is especially true in South Africa with its diverse populations. The focus should be to work towards reducing maternal mortality, and the promotion of women's rights is in a respectful and ethical manner to provide culturally competent healthcare (Miller & McLoughlin, 2014). Women receiving maternal care experienced good care. This is in line with the National Strategy for maternity services, which includes quality of care, and the healthcare workers should demonstrate respect and a genuine interest in their

clients, and avoid an arrogant, rude, or judgmental attitude (Department of Health (South Africa), 2015). The strategy further explains that this applied to perceived unsafe practices of certain pregnant women. The midwives, therefore, have the responsibility to care for women receiving maternal care within an environment that respects and accommodates their cultural practices. Esienumoh et al. (2016) support the statement that to create a positive impact on maternal care, midwives and other healthcare providers must deliberately and willingly seek to understand the cultural values and practices of their clients.

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CRediT authorship contribution statement

Khumoetsile Daphney Shopo: Conceptualisation, Methodology, Data collection, Data analysis, Writing – review & editing. **Tinda Rabie:** Conceptualisation, Methodology, Writing – review & editing. **Antoinette Du Preez:** Conceptualisation, Methodology, Writing – review & editing. **Petra Bester:** Writing – review & editing.

Declaration of competing interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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References

- Adokiye, E. A., Isioma, A. J., & Levi, W. O. (2016). Influence of culturally-based abdominal massage and antenatal care uptake among pregnant women in a tertiary hospital in Southern Nigeria. *Journal of Advances in Medicine and Medical Research*, 18(6), 1–9. <https://doi.org/10.9734/BJMMR/2016/27109>
- Bradshaw, C., Atkinson, S., & Doody, O. (2017). Employing a qualitative description approach in health care research. *Qualitative Global Nursing Research*, 4, 1–8. <https://doi.org/10.1177/2333393617742282>
- Callister, L. C., Eads, M. N., & Diehl, J. P. S. Y. (2011). Perceptions of giving birth and adherence to cultural practices in Chinese women. *The American Journal of Maternal/child Nursing*, 36(6), 387–394.
- Chauke, M. E., Matlakala, M. C., & Mokoena, J. D. (2015). Folk practices regarding childbearing. *South African Journal for Folklore Studies*, 25(1), 23–33.
- Chimatiro, C. S., Hajison, P., Chipeta, E., & Muula, A. S. (2018). Understanding barriers preventing pregnant women from starting antenatal clinic in the first trimester of pregnancy in Ntcheu District-Malawi. *Reproductive Health*, 15, 158. <https://doi.org/10.1186/s12978-018-0605-5>
- Creswell, J. W. (2014). *Research design: Qualitative, quantitative, and mixed methods approaches* (4th ed.). California: Sage Publications.
- Department of Health (South Africa). (2015). *Guidelines for maternity care in South Africa: A manual for clinics, community health centres and district hospitals* (4th ed.). Pretoria: Government printers.
- Esienumoh, E. E., Akpabio, I. I., Etowa, J. B., Allotey, J., & Waterman, H. (2016). Cultural diversity in childbirth practices of a rural community in Southern Nigeria. *Journal of Pregnancy and Child Health*, 3, 280. <https://doi.org/10.4172/2376-127X.1000280>
- Gray, J. R., Grove, S. K., & Sutherland, S. (2017). *Burns and Grove's the practice of nursing research: Appraisal, synthesis, and generation of evidence* (8th ed.). St Louis, Missouri: Elsevier.
- Lau, Y. (2012). Traditional Chinese pregnancy restrictions, health-related quality of life and perceived stress among pregnant women in Macao, China. *Asian Nursing Research*, 6, 27–34.
- Liamputtong, P., Yimam, S., Parisunyakul, S., Baosoung, C., & Sansiripun. (2005). Traditional beliefs about pregnancy and child birth among women from Chiang Mai, Northern Thailand. *Midwifery*, 21, 139–153.
- Mantula, F., Chamisa, J. A., Nunu, W. N., & Nyangongo, P. S. (2023). Women's perspectives on cultural sensitivity of midwives during intrapartum care at a

- maternity ward in a National Referral Hospital in Zimbabwe. *SAGE Open Nursing*, 9, 1–12.
- Mashile, S. P., Tshisikhawe, M. P., & Masevhe, N. A. (2019). Medicinal plants used in the treatment of maternal health-related problems by the Mapulana of Ehlanzeni District, Mpumalanga Province, South Africa. *Journal of Applied Pharmaceutical Science*, 9(12), 021–029.
- Miller, K., & McLoughlin, M. (2014). Comparison between an independent midwifery program and a district hospital in rural Tanzania: Observations regarding the treatment of female patients. *Health Care for Women International*, 35, 808–817.
- Mogawane, M. A., Mothiba, T. M., & Malema, R. N. (2015). Indigenous practices of pregnant women at Dilokong hospital in Limpopo Province, South Africa. *Curationis*, 38(2), 1–8.
- Mothiba, T. M., Davhana-Maselesele, M., & Lebesse, R. T. (2015). Assessment of indigenous knowledge and practices during pregnancy, labour and delivery in selected villages of the Limpopo Province, South Africa. *Journal of Human Ecology*, 51(1,2), 80–89.
- Moyer, C. A., Dako-Gyeke, P., & Adanu, R. M. (2013). Facility-based delivery and maternal and early neonatal mortality in sub-Saharan Africa: A regional review of literature. *African Journal of Reproductive Health*, 17(3), 30–43.
- M'soka, N. C., Mabuza, L. H., & Pretorius, D. (2015). Cultural and health beliefs of pregnant women in Zambia regarding pregnancy and child birth. *Curationis*, 38(1). <https://doi.org/10.4102/curationis.v38i1.1232>
- Mulaudzi, F. M., Phiri, S. S., Peu, D. M., Mataboge, M. L. S., Ngunyulu, N. R., & Mogale, R. S. (2016). Challenges experienced by South Africa in attaining Millennium Development Goals 4, 5 and 6. *African Journal of Primary Health Care & Family Medicine*, 8(2).
- Musie, M. R., Peu, M. D., & Bhana-Pema, V. (2022). Culturally appropriate care to support maternal positions during the second stage of labour: Midwives' perspectives in South Africa. *African Journal of Primary Health Care & Family Medicine*, 14(1).
- Naidu, M., & Nqila, K. (2013). Indigenous mothers: An ethnographic study of using the environment during pregnancy. *Journal of Human Ecology*, 7(2), 127–135.
- Ngomane, S., & Mulaudzi, F. M. (2012). Indigenous beliefs and practices that influence the delayed attendance of antenatal clinics by women in Bohlabele district in Limpopo, South Africa. *Midwifery*, 28, 30–38.
- Ngunyulu, R. N., & Mulaudzi, F. M. (2009). Indigenous practices regarding postnatal care at Sikhunyani village in the Limpopo Province of South Africa. *Africa Journal of Nursing and Midwifery*, 11(1), 48–64.
- Ngunyulu, R. N. (2014). The experiences of postnatal patients regarding postnatal care in Mopani district, Limpopo Province, South Africa. *Africa Journal for Physical, Health Education, Recreation and Dance (AJPHERD)*, 20(2:2), 685–697.
- Ogu, R. N., Agholor, K. N., & Okonofua, F. E. (2016). Engendering the attainment of the SDG-3 in Africa: Overcoming the socio-cultural factors contributing to maternal mortality. *African Journal of Reproductive Health*, 20(3), 62–74.
- Peltzer, K., & Pengpid, S. (2019). Maternal alcohol use during pregnancy in a general national population in South Africa. *South African Journal of Psychiatry*, 25. <https://doi.org/10.4102/sajpsychiatry.v25i0.1236>
- Prosen, M. (2015). Introducing transcultural nursing education: Implementation of transcultural nursing in the postgraduate nursing curriculum. *Procedia – Social and Behavioural Sciences*, 174, 149–155.
- Reshma, & Sujatha, R. (2014). Cultural practices and beliefs on newborn care among mothers in a selected hospital of Mangalore Taluk. *Nitte University Journal of Health Sciences*, 4(2), 21–26.
- Shen, Z. (2015). Cultural competence models and cultural competence assessment instruments in nursing: A literature review. *Journal of Transcultural Nursing*, 26(3), 308–321.
- Vaidya, D., Bennett, W. L., Sibley, C. T., Polak, J. F., Herrington, D. M., & Ouyang, P. (2014). Association of parity with carotid diameter and distensibility: Multi-ethnic study of atherosclerosis. *Hypertension*, 64, 253–258.
- Vaughn, E. J. (2008). Cultural competence and health education. In M. A. Perez, & R. R. Luquis (Eds.), *Cultural Competence in Health Education and Health Promotion* (pp. 43–65). San Francisco, CA: Jossey-Bass.
- Van der Kooi, R., & Theobald, S. (2006). Traditional medicine in late pregnancy and labour: Perceptions of kgaba remedies amongst the Tswana in South Africa. *African Journal of Traditional, Complementary and Alternative Medicines*, 3(1), 11–22.
- Watt, M. H., Eaton, L. A., Dennis, A. C., Choi, K. W., Kalichman, S. C., Skinner, D., & Sikkema, K. J. (2017). Alcohol use during pregnancy in a South African community: Reconciling knowledge, norms and personal experience. *Maternal Child Health Journal*, 20(1), 48–55.
- Williams, P. P., Jordaan, E., Mathews, C., Lombard, C., & Harry, C. D. H. (2014). Alcohol and other drug use during pregnancy and women attending midwife obstetric units in the Cape Metropole, South Africa. *Advances in Preventive Medicine*. <https://doi.org/10.1155/2014/871427>