

**GUIDELINES TO FACILITATE COLLABORATION
BETWEEN MIDWIVES AND TRADITIONAL BIRTH
ATTENDANTS IN KWAZULU-NATAL**

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Declaration

This is to certify that the work is entirely my own and not of any other person, unless explicitly acknowledged (including citation of published and unpublished sources). The work has not previously been submitted in any form to the Durban University of Technology or to any other institution for assessment or for any other purpose.

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Dedication

I dedicate this dissertation to my family, whose unwavering love and support have been the bedrock of my journey. Your encouragement and understanding have made the challenges of this PhD study more manageable, and your belief in my potential has fuelled my determination.

To my supervisors and critical friends whose guidance has been a beacon of wisdom and inspiration. Your expertise, patience, and encouragement have shaped my academic growth, and I am grateful for the invaluable lessons and insights you have shared.

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Proverbs 16:3 *Commit to the Lord whatever you do, and he will establish your plans.*

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Abstract

Introduction: Perinatal deaths are untimely deaths and are a major public health concern in many developing countries. They have enormous economic, social and health implications for families and society. Over 300 000 women die annually due to pregnancy-related and childbirth complications in sub-Saharan African countries including South Africa, and about 2.6 million babies are stillborn, particularly during the third trimester, with the majority of these deaths occurring in low-socioeconomic communities. Midwives, with their training, and traditional birth attendants (TBAs), with their cultural experience, play a pivotal role in maternal and newborn health, especially in the rural communities where they both bring their expertise to the care of women and newborn babies. There is evidence that in most settings these two groups coexist but work independently with no form of formal collaboration. Collaboration between these two groups could bridge the gap between formal and traditional health systems and ensure that women and babies receive quality healthcare support throughout pregnancy, labour and post-delivery. Therefore, strengthening collaboration between midwives and TBAs is crucial to reduce maternal and neonatal mortality rates and improve overall health outcomes especially in the rural settings where the services of both TBAs and midwives coexist.

AIM: This study aimed to develop practice guidelines to facilitate collaboration between midwives and TBAs in KwaZulu-Natal.

Method: A qualitative research design using explorative, descriptive, case study approaches was employed at uThukela District Municipality in KwaZulu-Natal, South Africa, guided by the structural functionalism theory of Talcott Parsons following the adaptation, goal attainment, integration, and latency process. The sample comprised 38 midwives and 18 women who were purposively sampled and 10 TBAs who were sampled using the snowball method. Data were collected between April and August 2023 following ethics approval (IREC 307/220) from the Durban University of Technology. Data were collected using interviews and focus group discussions and thematically analysed guided by the six steps of qualitative data analysis as described by Creswell and Creswell (2023).

Findings: The study findings confirmed that midwifery and TBA services coexisted in uThukela District and that women were utilising services from both groups during pregnancy, childbirth and the postnatal period. The study also confirmed that there was no existing collaboration between the midwives and TBAs in this district thus resulting in no formal communication between the two groups regarding the care of women and children. This had negative implications for the care of women and children, particularly regarding the continuity of care. However, midwives and TBAs expressed a willingness to collaborate because of their shared goal of reducing maternal and neonatal mortality rates in the district. The women also expressed their support for collaboration between the midwives and TBAs which they stated would address a number of challenges that they face as they sought healthcare from the two groups.

Recommendations: The study makes several recommendations mostly related to policy formulation/revision to incorporate TBAs, training and inservice education, midwifery, and TBA practices, as well as further research. Most importantly, guidelines to facilitate collaboration between the TBAs and midwives were developed as part of the study.

Conclusion: The findings from the study highlight the negative influences of lack of collaboration on the management of women and children and several benefits that could be achieved through collaboration. Benefits include establishing a shared vision, team work, benchmarking and sharing of good practices, all of which could have positive outcomes on the care of women and children. This could also aid in achievement of Sustainable Development Goals of the country especially goal number number 3 related to ensuring healthy lives and promoting the well-being of mothers and children. These guidelines are expected to assist in bridging the gap between midwives and TBAs, fostering a collaborative environment that leverages the strengths of both groups. Furthermore, the guidelines aim to foster community unity by involving various stakeholders, ultimately enhancing maternal and neonatal healthcare outcomes.

A. Table of Contents

Declaration	i
Dedication.....	ii
Acknowledgements.....	iii
Abstract	iv
Table of Contents	vi
List of Tables	xiv
List of Figures	xv
List of Appendices	xvi
Glossary of Terms	xviii
List of Acronyms	xx
Chapter Outline.....	xxii
CHAPTER 1: OVERVIEW OF THE STUDY	1
1.1 INTRODUCTION	1
1.2 BACKGROUND	2
1.3 PROBLEM STATEMENT.....	7
1.4 RESEARCH AIM	10
1.5 RESEARCH OBJECTIVES.....	10
1.6 RESEARCH QUESTIONS.....	11
1.6.1 Main question.....	11
1.6.2 Sub-questions	11
1.7 SIGNIFICANCE OF THE STUDY	12
1.7.1 Women.....	12
1.7.2 Traditional birth attendants.....	12
1.7.3 The health system.....	12
1.8 RESEARCH METHODOLOGY.....	14
1.9 CHAPTER SUMMARY	15
CHAPTER 2: LITERATURE REVIEW	16
2.1 INTRODUCTION	16

2.2	STRATEGIES USED TO SEARCH FOR RELEVANT LITERATURE FOR THE STUDY	16
2.3	GLOBAL STRATEGY TO CURB PERSISTENT MATERNAL AND CHILD MORTALITY	17
2.4	TRADITIONAL BIRTH ATTENDANTS AND THEIR ROLE IN HEALTHCARE.....	20
2.5	SERVICES OF TRADITIONAL BIRTH ATTENDANTS.....	23
2.5.1	Views regarding the services of traditional birth attendants	25
2.5.2	Conflicting demands between traditional beliefs, religious beliefs, and Westernised healthcare	27
2.6	COLLABORATION BETWEEN TRADITIONAL BIRTH ATTENDANTS AND THE HEALTHCARE SYSTEM	28
2.7	BARRIERS TO COLLABORATION	30
2.8	CHAPTER SUMMARY	31
CHAPTER 3: THEORETICAL FRAMEWORK.....		32
3.1	INTRODUCTION	32
3.2	USE OF THEORIES IN RESEARCH.....	32
3.3	THE STRUCTURAL FUNCTIONALISM THEORY	33
3.3.1	Historical development of the structural functionalism theory	33
3.3.1.1	Émile Durkheim (1858-1917).....	33
3.3.1.2	Bronisław Malinowski (1884-1942).....	35
3.3.1.3	Talcott Parsons (1902-1979):.....	36
3.3.1.3.1	Adaptation (A)	37
3.3.1.3.2	Goal attainment (G).....	38
3.3.1.3.3	Integration (I).....	38
3.3.1.3.4	Latency (L)	38
3.4	APPLICATION OF TALCOTT PARSON'S AGIL TO THIS STUDY	40
3.4.1	Adaptation (A)	41
3.4.2	Goal attainment (G).....	42
3.4.3	Integration (I).....	42
3.4.4	Latency (L).....	43
3.5	CHAPTER SUMMARY	44
CHAPTER 4: RESEARCH METHODOLOGY		45

4.1	INTRODUCTION	45
4.2	RESEARCH DESIGN	45
4.2.1	Understanding the three broad research designs	46
4.2.1.1	Quantitative research design.....	47
4.2.1.2	Qualitative research design.....	47
4.2.1.3	Mixed methods research design.....	47
4.2.2	The research design used for this study	48
4.2.2.1	Qualitative design.....	49
4.2.2.2	Exploratory research approach	49
4.2.2.3	Descriptive research approach.....	50
4.2.2.4	Case study design.....	50
4.3	THE WORLD VIEW	51
4.3.1	Positivist approach.....	51
4.3.2	Pragmatism.....	52
4.3.3	Constructivist approach.....	52
4.3.4	Philosophical assumptions.....	53
4.4	STUDY SETTING	54
	Source: Map of KwaZulu Natal Province Municipalities (2016)	55
4.4.1	Data collection sites	57
4.5	STUDY POPULATION.....	58
4.6	SIGNIFICANCE OF SELECTED STUDY SITES AND PARTICIPANTS TO THE STUDY	58
4.7	OBTAINING PERMISSIONS	60
4.8	IDENTIFICATION AND RECRUITMENT OF STUDY PARTICIPANTS.....	60
4.8.1	Registered midwives population	60
4.8.2	Traditional birth attendants population	61
4.8.3	Women.....	62
4.9	SAMPLING OF HEALTHCARE FACILITIES AND STUDY PARTICIPANTS.....	63
4.9.1	Sampling method	63
4.9.2	Eligibility to participate in the study	64
4.9.2.1	Midwives.....	64
4.9.2.2	Traditional birth attendants.....	64

4.9.2.3	Women.....	65
4.9.3	Inclusion and exclusion criteria	65
4.9.4	Sample size	66
4.9.4.1	Sample size for healthcare facilities	66
4.9.4.2	The sample sizes for the midwives, traditional birth attendants and women.....	66
4.10	CODING OF THE STUDY SITES AND PARTICIPANTS	67
4.10.1	Study sites	67
4.10.2	Study participants	67
4.11	DATA COLLECTION	69
4.11.1	Data collection instrument.....	69
4.11.1.1	Structure of data collection instruments for midwives and traditional birth attendants	70
4.11.1.2	Structure of data collection instruments for women.....	71
4.11.2	Data collection methods.....	71
4.11.2.1	Focus group discussions.....	72
4.11.2.2	Semi-structured interviews	73
4.11.3	Data collection process	74
4.12	DATA ANALYSIS.....	77
4.12.1	Preparation of data for analysis	77
4.12.2	Data analysis process	77
4.13	DATA MANAGEMENT AND STORAGE.....	79
4.13.1	Data management	80
4.13.2	Data storage	810
4.14	DEVELOPMENT OF GUIDELINES TO FACILITATE COLLABORATION BETWEEN MIDWIVES AND TRADITIONAL BIRTH ATTENDANTS	81
4.15	RESEARCH RIGOUR	82
4.15.1	Credibility	82
4.15.2	Dependability	83
4.15.3	Confirmability	84
4.15.4	Transferability	84
4.15.5	Authenticity	84
4.16	ETHICAL CONSIDERATIONS	854
4.16.1	Permission	85

4.16.2	Informed consent	86
4.16.3	Right to anonymity and confidentiality.....	86
4.16.4	Right to self-determination	86
4.16.5	Justice.....	87
4.17	CHAPTER SUMMARY	87
CHAPTER 5: PRESENTATION OF FINDINGS.....		88
5.1	INTRODUCTION	88
5.2	OVERVIEW OF DATA COLLECTION	88
5.3	SAMPLE REALISATION.....	89
5.3.1	Study sites	89
5.3.2	Sample realisation for study participants.....	90
5.3.2.1	Registered midwives	90
5.3.2.2	Traditional birth attendants.....	91
5.3.2.3	Women.....	92
5.4	DEMOGRAPHIC CHARACTERISTICS OF STUDY PARTICIPANTS...	92
5.4.1	Common demographic characteristics of all three participant groups	93
5.4.2	Specific demographic characteristics for each participant group	95
5.4.2.1	Midwives.....	95
5.4.2.2	Traditional birth attendants.....	96
5.4.2.3	Women.....	97
5.5	THEMES AND SUB-THEMES.....	100
5.5.1	Theme 1: Midwifery and traditional birth attendant services in the area.....	101
5.5.1.1	Sub-theme 1.1: Awareness of midwifery and traditional birth attendant services in the area	102
5.5.1.2	Sub-theme 1.2: Utilisation of midwifery and/or traditional birth attendant services	104
5.5.1.3	Sub-theme 1.3: Factors influencing utilisation of midwifery and traditional birth attendant services.....	106
5.5.2	Theme 2: Collaboration between midwives and traditional birth attendants	108

5.5.2.1	Sub-theme 2.1: Non-existence of collaboration between midwifery and traditional birth attendant services.....	108
5.5.2.2	Sub-theme 2.2: Factors influencing non-existence of collaboration between midwifery and traditional birth attendant services	110
5.5.2.3	Sub-theme 2.3: Teamwork between midwifery and traditional birth attendant services	111
5.5.3	Theme 3: Practices in the absence of collaboration.....	112
5.5.3.1	Sub-theme 3.1: Acknowledgement of each other's existence	113
5.5.3.2	Sub-theme 3.2: Attitudes and respect towards each other	115
5.5.3.3	Sub-theme 3.3: Influences of current practices on patient care outcomes.....	115
5.5.3.4	Sub-theme 3.4: Communication	117
5.5.4	Theme 4: Feasibility of collaboration.....	120
5.5.4.1	Sub-theme 4.1: Benefits of collaboration.....	122
5.5.4.2	Sub-theme: 4.2 Requirements for successful and sustained collaboration	124
5.6	CHAPTER SUMMARY	125
CHAPTER 6: DISCUSSION OF FINDINGS		126
6.1	INTRODUCTION	126
6.2	DEMOGRAPHIC CHARACTERISTICS OF STUDY PARTICIPANTS..	126
6.2.1	Common demographic characteristics across the participant groups	126
6.2.2	Specific demographics characteristics for midwives	128
6.2.3	Specific demographic characteristics of traditional birth attendants	128
6.2.4	Specific demographic characteristics of women	129
6.3	DISCUSSION OF FINDINGS BASED ON THEMES AND SUB-THEMES THAT EMERGED FROM DATA ANALYSIS.....	130
6.3.1	Existence of midwifery and traditional birth attendant services in the area.....	130
6.3.2	Collaboration between midwives and traditional birth attendant services.....	133

6.3.3	Practices in the absence of collaboration.....	138
6.3.4	Feasibility of collaboration.....	145
6.4	SUMMARY	150
CHAPTER 7: DEVELOPMENT OF GUIDELINES TO FACILITATE COLLABORATION BETWEEN MIDWIVES AND TRADITIONAL BIRTH ATTENDANTS IN KWAZULU-NATAL, SOUTH AFRICA		
		151
7.1	INTRODUCTION	151
7.2	OVERVIEW AND GENERAL USE OF GUIDELINES	151
7.3	THE PROCESS OF DEVELOPING GUIDELINES	153
7.3.1	Topic selection	153
7.3.2	Forming the guideline development group	157
7.3.3	Scope of the guidelines.....	157
7.3.4	Forming relevant key questions:	158
7.3.5	Evidence search	159
7.3.6	Evidence synthesis	159
7.3.7	Recommendations	162
7.3.8	Writing a draft.....	163
7.3.9	Stakeholder review	163
7.3.10	Approval.....	165
7.3.10.1	Publication.....	166
7.3.10.2	Updating / revising.....	167
7.4	SUMMARY	167
CHAPTER 8: GUIDELINES TO FACILITATE COLLABORATION BETWEEN MIDWIVES AND TRADITIONAL BIRTH ATTENDANTS IN KWAZULU- NATAL, SOUTH AFRICA		
		168
8.1	INTRODUCTION	168
8.2	PRESENTATION OF THE GUIDELINES	168
8.3	CONCLUDING REMARKS	187
8.4	CHAPTER SUMMARY	187
CHAPTER 9: SUMMARY, LIMITATIONS, RECOMMENDATIONS AND CONCLUSION FROM THE STUDY		
		189
9.1	INTRODUCTION	189
9.2	SUMMARY OF THE STUDY	189

9.3	SUMMARY OF FINDINGS	191
9.3.1	Existing strategies toward collaboration of traditional birth attendant and midwifery care in KwaZulu-Natal.....	191
9.3.2	Perceptions of TBAs regarding collaboration with midwives	193
9.3.3	Perceptions of midwives regarding collaboration with traditional birth attendents	195
9.3.4	Views of women regarding the collaboration of midwives and traditional birth attendents.....	196
9.3.5	Factors that influence collaboration between midwives and traditional birth attendents.....	197
9.3.6	Guidelines to facilitate collaboration between midwives and traditional birth attendants.....	200
9.4	LIMITATIONS	201
9.5	RECOMMENDATIONS.....	202
9.6	CONCLUSION.....	204
	REFERENCES	206
	APPENDICES	229

List of Tables

Table 4.1: Targeted data collection sites	577
Table 4.2: Coding of study participants.....	688
Table 4.3: Combined coding indicating data collection method, study site and study participants	698
Table 5.1: Alignment of research questions to collected data.....	899
Table 5.2: Total number of data collection sites included in the study per sub- district.....	90
Table 5.3: Total number of registered midwives included in the study (n = 38)	9191
Table 5.4: Total number of TBAs included in the study (n = 10).....	92
Table 5.5: Total number of women included in the study (n = 18)	92
Table 5.6: Summary of findings on age, gender and ethnicity	94
Table 5.7: Information on category of midwifery qualification	955
Table 5.8: Information on years of experience as a midwife	966
Table 5.9: Information on the duration in the current facility as a idwife.....	96
Table 5.10: information on years of experience as a TBA	96
Table 5.11: Information on number of pregnancies and deliveries	977
Table 5.12: Findings on death of a child below one year.....	988
Table 5.13: Summary of findings on marital, education and employment status	999
Table 5.14: Provision of care during pregnancy, labour, delivery and post- delivery	100
Table 5.15: The four themes and corresponding sub-themes	101
Table 7.1: Key questions that were developed for each of the guideline topics in line with the factors influencing effective collaboration	158

List of Figures

Figure 2.1: Keywords used for the literature search	17
Figure 3.1: The social system by Talcott Parsons	377
Figure 3.2: AGIL structural functionalism theory by Talcott Parsons	4040
Figure 4.1: The map of KwaZulu-Natal showing location of uThukela District .	555
Figure 4.2: The map of uThukela District showing the three Municipalities	556

List of Appendices

Appendix 1: Ethics clearance	228
Appendix 2a: Request letter to Health Research and Knowledge Management Unit1	229
Appendix 2b: Permission letter from Health Research and Knowledge Management Unit	231
Appendix 3a: Request letter for UThukela District Office	232
Appendix 3b: Permission letter from UThukela District Office	233
Appendix 4a: Request letter to the CEO Estcourt Hospital.....	234
Appendix 4b: Permission letter from the CEO Estcourt Hospital	235
Appendix 5: Sample letter to health institution managers	236
Appendix 6a: Request for permission from Community leader	237
Appendix 6b: Letter to request permission from the relevant Community Leader (isiZulu)	238
Appendix 6c: Permission letter from the Ward Councillor Inkosi Langalibalele Municipality.....	239
Appendix 7a: pre-selection tool women (English)	240
Appendix 7b: Pre-selection tool women (IsiZulu).....	241
Appendix 8a: information letter and consent form for midwives (English).....	242
Appendix 8b: Information letter and consent form for women (English).....	246
Appendix 8c: Information letter and consent form for women (IsiZulu)	250
Appendix 8d: Information letter and consent form for TBAs (English)	254
Appendix 8e: Information letter and consent form for TBAs (IsiZulu)	258
Appendix 9a: Interview guide for Midwives.....	260
Appendix 9b: Interview guide for Women (English)	262
Appendix 9c: Interview guide for Women (English)	263
Appendix 9d: Interview guide for TBAs (English).....	264
Appendix 9e: Interview guide for TBAs (isiZulu)	265
Appendix 10a: Sample of transcription and analysis report for focus group discussion eith midwives	266
Appendix 10b: Sample of transcription and analysis report for the interview with TBAs	269

Appendix 10c: Sample of transcription and analysis report for the interviews with women	271
Appendix 11: Statement of confidentiality	273
Appendix 12: Guideline checklist.....	275
Appendix 13: Preliminary guidelines.....	278
Appendix 14 Final Guidelines (IsiZulu)	287
Appendix 15: Introduction to Research Ethics Certificate	308
Appendix 16: Editor's Certificate.....	309
Appendix 17: Turnitin Report.....	310

Glossary of Terms

Antenatal care (ANC) is defined as the care provided by skilled healthcare professionals to pregnant women and adolescent girls during pregnancy in order to ensure the best health conditions for both mother and baby during pregnancy (World Health Organization [WHO] 2016).

Complications are unfavourable results of either a disease, health condition, or treatment where complications may adversely affect the prognosis, or outcome, of a disease (Centers for Disease Control and Prevention 2024).

Guidelines are statements which determine a course of action that aims to streamline particular processes according to a set routine or sound practices (Panteli et al. 2019).

Integration is the action or process of successfully joining or mixing with a different group of people to reach a common goal (Irfan 2023).

A midwife is a person who has successfully completed a midwifery education programme that is recognised in the country where it is located, that is based on the International Confederation of Midwives (ICM) essential competencies for basic midwifery practice and the framework of the ICM global standards for midwifery education, who has acquired the requisite qualification to be registered and or legally licensed to practice midwifery and use the title 'midwife', and who demonstrates competency in the practice of midwifery (International Confederation of Midwives [ICM] 2017). In the context of this study, midwife includes both male midwives (accouchers) and female midwives.

Morbidity is defined as a sick or an unhealthy state that includes the prevalence and effect of disease or medical disorders in a community and it measures a number of diseases, injuries, or health related issues in a population or locality (Hernandez and Kim 2019).

Mortality is the state or condition of being subject to death which is frequently used in medical and statistical contexts to estimate the number of fatalities in a

population over a defined time period which is presented as a rate (World Health Organisation 2023).

Mortality rate is a term used as a measure of the number of deaths in a particular population, scaled to the size of the population per unit of time (Hernandez and Kim 2019).

Skilled birth attendants (SBAs) are defined by the World Health Organization (WHO 2018), and the International Confederation of Gynaecology and Obstetrics (Fullerton et al. 2011) as accredited health professionals such as midwives, doctors or nurses who have been educated and trained to be proficient in the skills needed to manage normal pregnancies, childbirth and immediate postnatal period, and in the identification, management, and referral of complications in women and newborns

Neonatal deaths are defined by as death of a liveborn neonate by discharge/day 7 of life (Pathinara et al. 2016).

Teamwork is defined as the collaborative effort of a group to achieve a common goal or to complete a task in an effective and efficient way (Rosengarten 2024).

Traditional birth attendant (TBA) is person (usually a woman), who is independent (of the health system), non-formally trained, community-based provider of care during pregnancy, childbirth and the postnatal period who initially acquire her skills by delivering babies herself (self-taught) or by working with other TBAs (apprenticeship) who assist mothers at childbirth (Esan *et al.* 2023).

List of Acronyms

Acronym	Full term
AGIL	Adaptation, Goal attainment, Integration and Latency
ANC	Antenatal care
BANC	Basic antenatal care
BANC+	Basic antenatal care plus
CCEMD	Committee on Confidential Enquiries into Causes of Maternal Deaths
CEO	Chief Executive Officer
CHW	Community Health Worker
DCST	District clinical specialist teams
DHB	District Health Barometer
DOH	Department of Health
DUT	Durban University of Technology
FGD	Focus group discussions
FIGO	International Federation of Gynaecology and Obstetrics
ICM	International Confederation of Midwives
HDACC	South African National Health Data Advisory and Coordinating Committee
iMMR	Institutional Maternal mortality rate
IREC	Institutional Research Committee
IPC	Intra partum care
IRB	Institutional Review Board
IREC	Institutional Research Committee
KZN	KwaZulu-Natal
MCNH	Maternal child and neonatal health
MDG	Millenium Development Goals
MMR	Maternal mortality rate
MNCWH	Maternal, New born, Child and Women Health
NCCEMD	National Committee on Confidential Enquiries into Maternal Deaths
NHRD	National Health Research Database

PNC	Postnatal care
PNU	Postnatal unit
SBA	Skilled birth attendants
SDGs	Sustainable developmental goals
SMI	Safe Motherhood Initiative
TBA	Traditional birth attendant
UN	United Nations
WHO	World Health Organization

Chapter Outline

CHAPTER NUMBER	TITLE	CONTENTS
Chapter 1	Overview of the study	Presents the introduction and background, aim, objectives, research questions, problem statement and significance of the study.
Chapter 2	Literature review	Presents a literature review that covers readings by other authors on collaboration between midwives and TBAs globally, internationally, nationally and locally to gain a broader perspective regarding the integration of TBAs into the healthcare system.
Chapter 3	Theoretical Framework	A theoretical framework guiding the study is presented in this chapter, including details on how it was applied in this study.
Chapter 4	Methodology	Presents a step-by-step description of the research methodology and design that was used for the study including strategies to ensure research rigour and ethical considerations.
Chapter 5	Presentation of findings	Themes and the sub-themes that emerged from the interviews.
Chapter 6	Discussion of findings	Discusses the study findings and supports with relevant literature.
Chapter 7	Development of Guidelines to Facilitate Collaboration Between Midwives and Traditional Birth Attendants in KwaZulu-Natal	Presents the steps followed to develop the guidelines to facilitate collaboration between midwives and traditional birth attendants and the process of review of the guidelines by different experts for relevance and acceptance.
Chapter 8	Presentation of Guidelines to Facilitate Collaboration Between Midwives and Traditional Birth Attendants	Presents guidelines developed to facilitate collaboration between midwives and Traditional Birth Attendants.
Chapter 9	Summary of findings, limitations, recommendations and conclusion	Presents the summary of findings, limitations recommendations and the conclusions from the study.

CHAPTER 1: OVERVIEW OF THE STUDY

1.1 INTRODUCTION

Maternal, neonatal, child, and women's health (MNCWH) care is a critical programme in South Africa's healthcare system, aimed at improving healthcare outcomes for women, neonates, and children (Bhardwaj *et al.* 2018). Despite progress in recent years, several challenges and areas of focus shaping MNCWH care prevail in the region. South Africa has many clinics and hospitals and has set up systems to improve the quality of healthcare services in general. However, there is always a disparity in the quality and availability of MNCWH care services between urban and rural areas in South Africa, resulting in persistent perinatal mortality rates (Ngene, Khaliq and Moodley 2023). Many strides have been made to reduce the perinatal mortality rate including changing the approach to antenatal care (ANC) service provision from traditional ANC to a basic antenatal care (BANC) approach and later to BANC+, the introduction of programmes like the South Africa's national strategic plan for a campaign on accelerated reduction of maternal and child deaths in Africa (CARMMA), re-engineering of primary healthcare (PHC) services, the introduction of the district clinical specialist teams (DCSTs), and PHC ward-based outreach teams to name just a few (South Africa. Department of Health 2021a). However, the MNCWH care challenges remain, particularly in rural areas due to several factors such as poor quality of care, inaccessibility of healthcare services, poor socio-economic conditions, and the use of unskilled healthcare providers. Studies have found that some of the causes of increased perinatal mortality rates are maternal complications such as hypertension, haemorrhage, and HIV/Aids. Access and utilisation of MNCWH care services is crucial for the health of women and their babies so they can be well monitored during pregnancy, delivery and the postnatal period. Skilled birth attendance (SBA) provided by midwives and/or obstetricians plays a crucial role in ensuring care and safe delivery (Bomela 2020; Yaya *et al.* 2018).

1.2 BACKGROUND

Perinatal deaths remain a burden with slow improvement in most sub-Saharan African countries where over 300 000 women continue to die annually due to complications related to pregnancy, and childbirth (Mmusi-Phetoe 2016; Mwoma, Kituku and Gitome 2021; Taye *et al.* 2022) and about 2.6 million babies die as stillborn, especially during the third trimester, with the majority (94%) of these deaths occurring in low-socioeconomic communities. Strategies to reduce maternal and child mortality rates date back to the time of the Millennium Development Goals (MDGs), two of which were to improve child survival (MDG-4) and maternal health (MDG-5) which were not achieved by 2015 along with all the other MDGs, hence the summit to discuss Sustainable Development Goals (SDGs) held in 2015 (Onambebe *et al.* 2022).

According to the South African Saving Mothers Report by the National Committee on Confidential Enquiries into Causes of Maternal Deaths (NCCEMD), South Africa was one of the countries that were constantly not on track with the achievement of both MDG 4 and 5 between 2017 and 2020 (South Africa. Department of Health 2020). Subsections 3.1 and 3.2 of goal number 3 for SDGs target mothers and their babies respectively as they are related to ensuring healthy lives and promoting the well-being of mothers and children. The South African Saving Mothers Report (South Africa. Department of Health 2020) reported that between 2017 and 2020 the majority (92.4%) of maternal deaths reported to the NCCEMD occurred in health facilities, while 1.3% occurred in transit, and 6.3% occurred at 'home'. These statistics are not accurate but an underestimate since there is no proper reports from the communities, but home deaths are alarming and need to be prevented. According to Mwoma, Kituku and Gitome (2021), most causes of maternal mortality are preventable through utilisation of skilled care during pregnancy, birth and puerperium. Reduction of persistent high maternal and child death rates require care by skilled health professionals in well-equipped facilities (South Africa. Department of Health 2021b). Skilled birth attendants are defined

by the World Health Organization (WHO), the International Confederation of Gynaecology and Obstetrics (FIGO) and International Council of Midwives (ICM) (2014) as "accredited health professionals such as midwives, doctors or nurses who have been educated and trained to be proficient in the skills needed to manage normal pregnancies, childbirth and immediate postnatal period, and in the identification, management, and referral of complications in women and newborns". Furthermore, the WHO, FIGO and ICM (2014) recommends the utilisation of skilled birth attendants (SBAs) as a key strategy to improve maternal and newborn health. However, access to healthcare facilities and SBAs remains a problem especially in middle-income countries for various reasons (the WHO, FIGO and ICM 2014). Access to skilled healthcare services and being seen by SBAs during pregnancy, childbirth and postpartum should be prioritised for the improvement of maternal and child health. All women and babies must receive good maternity care throughout pregnancy, childbirth and post-delivery to enhance proper pregnancy outcomes (Mwoma, Kituku and Gitome 2021). Globally, a third of childbirth happens at home without any help by SBAs which poses a huge health risk to both mother and child, hence the plea for women is to utilise healthcare services even if they still utilise TBAs.

Hajaratu and Sunday (2022) found that enhanced access to SBAs was one of the core strategies of the Safe Motherhood Initiative of the WHO. The MDG goal number 5 focused on improving maternal health hence, the utilisation of SBAs remains the centre of global strategy and approach to improving maternal and newborn health. It was noted that there was an increase of SBAs (57% and 70%) in low and middle-income countries between 1990 and 2015. This contributed to the decline of the maternal mortality rates (iMMR), though many countries did not fully meet SDG 5. However, there was still a 44% reduction in maternal mortality (Hajaratu and Sunday (2022)). Despite all the hard work, there remains a gap in the proportion of births that are attended by SBAs after huge investments to promote their availability and utilisation globally.

In most vulnerable areas and mostly rural and deprived communities traditional birth attendants (TBAs) constitute the greater number of childbirth care

providers due to the unavailability or shortage of SBAs such as midwives, nurses, and doctors (WHO 2014). Several authors concur that the existing health workforce shortage, which is mainly caused by prevailing funding constraints, poses challenges to the workforce and service delivery globally, thus resulting in an increased demand to consult with TBAs (Fantaye Gunawardena and Yaya 2019; Sarmiento 2014). When the WHO developed the Safe Mother initiative, TBAs were highlighted as personnel who could provide culturally appropriate health education and emotional support to women during pregnancy and childbirth, but not the essential obstetric care needed to manage complications (MacDonald 2022). In addition, MacDonald (2022) confirms that the existence of TBAs was once promoted as part of the solution to reducing maternal mortality, however, their training and integration into formal healthcare systems was deemed a failure and side-lined in the late 1990s in favour of ensuring a skilled attendant at every birth. Nonetheless, TBAs continue to practice and participate in maternal health projects in many countries with varying degrees of inclusion within formal healthcare systems. Ohaja, Murphy-Lawless and Dunlea (2017) concur that a decision was made not to support the training of TBAs but to increase and promote the SBAs. The midwives who were participants in a study by Ohaja, Murphy-Lawless and Dunlea (2020) had diverse and conflicting responses with some of them believing that the TBAs should be banned, arguing that they are responsible for the low uptake of hospital-based maternity care by women which in turn leads to an increase in maternal deaths. In contrast, other midwives expressed a view that TBAs cannot be phased out due to their valid contributions, particularly in rural areas where access to formal maternity care is limited by intractable structural problems. Thus, the conclusion by Ohaja, Murphy-Lawless and Dunlea (2020) in their study on midwives' views of TBAs within formal healthcare in Nigeria was that policymakers need to reconsider the role of TBAs including their involvement not only in their integration into formal healthcare to work alongside formally trained maternity care providers, but also fostering a healthcare atmosphere where respect and recognition of each practitioner's skills are paramount.

Evidence shows different views regarding the services of the TBAs. The view that is commonly held by Western medical teams is that TBAs have a strong reliance on traditional ways of providing care to women including the use of traditional medication, which they cannot support. Aziato and Omenyo (2018) attest that most TBAs rely on herbal medicines to assist pregnant women before, during, and after labour and they believe this gift is culturally inherited. According to Scina (2017), most TBAs in KZN were found to be giving pregnant women herbal medication called *isihlambezo*, which is usually taken in the third trimester of pregnancy to induce and hasten labour. Herbal medication depends on the country and type of traditional healer or TBA attending to the pregnant woman (Boltman-Binkowski 2016). Another view is that of TBAs being a support to women, which includes encouraging and accompanying women to attend antenatal and postnatal care, having midwives during birth, and providing companionship to women during and after childbirth. According to Miller and Smith (2017), TBAs acknowledge their cultural and social acceptability by supporting the health of women and their newborn babies as well as strengthening the link to the formal health system. These authors highlight that TBAs have played a critical role in health promotion by preventing mother-to-child Human Immunodeficiency Virus (HIV) transmission in a region where HIV prevalence was remarkably high. Miller and Smith (2017), further found that trust between the hospital staff and local women had increased because of the changes to the organisation of care including the recognition of TBAs as a culturally acceptable bridge between women and the health system. The TBAs play a broader role at the community level where they give health education on different topics (Miller and Smith 2017). Chi and Urdal (2018) attest that TBAs' actions are largely motivated by the desire to help women in their communities. These authors further state that the role of TBAs in maternal health has received relatively little attention. Although in some countries TBAs have been integrated into the local health system and have been allocated different roles in different communities in other countries, this integration has not actually happened (Chi and Urdal 2018).

There is empirical evidence that many traditionally valued practices are prohibited in Western healthcare centres thus resulting in some women not being keen to use these healthcare services. On the other hand, taking into consideration the cultural and religious values as well as community traditions when performing roles helps the TBAs win the confidence of the pregnant woman and their families resulting in them choosing to be cared for and be delivered by TBAs rather than SBAs (Adatara, Strumpher and Ricks 2018). It also emerged in a study by Mwoma, Kituku and Gitome (2021) that men in Indonesia are confident that their wives will receive enough baby care support from TBAs, since they can teach their pregnant wives about customs and culture compared to SBAs. Women also reported that TBAs are always available, they are nearby, and they trust them as they provide them with culturally appropriate pregnancy care in line with traditional expectations of the community (Mwoma, Kituku and Gitome 2021). TBAs encourage pregnant women to attend antenatal clinics and after birth, encourage the mother to take the baby to the clinic. However, during delivery, the pregnant mother consults the TBA.

Garces *et al.* (2019) recommended that TBAs can serve as a bridge between the community and the formal health system, and once women are inside an institution, they can act like doulas. According to Bergström and Goodburn (2000), TBAs ensure that women feel comfortable when they have a community accompanist since they are in an uncomfortable unknown environment. Mwoma, Kituku and Gitome (2021) support the other researchers and attest that TBAs can provide the following maternal care during pregnancy, childbirth, and post-partum and newborn at healthcare centres:

- Monitor the progress of pregnancy, detect complications, provide preventive measures, develop birth and emergency plans with women and their families.
- Offer advice to women on healthy lifestyles and nutrition during pregnancy and post-delivery.
- Monitor the progress of labour and be on the lookout for complications.
- Stay with women in labour until delivery so that they are not unattended, and offer continuous support in many ways.

- Manage abnormalities like breech delivery and shoulder girdle dystocia. They can work with highly skilled obstetricians, paediatricians and anaesthetic doctors who are skilled in handling severe complications.
- In the postnatal wards, they can provide care in various ways like helping mothers and babies initiate breastfeeding, prevention and or management of postpartum haemorrhage and postpartum depression.

The WHO (2014) advocates for skilled care at every birth to reduce the global burden of 53 5000 maternal deaths, 3 million stillbirths, and 3.7 million newborn deaths yearly. Chi and Urdal (2018) found that the introduction of SBAs in areas where deliveries have traditionally been attended by TBAs led to improvements in maternal health outcomes. As a result, interventions to enhance collaboration and partnerships between TBA SBAs and facility-based staff were integrated into midwifery training in Indonesia (Mwoma, Kituku and Gitome 2021).

Collaboration between TBAs and midwives through integration within the formal healthcare system provides an opportunity for training and supervision thereby increasing the skill of the birth attendants (Ohaja, Murphy-Lawless, and Dunlea (2020). Ngotie, Kaura and Mash (2022) conducted a study exploring SBAs' awareness and found that they are familiar with cultural practices which led them to appreciate women's expectations with clinical care and encouraged more collaborative relationships among the TBAs and midwives. Ohaja, Murphy-Lawless, Dunlea (2020) stated that when SBAs collaborate with TBAs and TBAs are incorporated into the healthcare sector, this improves access to SBAs.

1.3 PROBLEM STATEMENT

The deaths of women during pregnancy, childbirth, and puerperium remain a major public health issue, particularly in low- and middle-income countries including South Africa (Moodley, Fawcus and Pattinson 2018; Onambele *et al.* 2022). In 2017, an estimated 295 000 maternal deaths occurred globally, with two-thirds of these (196 000; 66.4%) occurring in sub-Saharan Africa. A promising transition occurred between 2000 and 2017 where there was an

estimated 38.4% reduction in the global maternal mortality rate, from 342 deaths per 100 000 live births to 211 per 100 000 live births, with an annual rate of reduction of 2.9%. In sub-Saharan Africa, the maternal mortality rate declined by 38.3% over the same period, with an annual rate of reduction of 2.8% (Onambele *et al.* 2022). Sadly, this decline was overturned when in 2018/19, the District Health Barometer (DHB) reported 1 065 maternal deaths in South Africa resulting in maternal mortality in facility ratio of 105.9 per 100 000 live births which is marginally above the 2017/18 figure of 105.7 per 100 000 live births. This interrupted the ongoing decline which had been steadily observed since 2013/14 (Onambele *et al.* 2022). Thus, maternal deaths continue to be a problem in South Africa.

The NCCEMD estimated that approximately 60% of deaths in South Africa are potentially preventable. This is supported by the Confederation of Midwives triennial report 2014-2017 (International Confederation of Midwives 2017) where the higher proportions of avoidable deaths in district hospitals point was reported as one of the key challenges concerning the rendering of maternal health services. Both Health Systems Trust (2020) and the Saving Mothers Report (South Africa. Department of Health 2021b), report the KZN province as one of the leading provinces in terms of high maternal and neonatal mortality rates in South Africa. In 2017 KZN had the highest number of maternal deaths (245) compared to all the other provinces which had between 28 and 223 deaths (Onambele *et al.* 2022). The NCCEMD reports highlight non-attendance and late attendance of ANC as one of the major contributors to maternal deaths. The two major reasons for home delivery are either a preference of women and or responsible relatives regarding the type of care between traditional and Western healthcare, but this can lead to a delay in accessing healthcare (Gurara *et al.* 2020). Other studies highlight that pregnant women deliver at home due to delays in either seeking, reaching, or receiving healthcare. The delays are caused by factors such as lack of information, distance of healthcare facilities from the community, lack of transport to healthcare facilities and lack of skilled attendance (Sarmiento 2014; Adatara, Strumpher and Ricks 2018; Gurara *et al.*

2020). Irrespective of the reason for home delivery, evidence has shown that home delivery is associated with a significantly higher risk of maternal death.

There is anecdotal evidence as reported by the midwives that several pregnant women (especially from rural communities) either do not attend ANC, do not come on time for delivery, and do not attend postnatal care services, only presenting at the clinic late when there are already complications related to pregnancy, birth or postpartum. In most cases, these women are reported to have been under the care of either traditional healers or TBAs in their communities. The researcher who is a midwifery lecturer has also witnessed this. According to Moodley, Fawcus and Pattinson (2018), delays in accessing medical help by women account for about one-third of maternal deaths.

The high number of maternal deaths reflect inequalities in access to quality healthcare services and the gap between rich and poor (WHO, 2019). In rural areas, the majority of deliveries still take place at home, with more than 56% of these deliveries assisted by TBAs or family members (Sarker *et al.* 2016). Similar situations exist in other developing countries such as Bangladesh where 41% of women from the rural areas do not attend ANC, but they are attended to by TBAs since they feel comfortable with them instead of the formal health practitioners (Sarker *et al.* 2016). A study conducted in Ethiopia also highlighted that more than 70% of all births in that country occur outside of healthcare facilities and with the assistance of birth attendants (Gurara *et al.* 2020).

The SDG recommendation is that all sectors are expected to partner to develop healthcare solutions that work for people, families, communities, and the nation (United Nations 2018). Van Rooyen *et al.* (2017) note that support for the development of traditional medicine and the facilitation of collaboration between traditional health practitioners and allopathic health practitioners is encouraged globally and the growing demand exists to use both groups of health practitioners to strengthen healthcare delivery. However, the researcher has observed that there has been no established collaboration between the healthcare facilities and the TBAs in the uThukela District. Moodley, Fawcus

and Pattinson (2018) acknowledge that future interventions are more difficult to implement as they involve improving the healthcare system. These authors advise that managing complex obstetric conditions can only be effective if each aspect of the system works efficiently and in harmony. Therefore, improving knowledge, skills and resources is insufficient; the system itself must function efficiently. Adatara, Strumpher and Ricks (2018) attest that skilled birth attendants should foster collaboration with TBAs in rural communities to ensure that some refresher training is offered to all and that they are monitored and supported. This will assist in ensuring that the TBAs work within their limits and that women are promptly referred to healthcare facilities for further management.

The above-stated problems which include persistent high maternal deaths, services by TBAs who are often not appropriately skilled, and absence of collaboration between midwives and TBAs, offer an opportunity for the researcher in the current study to develop guidelines to facilitate collaboration between midwives and TBAs as a strategy to improve maternal care services in KZN. It is hoped that such guidelines will aid in developing an effective, risk-based referral process between the TBAs and midwives so that pregnant women can deliver live babies and help reduce the perinatal mortality and morbidity rates.

1.4 RESEARCH AIM

This study aimed to develop practice guidelines to facilitate collaboration between midwives and traditional birth attendants in KZN, South Africa.

1.5 RESEARCH OBJECTIVES

The specific objectives of the study were to:

- Explore if any strategies exist regarding the collaboration of TBAs and midwifery care in KZN.
- Describe perceptions of TBAs regarding collaboration with midwives.

- Describe the perceptions of midwives towards the collaboration with TBAs.
- Explore the views of women regarding the collaboration of midwives and TBAs.
- Critically analyse the factors that influence collaboration between midwives and TBAs.
- Develop guidelines to facilitate collaboration between midwives and traditional birth attendants.

1.6 RESEARCH QUESTIONS

This study aimed to answer the following questions:

1.6.1 Main question

What practice guidelines would facilitate collaboration between midwives and traditional birth attendants in KZN, South Africa?

1.6.2 Sub-questions

- What strategies exist for collaboration of TBAs and midwifery care in KZN?
- What are the perceptions of TBAs and midwives regarding collaboration between midwives and TBAs?
- What are the views of women regarding the collaboration of midwives and TBAs?
- Which factors and how do these factors influence collaboration between midwives and TBAs?
- What practice guidelines could facilitate collaboration between midwives and traditional birth attendants?

1.7 SIGNIFICANCE OF THE STUDY

The findings of the study will be helpful for a variety of stakeholders, as presented below.

1.7.1 Women

The findings will promote collaboration between TBAs and midwives thus helping women to be taken care of and have a healthy pregnancy, delivery and post-partum care. When women are healthy they will give birth to healthy babies thus reducing maternal mortality. Collaboration might also help women not to be scared to visit the health facilities during pregnancy knowing that they can also be attended by TBAs and that their cultural orientation will be understood by midwives.

1.7.2 Traditional birth attendants

The collaboration that may result from this study might help TBAs to understand midwives and Western healthcare better, thus boosting their confidence in caring for pregnant women and conducting deliveries. They will also be able to refer women to the health facilities knowing that they are a recognised partner.

1.7.3 The health system

The collaboration between midwives and TBAs holds significant potential for improving maternal health outcomes, reducing healthcare costs, and decreasing maternal mortality rates, particularly in rural and underserved communities. Access to skilled care during pregnancy, childbirth, and the post-partum period is critical for reducing maternal mortality and improving overall maternal health. However, in many rural areas, pregnant women often rely on TBAs for assistance during childbirth instead of seeking professional care at health facilities. This reliance typically continues until complications arise, which may result in tragic outcomes for both the mother and the infant.

As noted by Dhlomo (2016) the MEC for Health in Kwazulu-Natal, the integration of healthcare professionals and traditional healers is vital and he also emphasised the importance of collaboration between community leaders, mayors, councillors, and traditional healers to prevent maternal deaths. A maternal death can have devastating effects on both the immediate family and the broader community. This underscores the urgent need for skilled birth attendants and TBAs to work together in rural and deprived communities, offering culturally appropriate and effective care to facilitate the utilisation of health services in formal settings.

The researcher, through observations made as a midwifery lecturer during student accompaniment in healthcare facilities, has identified a concerning trend. Many pregnant women from rural areas seek hospital care only after complications arise, such as fetal death or maternal complications. These women often do not attend ANC appointments, preferring to consult TBAs in their communities instead. TBAs refer them to healthcare facilities only when they are unable to manage the complications. This delayed referral often leads to adverse outcomes, highlighting the critical need for collaboration between midwives and TBAs. In the province of KZN there is a high maternal mortality and morbidity rate, but very few studies have focused on TBAs. The absence of structured guidelines for TBAs means that there is no clear framework for when and how they should refer women to health facilities in case of complications. This lack of defined referral protocols can lead to delayed interventions, which often have fatal consequences.

The proposed study seeks to address this gap by developing a set of guidelines to facilitate collaboration between midwives and TBAs. Such guidelines will benefit the healthcare system by reducing maternal mortality rates, improving healthcare utilisation, and enhancing the overall delivery of maternal care. By fostering a collaborative relationship between midwives and TBAs, women in rural areas can receive timely and appropriate care, utilising both the healthcare services available and the culturally accepted practices provided by TBAs. This collaboration is expected to not only improve maternal health outcomes but also

reduce healthcare costs associated with complications arising from late referrals. Ultimately, this study aims to contribute to a more holistic, accessible, and effective healthcare model for maternal care, especially in rural communities.

1.8 RESEARCH METHODOLOGY

This study employed a qualitative design where explorative descriptive case study approaches were used to identify and develop the practice guidelines that would facilitate collaboration between midwives and TBAs in KZN. This study was a single-case holistic study that focused on one entity, Inkosi Langalibalele Local Municipality, and one unit of analysis, a collaboration of midwives and TBAs. A case study is a research method involving thorough in-depth analysis of an individual, group, or other social unit (Polit and Beck 2021). According to Heale and Twycross (2018), the case study design provides a framework for the evaluation and analysis of complex issues which assists in better understanding the phenomenon in question, shines a light on the holistic nature, and offers a perspective that informs improved approaches to situations. Polit and Beck (2021) attest that case studies are intensive investigations of a single entity or a small number of entities, such as individuals, groups, organisations, or communities. While a case study design can be either a single-case study or a multiple-case design both these designs can be either holistic or embedded. Yin (2014) and Polit and Beck (2021) describe the four basic types of case study designs such as;

- Single-case which is holistic
- Single-case which is embedded
- Multiple-case which is also holistic and
- Multiple-case which is also embedded.

The selected design assisted the researcher in creating a programme or an intervention to benefit the population (Gray and Grove 2020). Data were collected through semi-structured individual interviews with 10 TBAs who were identified through snowballing, 18 postpartum women, and 38 practicing

midwives who were purposively selected from the maternity healthcare facilities in KZN. Data were thematically analysed guided by the Tesch's method of qualitative data analysis (Tesch1992).

The study was guided by the structural functionalism theory of Talcott Parsons following the adaptation, goal attainment, integration, and latency (AGIL) process (Parsons 1954 cited in Orsini 2024; and Maier *et al.* 2024). Adaptation refers to the fact that systems are embedded in physical and socio-political environments to which they must adapt if they are to survive. Goal attainment refers to the need to define the primary goals of any system and the methods by which individuals accept those goals as their own and strive to achieve them. Integration refers to the need to coordinate the parts of the system so that they contribute to the maintenance of the whole. Latency refers to those structures that serve to maintain and revitalise the motivation of individuals to perform their roles according to social expectations.

1.9 CHAPTER SUMMARY

Chapter 1 presented the overview of the study where the background of the study, the problem statement, the aim of the study, the research questions, and the significance of the study and methodology of the study were discussed. This following chapter presents the relevant literature review so as to gain more insight and understanding, and support the relevance of the study.

CHAPTER 2: LITERATURE REVIEW

2.1 INTRODUCTION

Chapter 2 presents various findings from relevant literature sources. The literature review provides a framework for establishing the importance of the study and provides a benchmark by which to compare the results of the current study (Creswell and Creswell 2023). The literature review assists in supporting the importance of conducting this study and deciding on the theoretical framework used to guide the study.

2.2 STRATEGIES USED TO SEARCH FOR RELEVANT LITERATURE FOR THE STUDY

Choosing a perfect strategy to search literature is essential to obtain high-quality reviews. The researcher conducted a literature search before commencing the primary data collection, which took over 12 months using different scholarly search engines. Various World Wide Web search engines were used to ensure a thorough and broad search for relevant literature. The search included EBSCO Host, Google Scholar, medical literature, Cumulative Index to Nursing and Allied Health Literature (CINAHL) Plus, connectedpapers.com, and the Department of Health (DoH) website to access peer-reviewed literature. The researcher also used the Durban University of Technology (DUT) library to search for books, guidelines, and other journals.

The researcher used keywords that were first drafted before the literature search. These terms directed the researcher to the literature which covered the study. Some of the terms used to search were: antenatal care, collaboration, DoH, education, TBAs, midwives, integration, maternal and perinatal mortality, pregnant women and relationships. Some of the terms were combined to broaden the search. The studies that were included were in English and full text published within the previous 10 years. Figure 2.1 presents the keywords used for the literature search.

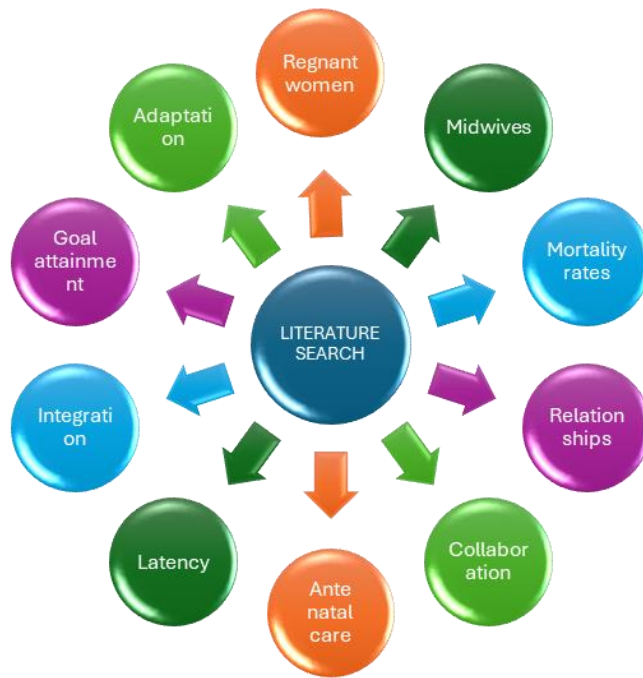


Figure 2.1: Keywords used for the literature search

The section below presents the literature review findings, which are structured according to the global, international and local context.

2.3 GLOBAL STRATEGY TO CURB PERSISTENT MATERNAL AND CHILD MORTALITY

Curbing persistent maternal and child mortality forms part of the SDGs that were adopted by all UN member states as a means of providing a shared blueprint for peace and prosperity for all people. One of the 17 SDGs, SDG 3, is related to ensuring healthy lives and promoting the well-being of all at all ages (United Nations 2018). Furthermore, the United Nations (2015) acknowledges the importance of partnership and proposes a global partnership for sustainable development, focused on the needs of the poorest and most vulnerable with the participation of all countries, all stakeholders and all people. Therefore, to accelerate progress and address new health challenges, all sectors are expected to partner in the development of healthcare solutions that work for people, families, communities, and nations.

SDG number 3 relates to ensuring healthy lives and promoting the well-being of all ages and includes 13 targets for its achievement by 2030. Three of these targets are related to MNCWH care services, namely:

- Reduce the global maternal mortality ratio (MMR) to less than 70 per 100 000 live births
- End preventable deaths of newborn babies and children under 5 years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1 000 live births and under-5 mortality rate to at least as low as 25 per 1 000 live births.
- Ensure universal access to sexual and reproductive healthcare services, including family planning, information and education, and the integration of reproductive health into national strategies and programmes (United Nations 2015).

Efforts to achieve these targets are underway, particularly those related to reducing maternal and newborn mortality and morbidity. These efforts have resulted in success in some countries, but regrettably, progress in most countries including South Africa has been unacceptably slow (Damian and Kühn 2019). Efforts to reduce maternal and child mortality rates date back to Millennial Development Goals (MDGs) adopted in 2000 which were to be achieved by 2015. South Africa was one of the countries that was unable to achieve both MDG 4 and 5 (South Africa. Department of Health 2016; Damian *et al.* 2017; WHO 2019; Mmusi-Phetoe 2016). This is also evidenced in the report by The WHO (2019) that only 16 countries demonstrated an average annual reduction of MMR based on the estimated points for MMR in 2000 and 2017. The WHO (2019) highlighted the strategies employed by these countries stating that these can illuminate routes to progress. The following are the five strategies highlighted by the WHO:

- Address inequities in access to and quality of sexual, reproductive, maternal, and newborn healthcare.
- Ensure universal health coverage for comprehensive sexual, reproductive, maternal, and newborn healthcare.

- Address all causes of maternal mortality, reproductive and maternal morbidities, and related disabilities.
- Strengthen health systems to respond to the needs and priorities of women and girls.
- Ensure accountability to improve quality of care and equity.

The expected projections indicate that accomplishing the target of a global MMR related to SDG 3 of less than 70 will result in nearly 70% fewer deaths by 2030 than the estimated number in 2015 and will save approximately 1.4 million women's lives between 2016 and 2030 compared to the reduction iMMR since 2015 (WHO 2019). Maternal mortality in-facility ratio measures the number of women who die in a facility during pregnancy, childbirth, and the puerperium or within 42 days of termination of pregnancy irrespective of the duration and site of the pregnancy and irrespective of the cause of death (obstetric and non-obstetric) per 100 000 live births in the facility (South Africa. Department of Health 2017). The target for this indicator is less than 70 maternal deaths for every 100 000 live births by the year 2030. This is an interim target of a downward trend of below 100 maternal deaths per 100 000 live births, which was set by the South African National Health Data Advisory and Co-ordinating Committee (HDACC) to be achieved by 2019. Following the encouraging and steep decline from 2010, with institutional (iMMR) of below 100 in 2019, there was a worsening of the ratio in 2020 (126.1) and 2021 (148.1) which shows an increased iMMR during the first two years of COVID-19 pandemic, but this has now been reversed, with the 2022 iMMR approaching pre-pandemic level which was 98.8 in 2019.

Khatiwada *et al.* (2020) declared that each day approximately 810 women die during pregnancy and childbirth, with 94% of these deaths occurring in low and middle-income countries. The concern is that the reported deaths are mostly from births attended to by the SBAs in health facilities, which is very low compared to those seen by TBAs, which are usually not reported. To date, TBAs still use common traditional practices according to their cultural values and beliefs during the care of natal women and neonates at home.

2.4 TRADITIONAL BIRTH ATTENDANTS AND THEIR ROLE IN HEALTHCARE

The WHO, ICM and FIGO (2014) issued a joint statement defining TBAs as traditionally independent, non-formally trained and community-based providers of care during pregnancy, childbirth and the postnatal period. A similar definition by Miller and Smith (2017) is that TBAs are non-professional people who conduct home births but lack the technical skills and training to manage obstetric complications although some of them may have received training for client referrals. Thus, the TBAs provide care during pregnancy, childbirth, and the post-partum period. Adatara and Amooba (2020) note that other services provided by the TBAs in Ghana and Zambia are psychological support and continuous counselling, and some TBAs are also traditional healers, herbalists, spiritual healers and some are diviners.

Traditional birth services are often provided by members of the community, usually elderly women, who are trusted by the community in assisting with delivery and other traditional activities related to pregnancy, birthing and care of women and young children during pregnancy and post-delivery (Adatara and Amooba 2020). The WHO (2014) concurs and adds that female traditional healers, spiritual healers and retired community nurses in some communities also render these services. Spiritual healers are also utilised since women will sometimes fear evil spirits or 'the evil eye', which is why sometimes they hide their pregnancy until after the third trimester when they think the foetus is strong enough and this sometimes leads to restricted or delayed ANC engagement. The TBAs are usually located within the communities where women who require maternity care are living, and they possess knowledge of community norms (Ohaja, Murphy-Lawless and Dunlea 2020).

Adatara, Strumpher, and Ricks (2018) stated that nurses and doctors are always busy and are unable to provide the required and expected psychological support to labouring women due to being so busy. This leads to pregnant women trusting

their TBAs in the communities that are always available for them (Adatara, Strumpher and Ricks 2018). Similarly, Mwoma, Kituku and Gitome (2021) state that most of the births occurring outside the health facilities occur in sub-Saharan Africa where about half of births occur without SBAs but are attended to by TBAs, and they are the only source of assistance women can rely on during delivery. Most women in the study by Adatara, Strumpher and Ricks (2018) described TBAs who also offer psychological support which assists in encouraging women to do their best during labour and delivery. They stated that TBAs are good at giving psychological support which is what is lacking in the health facilities leading to some women in rural areas not using the services of the SBAs. According to the WHO (2015), poor maternal health outcomes can be reduced by the utilisation of formal antenatal, childbirth and postnatal services in health facilities with professional health attendants. Therefore, women should be encouraged to utilise healthcare facilities as well as TBAs.

Several other studies concur that most women in rural areas prefer the support given by TBAs compared to SBAs since they perceive them as very respectful, skilled, friendly, and trustworthy. Ngunyulu, Mulaudzi and Peu (2020) highlight that the preference and choice of maternity care by pregnant women is influenced by various factors including disrespectful SBAs and abusive behaviour in maternity care. In addition, many TBAs, particularly those who are traditional or spiritual healers, use traditional herbs and holy water during pregnancy to assist the pregnancy and later to help the pregnant woman deliver normally and as fast as possible. Traditional herbs and holy water are also used to protect the woman and her unborn baby from evil spirits, which may be potentially dangerous to them (Scina 2017).

There is research evidence that the role of TBAs includes assisting and being present for women during pregnancy, labour, and puerperium and that this started before modern obstetric care (Adatara, Strumpher and Ricks 2018; Aziata and Omenyo 2018). Several services offered by the TBAs include: practices to assist the woman to fall pregnant and maintain pregnancy (*ukumisela*); family planning services (*imbelekisani*) which include women being

educated about safe sex practices and young women being advised that a male does not need to penetrate a woman but puts his penis in between the woman's thighs for pleasure (*ukusoma*); Protection of the unborn infant from any form of negative influence; Antenatal care services (*ukuxukuza*) during which palpation is done as well as estimation of gestational age; delivery services (*ukuzalisa/ukubelethisa*) and assisted delivery (*ukukhiphela*) (Scina 2017).

Chi and Urdal (2018) conducted a study on TBAs in Uganda and found that the main roles of TBAs are: providing advice on family planning; nutritional requirements; screening of high-risk mothers; fertility/infertility treatment and determination of ailments or abnormalities relating to reproductive organs and reproduction. These findings by Chi and Urdal (2018) concur with the findings by Imogie *et al.* that TBAs provide care for childbearing mothers during pregnancy, labour, and postnatal periods and take care of the infants in health and disease/sickness; recruitment of new acceptors into TBA practice; newborn counselling responsibilities; and preservation and conservation of herbal plants and their derivatives. According to Mwoma, Kituku and Gitome (2021), in Indonesia, the TBAs are trusted for providing culturally appropriate pregnancy care which is in line with the traditional expectations of the community and plays a critical maternal role in rural and deprived communities where there are inadequate SBAs. They assist in conducting uncomplicated deliveries at home since there is a shortage of SBAs and are also responsible for advising women to deliver in a hospital for maternal care if necessary. They provide health education on nutrition and natural family planning to women in different communities and arrange transport and accompany those who are in labour to give birth in hospital (Mwoma, Kituku and Gitome 2021).

In Ghana, the roles of TBAs include conducting deliveries at home in rural areas; arranging means of transport and accompanying women in labour to health facilities; providing health education to women on nutrition during pregnancy and lactation; natural family planning and support to women of childbearing age; and newborn counselling to women during pregnancy and childbirth (Adatar, Strumpher and Ricks 2018).

2.5 SERVICES OF TRADITIONAL BIRTH ATTENDANTS

Several researchers concur with the services that are provided by TBAs, most of which are synonymous with those provided by SBAs (Scina 2017; Adatara, Strumpher and Ricks 2018; Chi and Urdal 2018; Imogie *et al.* 2020). Adatara, Strumpher and Ricks (2020) highlight two roles which are not similar to those provided by SBAs, namely, providing health education to women on nutrition during pregnancy and lactation, and arranging transport and accompanying women in labour to the healthcare facilities. They also give the women psychological support and newborn counselling during pregnancy and childbirth. Chi and Urdal (2018) attest to this and include in their list of recommendations for healthcare, screening of high-risk mothers, fertility or infertility treatment and termination of ailments or abnormalities relating to reproductive organs and reproduction. Imogie *et al.* (2020) found that TBAs provide care for childbearing mothers during pregnancy, labour and postnatal periods. They also provide treatment and care for infants to ensure that they stay healthy. It is the function of the TBAs to recruit women into becoming TBAs and accepting them into the practice, provide counselling, and preserve and conserve herbal plants and their derivatives. Nonetheless the findings by Takon *et al.* 2023 do not fully agree with this as these authors concluded in their study on knowledge and practice of antenatal care among TBAs done in Southern Cross River State, that although TBAs were observed to have some good knowledge, positive attitude, and some level of good practices of antenatal care, an in-depth assessment of the knowledge of TBAs is still required using other research designs to confirm this.

TBAs provide women with different services in their communities which are crucial to maternal and neonatal health, especially in communities where there are problems with easy access to healthcare services (Mwoma, Kituku and Gitome 2021). TBAs serve as the first point of contact for women who rely on them from when they first realise that they are pregnant, so they will monitor them even though they cannot do pregnancy tests and do not have any guide

or policy. Mutale *et al.* (2020) recommended that there should be clear guidelines and interactions between midwives and TBAs which are needed to monitor women during pregnancy and the health outcomes and costs of care because of collaboration. Mwoma, Kituku and Gitome's (2021) study found that TBAs offer nutritional advice, natural family planning advice and self-care and they also give women psychological support. This type of education is important because education is crucial for improving maternal and child health outcomes and can be enhanced through collaboration with midwives who can provide up-to-date medical information and training.

During labour TBAs offer essential emotional and physical support since they are called to the woman's home or the woman in labour is taken to the TBA's house since it is usually close by. There is also privacy in the TBA houses since the woman who is delivering is usually the only one there compared to the clinic or hospital where there are other women who are in labour or delivering (Fantaye, Gunawardena and Yay 2019). Some can identify complications early such as a big baby and if they know they won't be able to deliver the woman, they advise them to go to the hospital, although sometimes women will refuse referral because they fear caesarean section. Most TBAs will assist in delivering women and send them to healthcare facilities for check-up post-delivery and for the newborn baby to be checked as well. Some are even willing to accompany these women to the hospital or clinic to ensure that they are well taken care of and for support (Musie *et al.* 2022). Garces *et al.* (2019) refer to doulas in their country who ensure that women are comfortable in the healthcare facility .

Post-delivery, TBAs continue to care for women and their newborn babies and assist them with breastfeeding and educate the mother on how to care for the baby until they are strong enough to go home (Ngunyulu, Mulaudzi and Peu 2020). According to Hermawan (2016) TBAs are also able to recognise signs of post-partum complications such as haemorrhage but they are unable to treat women and they are willing to learn from the midwives, and they do send women to the hospital for further management if necessary. This statement is supported by Musie *et al.* (2022) who highlight the importance of training TBAs on issues

such as induction of labour, cervical ripening before surgical procedures, and the importance of management of post-partum haemorrhage.

Since TBAs are from within the communities and as a preventive measure encourage women to utilise healthcare services since they are aware of the high maternal and neonatal morbidity rates. Some women will listen and go to the healthcare facilities since they trust the TBA's views. Some will not since they do not trust the midwives or it is too far to go to the healthcare centres. It has been noted that TBAs do refer women to healthcare facilities since they trust the midwives with the knowledge they have since they are trained for what they are doing, but the midwives do not refer women back to them, instead, they do not recognise their hard work (Mwoma, Kituku and Gitome 2021).

2.5.1 Views regarding the services of traditional birth attendants

Hajaratu and Sunday (2022) conducted a study in Nigeria on perceptions of the roles of TBAs in providing, caring, and support to mothers during pregnancy and after birth among refugee women. Their findings highlighted the following:

- TBAs are preferred by women because they are always available.
- TBAs offer individualised care to mothers compared to the healthcare facility.
- TBAs provide herbal medicine believed to quicken labour process.

Hajaratu and Sunday (2022) interviewed men and heard from them that:

- The TBAs play a critical role in caring for the unborn babies and the mother during pregnancy.
- They massage the woman's womb to estimate the birth date.
- There is no payment for TBAs, but they are paid in kind which makes it affordable to use them.
- They further revealed that they are confident with the care and support their wives receive from the TBAs since they also educate them about customs and culture which they do not receive the healthcare facilities.

Pregnant women who were interviewed for the study stated the following:

- They are comfortable being under the care of TBAs till delivery because they can be with their other children at home which saves them a lot of anxiety and worrying about who is taking care of them while they are away.
- TBAs escort them to healthcare facilities for immunisation and birth registration which gives them confidence.
- They also advise sick mothers to take their medication and the importance of eating well.

There is evidence from several sub-national primary healthcare programmes that deliveries by trained TBAs increased from 0 to 65% and healthy deliveries in the health facilities increased because of proper referral by TBAs (Graces et al. 2019). Referral of women to healthcare facilities would be of great benefit to women and their families, but most women still prefer to utilise TBAs instead of midwives. Andrea *et al.* (2017) found that when women decline maternal referral advice given, the decision-making process usually involves interactions with other family members especially husbands and it also depends on the prevailing family and economic situation at the time.

The above were mostly positive views about TBAs, but some authors including Sawyer (2024); Shimpuku et. al. (2021) and Amutah-Onukagha (2017) point out some negative aspects about the TBAs such as:

- TBAs have no formal education to care for pregnant women which poses a problem when complications arise during pregnancy labour and delivery. Lack of knowledge and training among the TBAs can lead to harmful outcomes such as infections and delayed referrals to healthcare facilities which puts the mothers and the unborn babies at high risk.
- The quality of care provided by the TBAs can vary depending on their experience and if they possess any training, and this may lead to negative health outcomes.

In many countries, TBAs practice without formally registering under any regulatory body like nurses who are registered with the South African Nursing

Council (SANC) ensuring patient safety and efficient services. This can cause problems between midwives and TBAs since TBAs are not registered anywhere and there is no regulatory body or membership organisation to guide them should there be a negative incident. This makes clear communication and coordination between midwives and TBAs difficult. Communication and coordination is challenging to establish and maintain, particularly in resource-limited settings. Therefore, developing guidelines for healthcare professionals and TBAs to work together can assist in also involving the community so that women can get support thus reducing the maternal mortality rate in KZN.

2.5.2 Conflicting demands between traditional beliefs, religious beliefs, and Westernised healthcare

Adatara, Strumpher and Ricks (2018) state that some traditionally valued practices are prohibited in Western healthcare centres thus resulting in some women not being keen to use these healthcare services. TBAs take into consideration the cultural and religious values as well as community traditions when performing their roles which helps them win the confidence of the pregnant woman and family resulting in them choosing to be cared for and be delivered by them rather than the SBAs (Adatara, Strumpher and Ricks 2018). Although some women want to comply with both traditional and Western practices, more often than not the demands of traditional and Western medical practices conflict with each other thus not allowing the women to satisfy both. For example, some women believe that to prevent negative outcomes of pregnancy they need prayer and holy water which most often is not just plain water but has some remedies added to it to chase away evil spirits Aziato and Omenyo (2018), yet such a practice is forbidden by Westernised medical care. Hernandez, Bastos and Shirazian (2017) attest that valued acts by some women such as taking isihlambezo to speed up the delivery process, traditional steam baths, massages with traditional medicine as well as the use of plant-based remedies, are prohibited in hospitals. There are cultures where women and their newborn babies are isolated post-delivery in order to protect them from evil spirits and to promote physical and emotional well-being; during this time most women utilise

TBAs since midwives no longer do home visits (Ngunyulu, Mulaudzi and Peu 2020). Where this is practiced, the women are unable to attend for the scheduled routine check-up visits as recommended in the Guidelines of Maternity Care if they are honouring this traditional practice (South Africa. Department of Health 2016).

Dantas, Singh and Lample (2020) acknowledge that women seek religious practices to ensure extra protection during pregnancy but emphasise that women should be encouraged and educated on the dangers of some of these practices that could lead to negative health effects on them and their unborn children. Being part of the community the TBAs are a good interface between women and the healthcare centres and therefore are in a better position to work with healthcare facilities in addressing the conflicting demands between traditional and religious beliefs and Westernised healthcare. Thus, the intention of the researcher in the current research was to develop guidelines to facilitate collaboration between midwives and TBAs in KZN.

2.6 COLLABORATION BETWEEN TRADITIONAL BIRTH ATTENDANTS AND THE HEALTHCARE SYSTEM

There is a need for SBAs to collaborate with TBAs in rural areas to provide and ensure woman-centred childbirth care and reduction of maternal mortality rate (Adatara, Strumpher and Ricks 2018). This idea is supported by Van Rooyen *et al.* (2017) by stating that there is an increased demand for consulting both traditional and health practitioners globally and in South Africa as they work within the same communities and their respective practices could complement or undermine the health of consumers using both health services. Collaborating with TBAs to promote improved access to skilled care at birth improves access to skilled care during pregnancy, childbirth, and post-partum which is a priority strategy for improving maternal health and is key to achieving one of the many indicators specified in sustainable development goal (SDG) 3, namely, reducing the global maternal mortality ratio (Miller and Smith 2017). Miller and Smith

(2017) also support the integration of other stakeholders to contribute to a support and monitoring system for the transition period.

The WHO (2014) advises that TBAs can assist in the provision of skilled care to women and newborn by serving as advocates for skilled attendants and maternal and newborn health needs, encouraging women to enrol for essential pre-and postnatal care and to obtain care from a skilled attendant during childbirth. They can also help women with nutrition, treatment, dietary supplementation, immunisation, scheduled appointments, plans for births and emergencies, etc. Encouragement of the involvement of the male partner in the care of the woman and their newborn is also part of their role as well as disseminating health information through the community and families regarding danger signs, where and how to seek care, healthy lifestyles, where to seek assistance for other reproductive health needs such as family planning, neonatal and immunisation (WHO 2014). Furthermore, the WHO (2014) proposes that TBAs could also play a role in giving social support during and after delivery, either as a birth companion or by taking care of their household while the woman is away for childbirth, and inform the community nurses about women who have become pregnant in the community so that they can make direct contact with them. Through these roles, the TBAs can link families, communities, local authorities and reproductive health services by encouraging community involvement in the development and maintenance of the continuum of care (WHO 2014). Thus, collaboration with other health professionals is needed for the effectiveness of maternity care (WHO 2004).

Cole *et al.* (2018) conducted a study in Nampula Province, Mozambique and emphasised the importance of collaboration between MNCWH nurses and TBA. This was to build TBAs' capacity for basic safe delivery, ANC, and postnatal care (PNC) knowledge and referral skills. It also prepared them to track beneficiaries from antenatal care through institutional delivery and the post-partum period. Adatara, Strumpher and Ricks (2018) on the other hand found that TBAs played a significant role in the intervention's successful implementation, working as partners with health systems to provide respectful

care throughout the MNCWH service cascade. Finally, this study supported the importance of meaningfully engaging community leaders in healthcare improvement interventions (Cole *et al.* 2018). However, in KZN, no evidence-based recommendations were found that facilitated the collaborative relationship between healthcare practitioners and TBAs. Professional collaboration between TBAs and healthcare services is therefore desirable.

2.7 BARRIERS TO COLLABORATION

It has been noted that some countries have tried to implement collaboration between TBAs and healthcare workers; some succeeded and others did not. Implementation challenges exist at different levels such as individual, facility and community as well as at the healthcare level and different factors and barriers were identified by Miller and Smith (2017). The continued preference for TBAs and traditional birth practices was noted and cultural practices in some regions have been recognised as a barrier to medical facility-based skilled care use as women and community members still trust and prefer to use TBAs. A lack of available or accessible medical skilled care in some remote communities is also a reason given for the continued use of TBAs (Miller and Smith 2017).

In Nigeria, Hajaratu and Sunday (2022) discovered that there were gaps in the health sector that needed urgent intervention by integrating the TBAs into the health sector. One of the barriers was that some healthcare workers viewed TBAs as a threat (Hajaratu and Sunday 2022). The following barriers were also highlighted in a study conducted in Tshwane and Johannesburg by Musie *et al.* (2022):

- Undermining and name-calling by healthcare workers.
- Stigmatisation towards TBAs since no one from healthcare is interested to come and know what the TBAs are doing. The healthcare professionals do not know how TBAs operate.
- Negative attitudes shown by the healthcare practitioners towards patients referred by TBAs and they also discriminate against them due to lack of understanding.

Miller and Smith's (2017) thorough systematic review identified barriers from different countries, such as:

- (1) Poor working relationships between TBAs and SBAs, and not being made welcome at facilities when working alongside skilled birth attendants.
- (2) Some husbands are the main decision-makers in their families and are unwilling to seek external assistance but trust TBAs more than midwives.
- (3) Geographical barriers were also identified where even with collaboration, they still preferred to utilize TBAs since they were closeby.
- (4) Since TBAs and healcare workers are expected to work together when collaboration starts, rivalry and negative attitudes were also noted as a barrier.
- (5) women continuing to utilize TBAs only as women and community members continued to trust and prefer to utilize only TBAs instead of both.

Miller and Smith (2017) state that these barriers may discourage the healthcare workers and TBAs and collaboration will not be feasible. Musie *et al.* (2022) in their study found that the TBAs are ready to collaborate with the healthcare system but they want to be recognised and acknowledged so the healthcare facilities need to improve their relationship with TBAs.

2.8 CHAPTER SUMMARY

This chapter presented various findings from relevant literature sources which assisted in supporting the importance of conducting this study and deciding on the theoretical framework which was used to guide the study. The chapter also presented an overview of uThukela District which was the district under study. The next chapter focuses on the identification and description of the theoretical framework guiding the study.

CHAPTER 3: THEORETICAL FRAMEWORK

3.1 INTRODUCTION

Chapter 3 presents the theoretical framework that guided the study. The researcher begins this chapter by providing an overview of the use of theories in research. Thereafter, the selected theory is described in detail including how it was used to frame the study. Visual representation in the form of figures is used to present the theory and its application to the study.

3.2 USE OF THEORIES IN RESEARCH

A theory is an abstract generalisation that explains how phenomena are interrelated (Polit and Beck 2021). Theoretical frameworks and conceptual frameworks play interrelated roles where theories allow the researchers to integrate observations and findings into an orderly scheme, and theories are an efficient framework allowing for accumulated facts to be drawn together (Polit and Beck 2021). Several theories must be reviewed to select the most appropriate and relevant one to guide the study based on the research problem. A framework for a qualitative study may provide a theoretical context for the research. The concepts in the framework must be linked to the study variables and are used to define the variables conceptually (Grove, Gray and Burns 2017).

A brief review of key background literature and a simple diagram of the conceptual framework should lead directly into the research questions or hypotheses that address the knowledge gap (Grove, Gray and Burns (2017). A framework provides the basis for generating and refining the research problem and purpose and linking them to the relevant theoretical knowledge in nursing or related fields. Theories from nursing and other disciplines are frequently used as frameworks which, according to Smith and Liehr (2013), include concepts and relationships among propositions, and are sometimes represented in a

model or a map. This study was guided by the structural functionalism theory of Talcott Parsons (Parsons 1954 cited in Orsini 2024; and Maier *et al.* 2024).

3.3 THE STRUCTURAL FUNCTIONALISM THEORY

The structural functionalism theory is mostly used in sociology. It is a sociological perspective that emerged in the early 20th century and became one of the dominant theoretical frameworks in sociology during the mid-20th century. The theory has undergone several developments and thus is available in various versions including those by Émile Durkheim, Bronisław Malinowski and Talcott Parsons. The historical development of the structural functionalism theory is discussed in the next section.

3.3.1 Historical development of the structural functionalism theory

Structural functionalism is as old as the history of sociology. This is evident in the works of the founding fathers of social thought like Auguste Comte (1798-1857) and Herbert Spencer (1820-1903) who used biological concepts to explain social order. However, structural functionalism emerged as a prominent sociological theory through the contributions of three eminent twentieth-century sociologists, namely: Émile Durkheim, Bronisław Malinowski, and Talcott Parsons.

3.3.1.1 Émile Durkheim (1858-1917)

Émile Durkheim introduced the concept of "social facts," which are external to individuals and exert a coercive influence on them which according to him include norms, values, institutions, and social structures, which shape individual behaviour. Durkheim believed that these social facts are crucial for understanding the functioning and stability of society.

In his ground-breaking work "The Division of Labour in Society" (1893), Durkheim explored the relationship between social order and the division of labour. He distinguished between mechanical solidarity (found in traditional,

small-scale societies) and organic solidarity (characteristic of industrial, complex societies). Durkheim contended that the division of labour promotes social integration and solidarity. In modern societies, individuals become interdependent, relying on each other for various goods and services, which contributes to the stability of the social order. Durkheim emphasised the importance of social integration in maintaining social order. He believed that a high degree of social integration fosters a sense of belonging and shared values among individuals, reducing the likelihood of deviant behaviour. He introduced the concept of "anomie" to describe a state of normlessness or breakdown in social norms. Anomie can occur when there is a lack of integration or regulation in society, leading to higher rates of suicide and deviant behaviour.

In his other work named "The Elementary Forms of Religious Life" (1912), Durkheim applied a functionalist perspective to the study of religion. He asserted that religious rituals and beliefs serve essential functions in society, promoting social cohesion and providing a moral framework. His analysis of religion highlighted its role in reinforcing collective values and symbolising the shared consciousness of a community. He conducted a ground-breaking study on suicide, published in "Suicide: A Study in Sociology" (1897). In this work, he analysed suicide rates across different social groups and identified social factors that influence suicide. Durkheim's research demonstrated the connection between social integration and suicide rates. He found that individuals with weaker social ties were more susceptible to suicide, reinforcing the idea that social factors play a crucial role in shaping individual behaviour. His concept of organic solidarity emphasised the idea that in modern, industrial societies, interdependence and specialisation contribute to social stability. He believed that while traditional societies relied on shared beliefs and values (mechanical solidarity), modern societies achieved cohesion through the functional interdependence of diverse individuals and institutions. In general, Émile Durkheim's contributions to structural functionalism provided a comprehensive framework for understanding the interplay between social structures, institutions, and individual behaviour. His emphasis on social facts, the division of labour, social integration, and the functional analysis of various phenomena

laid the groundwork for subsequent developments in structural functionalist theory.

3.3.1.2 Bronisław Malinowski (1884-1942)

Bronisław Malinowski, a Polish anthropologist, played a crucial role in the development of structural functionalism, particularly in the field of anthropology, by focusing on the role of institutions in satisfying basic human needs. His ethnographic studies through his fieldwork in the Trobriand Islands led to the understanding that cultural practices and institutions, such as marriage and religion, serve specific functions in meeting the fundamental needs of individuals and society. Malinowski is often considered one of the pioneers of functionalist anthropology. He advocated for a holistic approach to studying societies, emphasising the interdependence of cultural elements and the functional roles they play in maintaining social order. His work countered the prevailing evolutionary theories of the time, which viewed societies as progressing through stages. Malinowski advocated for a more nuanced understanding of cultures, focusing on the functions that specific customs and practices served in meeting the basic needs of individuals.

Malinowski introduced and popularised the method of participant observation, where the anthropologist immerses themselves in the everyday life of the studied community. This method allowed for a more intimate understanding of social practices and provided insights into the functions of different customs and institutions. Through participant observation, Malinowski aimed to uncover the "imponderabilia of actual life", the subtle and often overlooked aspects of social practices that contribute to the functioning of a society. Malinowski emphasised the idea that cultural institutions and practices fulfil basic human needs. He identified universal human needs, such as food, shelter, reproduction, and security, and demonstrated how cultural institutions developed to meet these needs. His approach highlighted the adaptive and functional nature of cultural customs, suggesting that they evolved to address the practical challenges faced by societies.

Furthermore, Malinowski's later works, such as "Sex and Repression in Savage Society" (1927) and "The Sexual Life of Savages in North-Western Melanesia" (1929), explored the relationship between individual psychology and cultural practices. He advanced that cultural norms and institutions are integral to shaping individual behaviour and personality. By understanding how cultural practices fulfil psychological needs, he contributed to a more holistic understanding of the interplay between culture and individual psychology. Malinowski, however, criticised the speculative and theoretical approach of armchair anthropologists who relied on second-hand information. He advocated for fieldwork and first-hand observation to ensure accurate and contextually rich data. This emphasis on empirical research became a cornerstone of anthropological methodology and contributed to the development of a more scientific and rigorous discipline.

3.3.1.3 Talcott Parsons (1902-1979)

Talcott Parsons, an American sociologist, made substantial contributions to the development and elaboration of structural functionalism in sociology (Parsons 1954 cited in Orsini 2024; and Maier *et al.* 2024). He is often considered the key figure in the American development of structural functionalism. In his work, particularly "The Structure of Social Action" (1937) and "The Social System" (1951), Parsons expanded on Durkheim's ideas and developed a comprehensive theory of social systems. One of Parsons' key contributions was the development of the adaptation, goal attainment, integration, and latency (AGIL) paradigm, which stands for, and became a central aspect of, his structural functionalist theory. This framework outlined the essential functions that social systems must perform to maintain stability.

The AGIL paradigm was developed by Talcott Parsons to analyse the functional requisites necessary for the survival and stability of a social system. The term 'system' implies an orderly arrangement, an interrelationship of parts. In the

arrangement, every part has a fixed place and a definite role to play. The parts are bound by interaction as presented in Figure 3.1.



Figure 3.1: The Social System by Talcott Parsons Source: Triumphias (2020)

To understand the functioning of a system, for example, the human body, one must analyse and identify the sub-systems (e.g. circulatory, nervous, digestive and excretory systems) and understand how these various subsystems enter into specific relations in the fulfilment of the organic function of the body (Chriss and Tedor 2023; Karimi 2023). Likewise, society can be viewed as a system of interrelated mutually dependent parts which cooperate to preserve a recognisable whole and to satisfy some purposes or goal. A social system may be described as an arrangement of social interactions based on shared norms and values. Individuals constitute it and each has a place and function to perform within it (Chriss and Tedor 2023). The key elements used in this study, which are collectively referred to by Talcott Parsons as AGIL, are described below.

3.3.1.3.1 Adaptation (A)

This refers to the system's ability to interact effectively with its environment. It involves the processes through which a society adjusts and adapts to changes in its external conditions, ensuring the satisfaction of material and biological needs (Parsons 1954). In the current study, adaptation refers to midwives,

TBAs, and women/community adapting to working collaboratively including with the Department of Health.

3.3.1.3.2 Goal attainment (G)

This component focuses on the system's ability to set and achieve its collective goals. It involves the formulation of societal objectives, the allocation of resources to achieve those objectives, and the development of mechanisms to monitor progress and success (Palomares and Sotto 2024). Midwives and TBAs will set collective goals so that they have a common goal where they can work together collaboratively to assist women with maternity care.

3.3.1.3.3 Integration (I)

Integration refers to the coordination and regulation of various elements within the social system. Parsons emphasised the importance of shared values, norms, and institutions that promote social cohesion and prevent conflicts. Social institutions, such as the family, education, and legal systems, play a crucial role in integration (Jones *et al.* 2018). In this study, integration will be achieved by developing a guideline for collaboration between midwives and TBAs who have a similar goal of assisting women from pregnancy to the post-delivery period.

3.3.1.3.4 Latency (L)

Latency pertains to the maintenance and reproduction of the societal system over time. It includes the cultural and socialisation processes that transmit values and norms across generations, fostering a sense of continuity and stability. Latency also involves the management of tensions and conflicts within the system.

Parsons introduced the concept of functional differentiation, emphasising the increasing specialisation and differentiation of societal institutions to fulfil specific functions. He asserted that as societies evolve, they develop

specialised structures to handle different aspects of the social system. Functional differentiation helps maintain social order by ensuring that each institution focuses on its specific role, contributing to overall system stability. For example, in modern societies, economic, political, educational, and religious institutions are distinct entities, each with its functions and roles. Parsons developed the idea of pattern variables, which are sets of contrasting values that individuals and societies use to navigate social situations. These variables include dichotomies such as affectivity versus affective neutrality, specific versus diffuse relationships, and self-orientation versus collective orientation. The pattern variables are essential for understanding how individuals and societies make choices and establish norms. They highlight the tensions and trade-offs that exist between different values and orientations within a social system.

Parsons contributed to the development of action theory, emphasising the importance of understanding individual behaviour in the context of social systems. He argued that actions are guided by both individual motives and societal norms, and his work sought to reconcile the micro-level analysis of individual behaviour with the macro-level analysis of social structures. Talcott Parsons' contributions to structural functionalism, particularly the AGIL paradigm, provided a comprehensive framework for understanding the interplay between social systems, institutions, and individual behaviour. While his work faced critiques, it significantly shaped the landscape of sociological theory and paved the way for subsequent developments in the discipline. In this study, both TBAs and midwives will be motivated to work together and perform their roles according to social expectations (Umam and Mubarok 2023). Figure 3.2 presents the AGIL structural functionalism theory by Talcott Parson's as presented by Triumphias (2020).

Talcott Parsons: *The Social System*

The AGIL Model of Social Organization

	Universalism over Affective Neutrality	Particularism over Affectivity	
	Adaptation	Goal Attainment	
Specificity over Performance Problem Solving	-system must cope with situational exigencies.	-system must achieve goals	Performance over Specificity
System Maintenance Qualities over Diffuseness	Latency -renew, maintain cultural cultural patterns: -tension management -pattern maintenance	Integration -insured cooperation system must regulate interrelations	Diffuseness over Qualities
	Affective Neutrality over Universalism	Affectivity over Particularism	

Figure 3.2: AGIL structural functionalism theory by Talcott Parsons
Source: Triumphias 2020

3.4 APPLICATION OF TALCOTT PARSON'S AGIL TO THIS STUDY

Talcott Parsons' structural functionalism views society as a system made up of interrelated parts that together form a whole (Haralambos and Holborn 2021). Functionalism focuses on the structures of society and their functional significance (positive or negative consequences) for other structures. The primary concern of functionalism is the large-scale social structures and institutions of society, their interrelationships, and their constraining effects on actors (South Africa. Department of Health. 2021a). The other focus is how the

basic parts of the society, that is, the various institutions, such as the religious, family, political, economic, legal, and health institutions, co-relate together and function for the survival of the society. Talcott Parsons was the first to simplify structural functionalism into four paradigms. He affirmed that the sustained survival of all social institutions or structures depends on the following four functional imperatives or paradigms: adaptation, goal attainment, integration, and latency (AGIL). In this study, the social institution of interest is the healthcare system (health sector).

3.4.1 Adaptation (A)

Adaptation refers to the fact that systems are embedded in physical and socio-political environments to which they must adapt to survive. Parsons (1954) defines adaptation as a system's ability to adapt to its surroundings and is known as its adaptive function. This is an instrumental function by which a system adapts to the external environment or adapts the external environment to the system. In the case of this study, TBAs and women are external to the health system which needs to adapt to their presence if they are to work closely with the midwives who are internal to the health system. It has been established through many studies that TBAs play a major role in the child and maternal health of pregnant women, particularly in rural communities, where the majority of women in South Africa are living (Robinet, Jeffredo and Clesse 2023; Chikovore and Sooryamoorthy 2024; Zieff *et al.* 2024). Hence, it is necessary for the healthcare system in South Africa to adjust and adapt its processes and practices to suit the needs of this large population by formally integrating TBAs into the healthcare sector with an appropriate guideline. In the context of integrating TBAs into the health system, adaptation involves recognising how TBAs function including their cultural practices regarding antenatal care and childbirth, and acknowledging the knowledge of community customs that are positive or negative to maternal health and childbirth. These will be incorporated in the development of guidelines to facilitate the collaboration. When both parties adapt to working together, they will learn from each other by opening the lines of communication, which will enable them to refer to one another.

Therefore, the TBAs and midwives need to adapt to each other's practices and open lines of communication.

3.4.2 Goal attainment (G)

Goal attainment refers to the need to define the primary goals of any system and the methods by which individuals accept those goals as their own and strive to achieve them. It is key function that sets the goals for the system and organizes resources to attain them (Palomares and Sotto 2024). In this study, the researcher met with TBAs, midwives, and women and obtained their views on collaboration and the findings were clear that they all supported collaboration between one another and had the same goal that they needed to attain, that of providing and ensuring quality care as well as ensuring the safety of women from pregnancy to post-delivery. At the time of my meetings with TBAS, there was no collaboration. The guidelines that appear in Chapter 8 were developed and built on these findings to facilitate collaboration. Therefore, for midwives and TBAs to attain their goals, it is important for the two parties to work together, have good communication, and respect and trust each other and work as a team and integrate their knowledge.

3.4.3 Integration (I)

Integration refers to the need to coordinate the parts of the system so that they contribute to the maintenance of the whole. Jones *et al.* (2018) agree that many societal problems transcend the boundaries of singular scientific disciplines as they exist today, and scholars now acknowledge that solutions to these problems will require the integration of knowledge across multiple disciplines and stakeholders. Parsons (1954) defines integration as coordinating, adjusting, and regulating interactions among different actors or units inside the system to eliminate mutual interference and maintain system functionality. In this case, the integration of TBAs with the healthcare system assists by increasing the skilled birth attendance rate since TBAs will gain some skills and also refer women to healthcare facilities (Kassie *et al.* 2022).

For integration to be successful it is important to develop guidelines which will facilitate collaboration between the TBAs and midwives. This study developed these guidelines to attain SDG 3 by involving a multidisciplinary health team. Other community stakeholders will automatically be part of the collaboration since all the parties serve the same community. The guidelines will assist in the establishment of effective communication channels between TBAs and midwives which are essential for information sharing.

3.4.4 Latency (L)

Latency refers to maintaining cultural patterns, values, and norms within a society. In this context, it involves ensuring that both TBAs and midwives understand and respect each other's roles while fostering an environment that supports continuous learning. It also refers to those structures that serve to maintain and revitalise the motivation of individuals to perform their roles according to social expectations and it also speaks about the aspects of cultural patterns, values and norms within society (Umam and Mubarok 2023). Furthermore, pattern maintenance and tension control are two related issues in latency. The first aspect deals with the issue of how to ensure that social system players exhibit good traits, such as motivations, needs, and role-playing abilities and the second aspect focuses on resolving the internal conflicts and strains of social system players (Diakolambrianou and Bowman 2023; Kordyaka *et al.* 2023).

In the context of this study, latency ensures that both TBAs and midwives understand, acknowledge and respect each other and the roles they play in an environment that facilitates their collaboration. Women in many communities rely on and trust TBAs more than they do midwives and SBAs, therefore, there is a need for midwives and TBAs to learn from each other, understand each other's practices and acknowledge the role each play in the lives of women, thus fostering respect and collaboration.

3.5 CHAPTER SUMMARY

This chapter outlined the theoretical foundation and historical development of structural functionalism. Application of the theoretical framework guiding the study in integrating TBAs into the healthcare system. The application of Talcott Parson's theory provides a framework that enables the understanding of how TBAs and midwives can collaborate using AGIL principles to assist in the development of guidelines in order to improve maternal and child health while acknowledging and respecting each other's practices. Clear role definitions are important for successful collaboration.

CHAPTER 4: RESEARCH METHODOLOGY

4.1 INTRODUCTION

Chapter 4 discusses research methodology portraying the steps and procedures that were undertaken to conduct the study. According to Tashakkori, Johnson and Teddle (2021), research methods are the specific strategies, techniques and procedures followed to implement research design, sampling, data collection, data analysis and interpretation of the findings. Polit and Beck (2021) define research methods as steps, procedures, and strategies for designing a study and gathering and analysing data. Tashakkori, Johnson and Teddle (2021) explain and define the kinds of problems that are worth investigating: what constitutes a researchable problem; testable hypotheses; how to frame a problem in such a way that it can be investigated using particular designs and procedures; and how to select and develop appropriate means of collecting data. Gray and Grove (2020) state that a research methodology is a theory of how an inquiry should proceed and involves analysis of the assumptions, principles, and procedures in a particular approach to inquiry. This methodology chapter provides a step-by-step description of how the planned inquiry proceeded including the assumptions, principles, and procedures used.

4.2 RESEARCH DESIGN

The definition and description of research design by Creswell and Creswell (2023) informed the selection and the structure of the design for the current study. Creswell and Creswell (2023) define a research design as a plan and the procedures for research that span the decisions from broad assumptions to detailed methods of data collection and analysis, which is based on the nature of the research problem or issue being addressed, the researchers' personal experiences, and the audiences for the study. Polit and Beck (2021) go further to state that the research design involves several decisions informed by the worldview assumptions the researcher brings to the study, procedures of inquiry (called strategies), and specific methods of data collection, analysis, and

interpretation. According to Creswell and Creswell (2023), the type of design directs the researcher to the selection of a population, procedures for sampling, methods of measurement, and plans for data collection and analysis. The three broad research designs are quantitative, qualitative and mixed methods designs (Tashakkori, Johnson and Teddlie 2021). A brief description of these designs is provided below as background for the choice of method that best fitted the inquiry .

4.2.1 Understanding the three broad research designs

The quantitative and qualitative research methods are the two most common techniques used by the researchers to structure a study to gather and analyse information that is relevant to the research question (Polit and Beck 2021). Qualitative research design aims to explore and understand the underlying meanings, motivations, and experiences of individuals or groups. It is often used to generate theories or hypotheses and provide a deeper insight into a subject. Quantitative research design focuses on measuring and quantifying data, aiming to establish relationships, patterns, and generalizability. It seeks to test hypotheses and make predictions based on numerical data (Polit and Beck 2021). According to Tashakkori, Johnson and Teddlie (2021), mixed methods design is a type of research design where the researcher collects and analyses data, integrates the findings and draws inferences using both qualitative and quantitative approaches in a single study.

The two main alternatives (qualitative and quantitative) correspond to different methods for developing evidence. However, sometimes, due to the nature of the inquiry, researchers require the two designs to complement each other (Polit and Beck 2021) and therefore use both in a single study as a mixed-method design. Gray and Grove (2020) explain mixed-methods design as a systematic review which is the synthesis of findings from individual studies conducted with a variety of methods namely: quantitative, qualitative, and mixed-methods used to determine the current knowledge in an area.

4.2.1.1 Quantitative research design

Polit and Beck (2021) define quantitative research design as a systematic, structured approach to collecting and analysing numerical data to address research questions or test hypotheses. This type of research design is characterised by its emphasis on measurement, statistical analysis, and objectivity. Similarly, Creswell and Creswell (2023) define quantitative research design as a systematic and structured approach to collecting and analysing numerical data to address research questions, test hypotheses, and draw conclusions.

4.2.1.2 Qualitative research design

Qualitative research design is defined by Polit and Beck (2021) as an investigation of phenomena by qualitative techniques, providing data by activities through the collection of rich materials from primary sources. Qualitative research is a methodology that focuses on exploring and understanding complex social phenomena, often from the perspective of the participants. Creswell and Creswell (2023) define qualitative designs as the type of research which involves a fairly linear progression of tasks where the researchers plan the steps to be taken in advance to maximise study integrity and those steps are then followed as faithfully as possible. Qualitative researchers examine and interpret data continually so as to decide on how to proceed based on the emerging findings (Polit and Beck 2021). Creswell and Creswell (2023) explain that qualitative approach inquiry can be descriptive, phenomenological, grounded theory, contextual and exploratory, etc. A researcher can use one or combine two approaches in one study.

4.2.1.3 Mixed methods research design

Mixed methods is characterised as a research approach that contains elements of both qualitative and quantitative approaches. As research methodologies have evolved, the mixed-method approach offers researchers the ability to use the strengths of both qualitative and quantitative research designs (Tashakkori,

Johnson and Teddlie 2021). Polit and Beck (2021) explain the mixed methods approach as being one in which the researcher collects and analyses data, integrates the findings, and draws inferences using both qualitative and quantitative approaches in one programme of inquiry. Mixed methods research involves the integration of quantitative and qualitative research designs at some stage of the research process, giving rise to meta-inferences with a conclusion generated by integrating inferences obtained from the results of the qualitative and quantitative strands of a mixed methodology study (Polit and Beck (2021).

4.2.2 The research design used for this study

The researcher identified a qualitative research design employing an exploratory descriptive case study approach as the best-fitting research design for the planned inquiry. The selected design was deemed appropriate to elicit information from the participants in that it informed the development of guidelines to facilitate collaboration between midwives and TBAs in KZN, South Africa. This research approach enabled the collection of data from:

- Midwives, who possessed valuable insights into women utilising TBAs in the district through focus group discussion;
- Pregnant women attending ANC and those who had already given birth who had sought the services of TBAs during pregnancy, labour and post-delivery through one-on-one structured interviews; and
- The TBAs who were caring for women during pregnancy, labour and post-delivery through one one-on-one semi-structured interviews.

A combination of an exploratory descriptive case study approach with qualitative inquiry allowed the researcher to meet with the participants, talk directly with them, and witness their behaviour and actions within their context to be able to generate rich, detailed data that left the participants' perspectives intact and provided multiple contexts for understanding the phenomenon under study (Creswell and Creswell 2023).

4.2.2.1 Qualitative design

Polit and Beck (2021) define qualitative research design, as an investigation of occurrences by quality techniques that provide data by activities through collection of rich materials from a primary source. Gray and Grove (2020) state that qualitative designs are developed to provide information and insight into clinical or practice problems in order to obtain information needed to develop a programme or intervention for a specific group of patients and to explore a new topic or describe a situation. Creswell and Creswell (2023) explain that qualitative designs can be descriptive, phenomenological, grounded theory, contextual and exploratory and that a researcher can use one or combine two or more approaches in one study.

The advantage of using qualitative methods is that they generate rich, detailed data that leave the participants' perspectives intact and provide multiple contexts for understanding the phenomenon under study. Therefore, qualitative research was used since the researcher wanted to meet with the participants and be able to talk directly with them, see their behaviour and actions within their context which is a major characteristic of qualitative research (Creswell and Creswell 2023). In qualitative research, qualitative researchers usually collect their data in real-world, naturalistic settings (Polit and Beck 2021). This study followed the same approach with all participants although the interview settings were different: at home for the TBAs, at work for the midwives, and in the units where the pregnant women were found at the time of data collection.

4.2.2.2 Exploratory research approach

Polit and Beck (2021) describe exploratory research as research that explores the dimensions of a phenomenon or develops or refines hypotheses about relationships between phenomena. The authors further explain that the goal of exploratory research is to understand the underpinnings of specific natural phenomena. Gray and Grove (2020) concur and state that researchers design exploratory descriptive designs to obtain information needed to develop a programme or intervention for a specific group of patients. For this study, the

researcher intended to develop guidelines to facilitate collaboration between midwives and TBAs in KZN. Explorative designs allowed the researcher to explore primary sources of information, namely midwives and TBAs, to answer all study questions, better understand the collaboration between these two groups and ultimately develop guidelines to facilitate their collaboration as a strategy to achieve SDG 3 through partnerships as proposed by the UN.

4.2.2.3 Descriptive research approach

A descriptive research approach is the description of phenomena in real-life situations, used to describe the current situation completely (especially certain health aspects) and to provide an accurate account of characteristics of particular individuals, situations and groups (Gray and Grove 2020). Gray and Grove (2020) further explain that a descriptive research approach is utilised to gain insights and discover meaning about a particular phenomenon, situation, cultural element, or historical event. Similarly, Polit and Beck (2021) state that descriptive qualitative studies discuss the portrayal of everyday life experiences like hearing, seeing, believing, feeling, remembering, deciding and/or evaluating. Using a descriptive approach allowed the researcher to describe the situation of collaboration between midwives and TBAs as it exists in this community.

4.2.2.4 Case study design

A case study is a research method involving a thorough in-depth analysis of an individual, group or other social unit (Polit and Beck 2021). According to Heale and Twycross (2018), the case study design method provides a framework for the evaluation and analysis of complex issues which assists in better understanding the phenomenon in question, shines a light on the holistic nature of the phenomenon, and offers a perspective that informs improved approaches to such situations. Polit and Beck (2021) attest that case studies are intensive investigations of a single entity or a small number of entities, such as individuals, groups, organisations, or communities. While a case study design can be either a single-case study or a multiple-case design both these designs can be either

holistic or embedded. Thus, Yin (2014) and Polit and Beck (2021) describe the four basic types of case study designs as the single-case, holistic; single-case, embedded; multiple-case, holistic; and multiple-case, embedded. This study used a single-case holistic study in that it focused on one entity, uThukela District Municipality, and one unit of analysis, the collaboration of midwives and TBAs.

4.3 THE WORLD VIEW

A paradigm, according to Polit and Beck (2021), is a worldview and a general perspective on the complexities of the world. Tashakkori, Johnson and Teddlie (2021) state that a paradigm is a set of philosophical and methodological assumptions and beliefs. The three main paradigms used by researchers in the social and behavioural sciences are positivism, constructivism and pragmatism (Tashakkori, Johnson and Teddlie 2021). A key methodologic distinction is between quantitative research, which is most closely allied with positivism, and qualitative research, which is associated with constructivist inquiry (although positivists sometimes undertake qualitative studies, and constructivist researchers sometimes collect quantitative information) (Polit and Beck 2021). The three paradigms are discussed briefly below.

4.3.1 Positivist approach

According to Creswell and Creswell (2023), the positivist philosophical stance asserts that there is an objective reality "out there", that truth is absolute, and that there is a single reality that one could define by careful measurement. The positivist paradigm is mostly allied to quantitative research. Grove, Gray and Burns (2017) further assert that positivists value objectivity and attempt to hold their personal beliefs and biases in check to avoid contaminating the phenomena under study and consider empirical discovery the only dependable source of knowledge. For these reasons, positivism cannot be applied as a philosophical assumption for the study as the study sought to use human participants i.e. registered midwives, pregnant and delivered women as well as

TBAs to obtain an in-depth understanding of the roles of TBAs in maternity care to ensure collaboration with the midwives in managing midwifery.

4.3.2 Pragmatism

Pragmatism is defined as a deconstructive paradigm that debunks concepts such as 'the' truth and reality and focuses instead on what works as the truth regarding the particular research question/s under investigation, and acknowledges that the values of the researcher play a large role in the interpretation of results (Tashakkori, Johnson and Teddlie 2021). The pragmatic paradigm is a philosophical orientation that is mostly associated with mixed-method studies. Therefore, this was not appropriate for this study which used a qualitative method.

4.3.3 Constructivist approach

For the naturalistic researcher, Polit and Beck (2021) assert that reality is not a fixed entity but a construction of the individuals participating in the research. This statement is supported by Creswell and Creswell (2023) who state that constructivist researchers often address the processes of interaction among individuals. If multiple interpretations of reality exist in people's minds, then there is no process by which the ultimate truth or falsity of the constructions can be determined (Polit and Beck 2021). Agreeing with these descriptions, the researcher's position was aligned with that of the constructivist paradigm. Constructivists also focus on the specific contexts in which people live and work to understand the historical and cultural settings of the participants (Creswell and Creswell 2023). This study adopted a case study approach related to a specific setting. Qualitative researchers as constructivists emphasise the inherent complexity of humans and their ability to create and shape their own experiences with the idea that truth is a composite of realities. Consequently, Polit and Beck (2021) state that constructivist studies are focused on understanding the human experience as it is lived, usually through the careful collection and analysis of qualitative materials that are narrative and subjective. Polit and Beck (2021) encourage an inductive process where the researcher

integrates information to develop a theory or description that helps clarify the phenomenon under observation.

Constructivist researchers usually emphasise the dynamic, holistic, and individual aspects of human life and attempt to capture those aspects within the context of those who are experiencing them, which is the reason why the researcher used the constructivist approach. Constructivist inquiry usually takes place in the field such as a naturalistic settings and often takes place over an extended period. This study took place in a naturalistic setting where the midwives and women were interviewed at different clinics and a district hospital and the TBAs in their homes. Data collection with midwives was conducted at the healthcare facilities where they were working, with timing dependent on their availability and according to their off duties. Data collection from women, occurred at the hospital and clinics while they were waiting for services. TBAs were visited in their homes where they were comfortable and free to talk since it was a safe space for them. Since TBAs did not follow any strict working schedule, these interviews were flexible in terms of timing.

4.3.4 Philosophical assumptions

Human inquiry is often characterised in terms of how human respond to basic philosophical questions referred to as ontology and epistemology (Polit and Beck 2021; Tashakkori, Johnson and Teddlie 2021).

Ontology is defined as the nature of reality (Creswell and Creswell (2023). Constructivists believe that there are multiple constructed realities (Tashakkori, Johnson and Teddlie 2021). The current study gathered data from multiple sources and included multiple sites and varying participants so multiple constructed realities were at play.

Epistemology highlights how we know things and what we know. Scientists distinguish between a naturalist paradigm, sometimes referred to as a constructivist paradigm, and a positivist paradigm (Creswell and Creswell 2023).

Constructivists believe that the knower (the subject) and the known (object) are inseparable (Tashakkori, Johnson and Teddlie 2021). Thus, in the current study, the researcher believed that the knowers, who were the study participants (midwives TBAs and women), and the known (collaboration of women and TBAs) were inseparable.

4.4 STUDY SETTING

Grove, Gray and Burns (2017) denote a study setting as being the site where the study is conducted. The study was conducted in uThukela District Municipality, which is one of the eleven district municipalities in KZN. The uThukela District Municipality was chosen as the ideal setting for the study because the researcher had observed during her encounter with this setting as a clinical instructor for the undergraduate nursing programme, that most women in the area still used both the TBAs and healthcare facilities for maternity services. Figure 4.1 presents the map of KwaZulu-Natal showing the location of uThukela District .

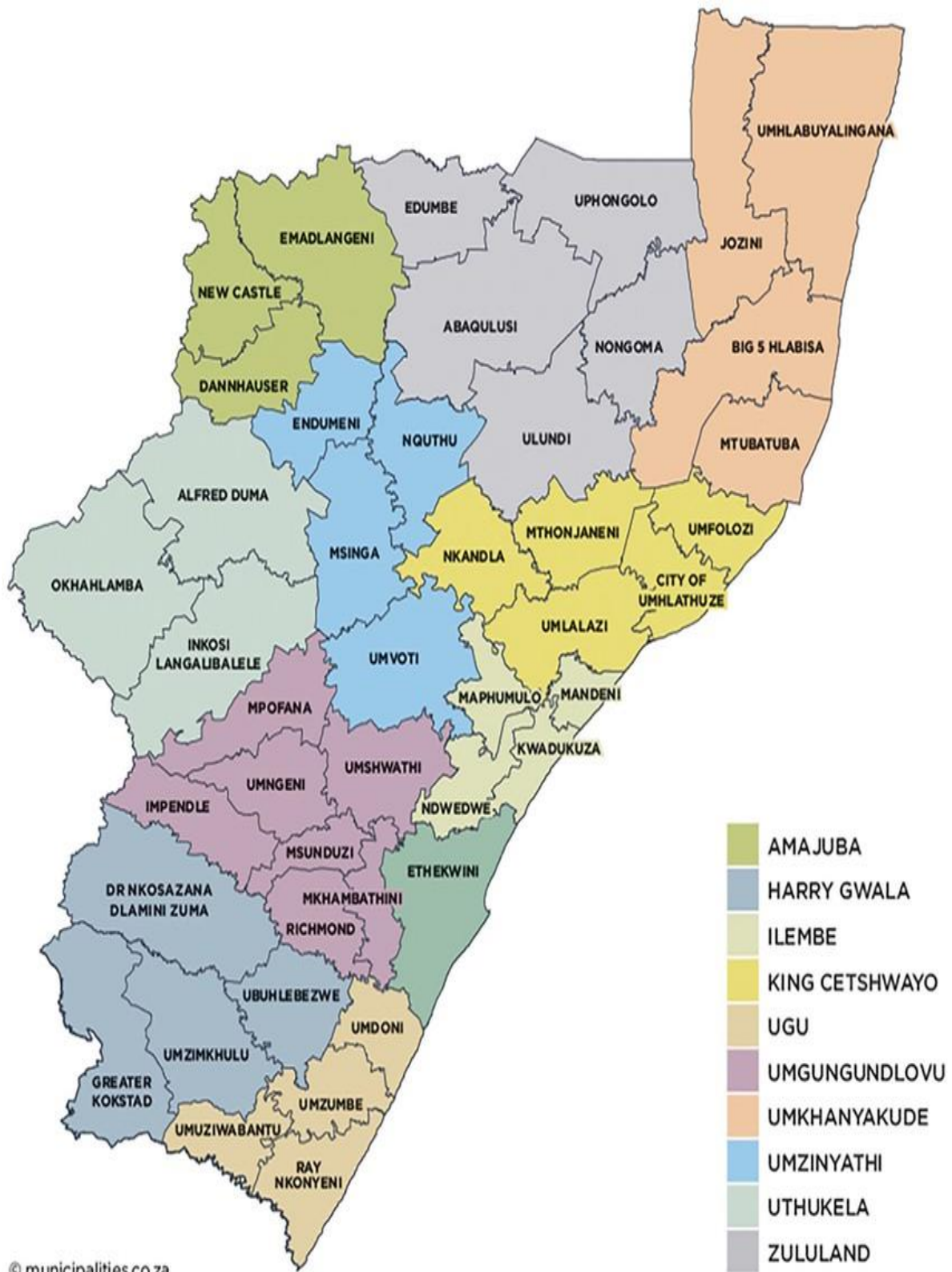


Figure 4.1: The map of KwaZulu-Natal showing the location of uThukela District
 Source: Map of KwaZulu Natal Province Municipalities (2016)

UThukela District Municipality has three local municipalities namely; Alfred Duma, Inkosi Langalibalele, and Okhahlamba Local Municipalities. The local municipality under study was Inkosi Langalibalele, which is divided into the Estcourt and Weenen sub-districts. Only Estcourt sub-district was included in the study since it had more healthcare facilities including a district hospital, whereas Weenen sub-district only had three clinics. Figure 4.2 presents a map showing the three local Municipalities (sub- districts) under uThukela District; Alfred Duma, Okhahlamba and Inkosi Langalibalele.



Figure 4.1: Map showing the three local municipalities under uThukela District Municipality
Source: UThukela District Health Plan 2021

4.4.1 Data collection sites

Polit and Beck (2021) assert that qualitative research is conducted in a real-world and naturalistic setting to maintain control over the environment. For this study, the setting for the healthcare workers and the women was the healthcare facilities in the uThukela District where the midwives worked and where women received healthcare services. At the time of the study, there was one district hospital and 15 PHC clinics distributed as follows; the district hospital and 13 PHC clinics were located in the Escourt sub-district and healthcare services were provided in all healthcare facilities. The hospital provided ANC, intrapartum and postnatal care (PNC) services. Maternity services in the PHC clinics differed according to the size of the clinics, larger clinics and most of the clinics in rural areas provided all maternity services including ANC, intrapartum and PNC while in smaller PHC clinics the maternity services were limited to ANC and PNC services only.

The researcher had anticipated using either the TBAs' homes or other settings in the community where the TBAs were identified and preferred to be interviewed such as the community halls. However, all TBAs opted to have interviews in their homes. Table 4.1 presents the different sites where data was collected.

Table 0.1: Targeted data collection sites

Study site	Number in the study area	No. targeted for inclusion
Sub-districts	2	2
Hospitals	1	Depending on eligibility criteria
PHC clinics sub-district 1	13	Depending on eligibility criteria
PHC clinics sub-district 2	3	Depending on eligibility criteria
TBA homes	Not known	All identified
Alternate venues such as community halls	Not Known	Depending on preference by TBAs

4.5 STUDY POPULATION

Polit and Beck (2021) define a population as the entire aggregation of cases the researcher is interested in. The population in the proposed study comprised the midwives involved in the provision of maternity care services in the selected healthcare facilities, the women who were either pregnant or in the post-partum period at the time of data collection, and the TBAs from the local community involved in caring for women from pregnancy up to delivery.

4.6 SIGNIFICANCE OF SELECTED STUDY SITES AND PARTICIPANTS TO THE STUDY

The data collection sites were six healthcare institutions that were providing antenatal, intrapartum and postnatal care (one district hospital and five PHC clinics), and ten homes of TBAs. Mattessich and Johnson (2018) highlight several factors that influence successful collaboration which include the environment, membership characteristics, process and structure, communication, purpose and resources. Mattessich and Johnson (2018) highlight that the environmental characteristics that influence collaboration include geographic location and the social context within which collaborative groups exist. The settings used for the current study were the actual environments where collaboration and related activities is expected to take place. Going into these settings afforded the researcher an opportunity to have an idea regarding the type of environment where the two groups exist and how this could influence collaboration. This additional knowledge assisted the researcher in structuring the guidelines to facilitate collaboration between the two groups and the recommendations arising from the study.

Furthermore, while these study sites were selected on the basis that they were environments where the target population could be accessed, most importantly, the sites formed a familiar environment where interviews could be conducted without fear of intimidation. Each participant was afforded a choice to between

using the healthcare facility or a private place like home for an interview or group discussion session. Thus, the data collection sites were decided upon by each study participant. Elhami and Khoshnevisan (2022) highlight that the place where interviews and focus group discussions (FGD) take place is an important point to consider in qualitative studies and advise that ideally the place should be decided upon by the study participants to ensure that they feel safe and comfortable during the interview.

The study comprised three participant groups:

- Midwives, actively engaged in attending to women from antenatal care, labour and postnatal care within the designated healthcare facilities;
- TBAs from the local community who were caring for the women during ANC, labour and post-delivery; and
- Women who were either pregnant or in the postnatal period and had or were using maternity healthcare services from both the midwives and the TBAs.

Mattessich and Johnson (2018) advise that the membership of collaborative groups should be representative of all the community members that can affect, or be affected by, the collaboration. In line with this recommendation, the participant groups included. Furthermore, Sargeant (2012) attests that the qualitative researchers should ensure that the selected participants can best inform the research questions and enhance understanding of the phenomenon under study. Decisions regarding the selection should be based on the research questions, theoretical perspectives, and evidence informing the study. The rationale for including these specific groups was rooted in their integral roles within the maternity care framework either as recipients or providers of maternity healthcare, ensuring a comprehensive exploration of experiences and perspectives in the study. Midwives and TBAs were the providers of care and they were thus the two groups that were required to collaborate. However, the women as recipients of care of that collaboration were also identified as a critical group to include.

4.7 OBTAINING PERMISSIONS

Identification and recruitment commenced after receipt of full ethical clearance from the DUT Institutional Research Ethics Committee (IREC) (IREC: 307/22, Appendix 1) and permission from relevant gatekeepers, namely, the KZN Department of Health Research Office (Appendix 2b), uThukela District Municipality Manager (Appendix 3b) and Induna or ward councillor (Appendix 6c) for the TBAs. These approvals allowed the researcher to engage with all relevant healthcare facility authorities to request permission to collect data from the selected healthcare facilities. The researcher also engaged with these gatekeepers through telephonic communication to make arrangements for her to recruit potential study participants. Thereafter, recruitment of all participant groups commenced as detailed in the next sections.

4.8 IDENTIFICATION AND RECRUITMENT OF STUDY PARTICIPANTS

Identification and recruitment commenced immediately after receipt of full ethical clearance from the DUT IREC (IREC 307 22, Appendix 1) and permission from relevant gatekeepers, namely, the Health Research and Knowledge Management Unit (Appendix 2b), uThukela District Manager (Appendix 3b), Chief Executive Officer (CEO) Estcourt Hospital (Appendix 4b) and a community leader (Appendix 6b). Participants were then identified in different facilities which were part of the study and TBAs were identified through women who referred new participants to the researcher since they were the ones who knew them. Identification and recruitment is discussed in detail below:

4.8.1 Registered midwives population

The researcher requested a slot to address operational managers in the sub-district management meeting. At the meeting the researcher informed the managers about the study and addressed all their concerns and questions about the planned research project. The clinics that met the inclusion criteria, their managers and contact details were identified with the assistance of the managers at this meeting. The managers for the selected healthcare facilities

were advised that each one would be contacted telephonically to organise the information-giving session for the midwives. Information letters (Appendix 8a) were given to the managers to share with the midwives from their institution so that they could start reading about the study.

The researcher visited each healthcare facility on the day that was agreed upon with the manager for the information-giving session with the midwives. The researcher brought more information letters for distribution to midwives who had not received them from the manager. Consent forms were part of the information letter (Appendix 8a) and were provided with envelopes to seal the signed consent form before posting it into a sealed box that was left at a strategic point in each healthcare facility included in the study. The box was available at the healthcare facilities for a maximum of four weeks and the researcher collected the box after four weeks and checked the number of consent forms posted in a box. The researcher then made appointments for the FGD with the midwives who volunteered to participate in a study.

4.8.2 Traditional birth attendants population

The TBAs were identified with the assistance of the women and other TBAs taking part in the study as well as community members. The midwives who knew about the TBAs in the area also assisted with the identification of this targeted population. The researcher requested permission from the community leader, the Induna (Appendix 6), to address the community at their local gatherings such as community meetings to try to reach out to the TBAs. On identification of a TBA, the searcher paid them a visit at their homes to inform them about the study and request them to participate in the study. The TBAs were issued with an information letter in both isiZulu and English (Appendices 8c and 8d) should they require to read further about the study. The TBAs who agreed to take part in the study were required to give written consent. Those who were unable to write were assisted by the research assistant to sign the consent form using thumbprints. The researcher requested the TBA to advise her of any other TBAs

in the area if there was any that she was aware of and that is how other TBAs were identified and recruited.

4.8.3 Women

Women were recruited from the ANC, PNC, family planning and well-baby clinics within the healthcare facilities included in the study. Information letters which were in isiZulu and English (Appendices 8b and 8c) were made available in the units within the healthcare facilities where these clinic services were being provided so that women could have them and start reading about the study even before the researcher came to address them. English and isiZulu are the languages that are the most commonly used medium of communication by the community in the area. The researcher requested permission from each facility manager to address women while in the waiting area awaiting clinic services and arranged a private room where a more detailed information-giving session was conducted. Those who were in PNC were interviewed in their beds with privacy provided using a screen or curtains. The operational managers delegated the team leaders for the various components (ANC, PNC, family planning and well-baby clinics) in each study site to assist the researcher in addressing women in these sections to inform them about the study.

The researcher conducted a brief presentation about the study with all women who were present in the waiting area. At each information-giving session for the women, the researcher used a self-administered preselection tool (in isiZulu and English) which identified those who had used both the midwives and TBAs during pre-, intra- and post-partum periods in their current and/or previous pregnancies (as per the study's inclusion criteria) (Appendices 7a and 7b). All women who met the inclusion criteria were invited to a more detailed information session that took place on the same day in a private room at the clinic. The researcher brought more information letters for distribution to women who had not received them beforehand. Consent forms were also distributed during the information-giving session. The researcher met with women who agreed to take part in the study individually, assisted them to sign the consent form, and

negotiated the date, time and venue for the interview. Women who still wished to decide about taking part in the study were allowed to take the information letter and consent form home and were requested to send a telephone text message to the researcher should they decide to take part in the study. The researcher called them back telephonically to confirm their willingness to take part in the study, to check eligibility, and to schedule the date time and venue for the interview.

4.9 SAMPLING OF HEALTHCARE FACILITIES AND STUDY PARTICIPANTS

Polit and Beck (2021) define a sample as a subset of the population and sampling as the process of selecting a portion of the population to represent the entire population in the study. The sample in this study comprised of the healthcare facilities, the midwives working in the selected healthcare facilities, women and the TBAs from the study area who meet the specified inclusion criteria as detailed in section. In this study, sampling was done differently for the different population groups as discussed below.

4.9.1 Sampling method

Non-probability sampling comprises three types of sampling methods, namely, convenience, quota and purposive also referred to as judgemental, purposeful or selective sampling. Purposeful sampling methods were used to select the healthcare facilities, midwives and women. Purposeful sampling involves choosing exemplars or types of people who can best enhance the researcher's understanding of the phenomenon (Polit and Beck 2021). In purposive sampling, the researcher selects information-rich cases that can teach them a great deal about the central focus or purpose of the study (Polit and Beck 2021; Grove, Gray and Burns 2017). Polit and Beck (2021) further describe purposive sampling as the process of purposefully selecting persons or settings with variation on dimensions of interest, which allows participants with diverse perspectives and backgrounds. With purposive sampling, the researcher ensured that suitable healthcare facilities, midwives and women with diverse

backgrounds were represented in the sample. For example, in this study, purposive sampling facilitated that women who had received services from both midwives and TBAs were selected and they varied since there are those who received both these services either during ANC, intrapartum or PNC or throughout pregnancy and the postpartum period.

4.9.2 Eligibility to participate in the study

The researcher determined the criteria and ensured that only persons qualified to be part of the population were included in the study (Polit and Beck 2021). The population for this study were midwives, TBAs and pregnant/postpartum women.

4.9.2.1 Midwives

The registered midwives who were included in the study were those working in the maternity section at the selected mother hospital, comprehensive healthcare centres (CHCs), and PHC clinics under this hospital. These registered midwives were those who had been involved in the provision of ANC, intrapartum care and PNC for more than six months. Some of the registered midwives were operational managers in the maternity units and clinics and the others were midwives working on the floor with women.

4.9.2.2 Traditional birth attendants

The TBAs were another group that participated in this study, and were approached in their homes after the researcher obtained the information from the women who utilised them. TBAs were people who offered maternity care to the women of the uThukela District. The TBAs were sampled using snowballing, because of their limited numbers in the community, which made it difficult to find them. Polit and Beck (2021) attest that in qualitative research the researchers may use snowballing by asking participants for referrals to other people because they are hard to find.

4.9.2.3 Women

Women eligible for this study were those who were attending the selected mother hospital, CHCs and PHC clinics under this hospital. They were approached in ANC which were clinics and antenatal wards and in PNC units. Women who were approached were those who had attended TBAs during pregnancy, labour and/ or post-delivery and who were 18 years and above.

4.9.3 Inclusion and exclusion criteria

❖ ***Inclusion criteria:***

- **Healthcare facilities** that were providing comprehensive maternity healthcare services (ANC, Intrapartum and PNC).
- **Registered midwives** who had been involved in the provision of ANC, intrapartum and PNC healthcare services for more than six months.
- **TBAs** who were offering maternity care to the women of uThukela District Municipality.
- **Women** attending the selected healthcare facility who were either pregnant or were in the postpartum period who had attended TBAs during pregnancy, labour and/or post-delivery.

❖ ***Exclusion criteria:***

- **Healthcare facilities** not providing comprehensive maternity healthcare services.
- **Midwives** who had worked in the maternity department for a period less than 6 months and those not working in maternity units.
- **TBAs** not attending to women in this district.
- **Women** attending the selected healthcare facility who were pregnant or in the post-partum period who had not utilised services of the TBAs during pregnancy, labour and/ or post-delivery.
- **Women** who were beyond the postpartum period post-delivery at the time of recruitment.

4.9.4 Sample size

The sample size, according to Polit and Beck (2021), is the number of people who participate in a study. In qualitative studies this number is guided by data saturation, which according to Grove, Gray and Burns (2017) occurs when interviews provide no new information but only redundancy of previously collected data. In this, the sample size was guided by data saturation which was monitored separately for each sample group (midwives, TBAs, women). Data saturation was confirmed by interviewing two more FDGs with the midwives, three more TBAs and three women from two different clinics.

4.9.4.1 Sample size for healthcare facilities

Census sampling is defined by Polit and Beck (2021) as a survey which is conducted to cover the whole population. The number of healthcare facilities was six which included one district hospital in Escourt and five clinics in Inkosi Langalibalele Local Municipality, thus ensuring a census sample of all the targeted healthcare facilities in the area.

4.9.4.2 The sample sizes for the midwives, traditional birth attendants and women

The sample sizes for the midwives, women and TBAs were guided by data saturation where midwives were $n = 38$, TBAs $n = 10$ and women were $n = 18$. Polit and Beck (2021) state that in qualitative studies, the sample size should be based on informational needs hence, a guiding principle is data saturation, which is sampling to the point at which no new information is obtained and redundancy is achieved. Grove, Gray and Burns (2017) agree that data saturation in qualitative research is a process at which new data begins to be redundant with what has already been found, and no new themes can be identified. The goal is to generate enough in-depth data to illuminate the patterns, categories, and dimensions of the phenomenon under study. Redundancy, and hence sample size, can be affected by the purpose of the

inquiry, the quality of the informants, and the type of sampling strategy used. Data saturation was monitored separately for each participant group.

4.10 CODING OF THE STUDY SITES AND PARTICIPANTS

Study sites and participants were allocated codes to ensure confidentiality and anonymity during data collection and reporting as described below.

4.10.1 Study sites

- **Health Facilities: '00'** was used to code the healthcare facilities (hospital and clinics). Thus, the healthcare facilities that were included in the study were coded as 001-006.
- **TBA Homes:** The researcher had planned to interview TBAs in their place of choice and convenience between the clinic, home or community hall. All TBA participants chose to be interviewed in their homes. Thus, the code used to represent home is the letter '**H**'. Ten TBAs were included in the study. Only one participant was available in each study site (home), thus 10 homes were used as data collection sites. The codes for homes range from 'H1 to H10'.

4.10.2 Study participants

Registered midwife participants: The letter '**M**' was used for the registered midwife participants. The code for midwife participants carried the code for a health facility whether hospital or clinic, the letter '**M**', and the number indicating the sequence in the interview for a particular setting: 001: 'M3' represents the third midwife in health facility 001.

TBA participants: The letter '**T**' was used for TBA participants, because only one participant was available in each study site (home). Ten TBAs were interviewed in the 10 homes thus the code for TBAs ranged from T1 to T10. The code for each TBA participant carried the code '**H**' for the study site and the letter '**T**', with both letters carrying a number indicating the sequence in the interview

for a particular setting. Thus, H2: 'T2' represented the second TBA in the second home.

Women participants: The letter '**W**' was used for the women participants. The code for each woman participant carried the code for a health facility whether a hospital or clinic, the letter 'W', and the number indicating the sequence in the interview for a particular setting. Thus, 001: 'W2' represents the second woman in Health facility 1. Table 4.2 presents of summary of the coding of participants.

Table 0.2: Coding of study participants

DATA ELEMENT	CODE	NO. INCLUDED	CODE RANGE
SINGLE CODES: DATA COLLECTION METHOD			
Focus Groups	F	11	F1-F11
SINGLE CODES: STUDY SITES			
Healthcare facilities	00	6	001-006
TBA homes	H	10	H1-H10
SINGLE CODE STUDY PARTICIPANTS			
Registered midwives	M	38	M1-M38
TBA's	T	10	T1-T10
Women	W	18	W1-W18

The participants within a study site were assigned numbers based on sequence in the interview process for the entire data collection. Interviews were coded as 'I' and focus groups coded as 'F'. Therefore, each code includes data collection type (interview or focus group) the study site (regional hospital or PHC clinic), the participant group (registered midwife, TBA or woman) and the number in the sequence of interviews or focus group. Example: 'F1/001/M1' represent first midwife in the first focus group in the first healthcare facility; while 'I1/H1/T1' represent the first TBA interviewed in the first home. Table 4.3 summarises how combined codes were created and assigned.

Table 0.3: Combined coding indicating data collection method, study site and study participants

Data Element	Elements included: Method/Health Facility/Group	Code	Example	Description
Registered Midwife	Focus group/Health Facility/Registered Midwife	F/00/M	F9/H3/M38	Focus group No. 9, health facility No. 3 midwife No. 38.
TBAs	Interview/Health Facility/TBA	I/H/T	I0/H3/T10	Interview No. 10, TBA home No. 3, TBA No. 10.
Women	Interview/Health Facility/Women	1/H/T	I9/H6/W18	Interview No. 10, health facility No. 3, Woman No. 18.

4.11 DATA COLLECTION

Data collection is defined as a precise, systematic gathering of information relevant to the research purpose and the specific objectives, questions, or hypotheses of a study (Grove, Gray and Burns (2017). The researcher collected data from the participants who met the inclusion criteria and gave consent to take part in the study. Data were collected concurrently from the three groups of participants who were present at the data collection site at any given time.

4.11.1 Data collection instrument

The Institutional Review Board (IRB) at Teachers College, Columbia University describes a data collection instrument as a tool that is tied to the study methodology which is determined by the researcher and used to collect, measure, and analyse data related to the research interests . The researcher chooses the tool after conceptualizing the research project and the units of analysis, before figuring out exactly how the concepts can be measured and before creating the actual data collection instruments. The characteristics of a good research instrument include that it should be valid and reliable, based on a conceptual framework, or the researcher's understanding of how the particular variables in the study connect with each other, should be able to gather data suitable for and relevant to the research topic, be able to test hypothesis and/or answer proposed research questions under investigation, free of bias and

appropriate for the context, culture, and diversity of the study site, and contain clear and definite instructions on how to use the instrument (Teachers College, Columbia University n.d.). Researchers use different types of data collection instruments with different types of questions to suit their study. For this study, the researcher developed interview and focus group discussion (FGD) guides with open-ended questions to allow the participants to respond in their own words, unlike in questionnaires where respondents are asked to give a written response to open-ended questions (Polit and Beck 2021). Therefore, participants in this study were requested to respond to the same main questions, in the same order, except for probing questions which differed based on individual responses and clarity required. Closed-ended questions were avoided since they offer response options, from which respondents choose the one that most closely matches the appropriate answer like yes or no which could have limited the researcher. The researcher appreciated that both open and closed-ended questions have certain strengths and weaknesses hence the use of open-ended questions (Polit and Beck 2021).

Three separate data collection tools were developed to keep the data collection focused and semi-structured. These included an FGD guide for midwives (Appendix 9a), an interview guide for women (Appendix 9b) and an interview guide for TBAs (Appendix 9d). All data collection instruments were prepared in English. However, the instruments for TBAs and women were also available in isiZulu (Appendices 9c and 9e). The data collection tools had the same grand tour question; "Please share with me your experiences regarding the collaboration between the midwives and TBAs".

4.11.1.1 Structure of data collection instruments for midwives and traditional birth attendents

The structure for the data collection instruments for midwives and TBAs were almost the same in that both had two sections marked as Section A and B. Section A was to capture demographic characteristics and Section B included the predetermined interview questions. The demographic information required

in Section A was age, ethnicity, home language, and gender. The information in Section A differed for each participant group because information for midwives included work experience and duration in the current institution as a midwife, while for TBA the information included the number of years as a TBA and qualifications. Section B for each instrument had one grand tour statement to get the discussion started and three predetermined questions that were prepared in line with the study objectives.

4.11.1.2 Structure of data collection instruments for women

The interview guide for the women had one section only that included interview questions (Appendices 9b and 9c). This was because the demographic characteristics for this participant group were collected during the preselection of study participants as described in Section 4.6.2. As the preselection tools were collected from the women, the researcher identified those who met the selection criteria.

4.11.2 Data collection methods

Data were collected from midwives using FGDs and from women and TBAs using semi-structured individual interviews. The reasons for this variation were the following:

- 1) It was possible to get the midwives together into a group and the subject was not sensitive to them thus they could discuss it freely in a group;
- 2) The researcher anticipated that some women might not be comfortable declaring and discussing in front of other people regarding services received from TBAs; and
- 3) It was not going to be easy to get the TBAs together in a group due to their numbers and distribution.

4.11.2.1 Focus group discussions

Both Dzino-Silajdzic (2018) and van Eeuwijk and Angehrn (2017) describe a FGD as a qualitative data collection method that engages six to 12 people with shared characteristics pertinent to the specific discussion topic that is led by a trained facilitator. According to Mishra (2016), FGDs are a good way to gather people from similar backgrounds or experiences to discuss a specific topic of interest. The discussion probed specific, predetermined topics while allowing flexibility and stimulating participants to share and discuss with one another. Therefore, they were semi-structured and facilitated by the researcher using a semi-structured interview guide to foster active participation and in-depth discussion (Dzino-Silajdzic 2018). The strength of the FGD is that it encourages the participants to talk to one another, discuss and build upon or challenge each other's opinions.

Advantages and disadvantages of focus group discussions

The FGDs have advantages and disadvantages. The advantages highlighted by Dzino-Silajdzic (2018) include that it is a low-cost method whose flexible format allows the facilitator to explore unanticipated issues because of their flexible design and the exchanges among participants and the discussions may lead to the discovery of attitudes and opinions that may not be revealed through methods targeting the individual, such as structured interviews, surveys or semi-structured key informant interviews. In addition, the FGD enables rapid collection of multiple perspectives on the topics under investigation, thus generating more information faster than in individual interviews. Interaction among FGD participants provides rich insights, and checks and balances, thus minimising unique or outlying opinions. FGDs are an excellent method for obtaining information from, and hearing the concerns and ideas of, communities that cannot read or write.

The disadvantages highlighted by Dzino-Silajdzic (2018) include that FGDs may not be the best method to explore sensitive topics that may bring a sense of shame or discomfort to the participant, are susceptible to the facilitator's bias

which may undermine the validity and reliability of findings, and provide limited confidentiality of information shared during the discussion. In the absence of a skilled facilitator, there is the risk of the discussion getting side-tracked by topics that may not be the primary focus and that of the discussion being dominated by one or more individuals, thus silencing other participants or simply making them agree with the most dominant person (Dzino-Silajdzic 2018).

Influenced mainly by the advantages of the FGDs, the researcher chose to use the FGD method of data collection for the midwives. The researcher was convinced that her previous experience in working with midwives and as a midwife herself would enable her to overcome all the possible risks of this method listed as the disadvantages in the previous section. The number of participants in each FGD was determined by the number of midwives in the healthcare facility who agreed to take part in the study. The minimum was four and the maximum was twelve midwives in each group. Each FGD session lasted for a maximum of one hour to allow enough time for gathering rich data while preventing boredom and disruption of normal operations in the healthcare facility.

4.11.2.2 Semi-structured interviews

An interview is defined by Tashakkori, Johnson and Teddle (2021) as the interaction between the researcher and the participants who are the holders of knowledge. Interviews in qualitative studies can be open ended and are conducted face-to-face, but they may also be conducted telephonically. These may be structured, semi-structured or unstructured (Tashakkori, Johnson and Teddle 2021). This study used semi-structured interviews to collect data from the women and TBAs. All interviews were individual (one-on-one), conducted on a face-to-face basis. The individual semi-structured interviews allowed each study participant to share her own personal views and experiences without fear of intimidation by other participants. This enabled participants to share information that was personal, sensitive or considered private and confidential.

Advantages and disadvantages of semi-structured interviews

In a semi-structured interview session the interviewer guides the interview in the required direction. A semi-structured interview ensures that the interviewer obtains all the information required by affording the interviewer the opportunity to probe and request clarity. The method is more relaxed and comfortable for the participants but can still be contained and focused. It gives the interviewees freedom to respond in their own words and provide as much detail as they wish, and offer illustrations and explanations.

The limitations of the semi-structured interview are that the interview requires that the interviewer must be knowledgeable about the subject, be able to probe and to exercise good control, as interviewees' responses might be irrelevant to the topic. In the absence of these qualities, the semi-structured interviews might get out of control or move in the wrong direction, failing to achieve the purpose. The researcher, with her experience and skills as a midwife, was able to conduct and control the semi-structured interviews.

4.11.3 Data collection process

Focus group discussions with midwives

Focus group discussions were held with the midwives. Data collection was done by the researcher in person. In each venue the researcher negotiated with a person in charge to make sure that there was a private room with limited or no distractions, that would facilitate comfortable and appropriate seating arrangements be it for a group or individuals. The FGD with midwives was conducted in English as this is the official language used between healthcare providers in KZN.

On the day of the FGD with midwives, the researcher and the research assistants arrived early to ensure that the room was appropriately set, the recording system was working well, and to receive the participant/s on arrival. The process began with the researcher introducing herself and welcoming the FGD participants. The researcher confirmed that the participants met the

inclusion criteria, the consent form had been correctly signed and that they were still willing to proceed with the session, and asked whether there were any questions about the study that still needed to be addressed. Thereafter, the participants were orientated regarding the procedure that would be followed during the FGD and verbal consent to record the session was requested by the researcher and was given by the participants. The participants were advised about the possible duration of the session and that they were allowed to withdraw at any point or to state upfront should they feel uncomfortable responding to any of the questions. The participants were assured of confidentiality and anonymity and encouraged to talk freely. The researcher facilitated nine FDGs in six different healthcare facilities, and the discussions and each session lasted for about 30 minutes.

Semi-structured interviews with women

The clinic nurse manager allocated a room on each day that there were interviews. Either a consulting room or any other room that was not in use by the clinic staff on the day of the interview was used to ensure privacy. A do not disturb sign was posted on the door to ensure that there were no intrusions by people entering or knocking at the door while the interview was in progress. The researcher ensured good lighting and ventilation. The chairs for the researcher and participant were placed opposite each other.

The researcher and the research assistant confirmed with the participants that the information in the preselection tool was correct and that the participant was consenting that the information provided would be used as data for the study. The researcher began the interview by starting the recording with the participant's consent and pronouncing the allocated participant's and health facility codes for the recording, as well as the date and time of the session. The introduction and ethical considerations were conducted in the same way as for the FGDs. From this point, the researcher refrained from calling the healthcare facility nor the participant's name to ensure confidentiality and anonymity. Thereafter, the researcher asked the participant to respond to the first grand tour statement which was the same across all study groups. From this point, the

interview session continued until the end. The researcher allowed the participant to talk freely with minimal instruction to probe or redirect the participant as the need arose and continuously encouraging the participant to talk with gestures and remarks such as "Hmm, yes, I get you, ok, continue, tell me more, I am listening etc". On completion of the interview, the researcher thanked the participant for participating in the study. Interviews lasted between 10 and 15 minutes.

Semi-structured interviews with traditional birth attendants

The TBAs were met in their homes at the time and date agreed with them. The researcher allowed each TBA to choose where in the house they would like to sit and be interviewed where there was good lighting, less noise and good ventilation. In some TBA houses the researcher and TBA sat on a floor mat, in some they sat on a bench and in some they sat on the chairs placed opposite each other.

The researcher requested permission to record the interview before beginning and all TBAs did not have a problem with recording. The TBAs were reassured that they would not be called by names, but with codes ensuring confidentiality and anonymity. At the beginning of each interview the participants were mentioned by their codes including the date and time of the session. Thereafter, the researcher asked the participant to respond to the first grand tour question. The researcher allowed the participants to talk freely with minimal probing. TBAs were free and spoke well during interviews, with only two having to be encouraged to elaborate on their responses, otherwise they would talk until the researcher stopped them to move to the next question. The researcher showed interest and that she was following by using gestures and remarks such as "Hmm, yes, I get you, ok, continue, I am listening etc". On completion of the interview, the researcher thanked the participant for participating in the study. Each interview lasted between 10 and 20 minutes.

4.12 DATA ANALYSIS

Polit and Beck (2021) state that in qualitative studies data analysis generally occurs concurrently with data collection instead of only afterwards, thus the researcher attempts to gather, manage, and interpret the data simultaneously. Guided by this approach, data collection and its analysis typically progressed concurrently for the researcher to be able to sift through information to see what insights are gained and if new questions emerge or further evidence is needed to amplify or confirm the insights (Polit and Beck 2021). Furthermore, Polit and Beck (2021) mention that the purpose of data analysis is to organise, provide structure, and elicit meaning, from the collected data.

4.12.1 Preparation of data for analysis

The researcher transcribed the audio-recorded data verbatim, and listened to the recordings several times to gain in-depth understanding and be fully immersed in the content of the data. Throughout the data collection process, the researcher continuously referred to all relevant records to clearly understand and deepen the comprehension of the gathered information.

All data were consolidated by transcribing them into written format. The transcribed data was then carefully read and re-read several times then compared against the original recordings to ensure that no meaning was lost, added or altered during the transcription process.

Finally, the transcribed data from the interviews and FGDs was then captured onto a master file through Microsoft Word, ensuring that it was ready for analysis.

4.12.2 Data analysis process

Information gathered for Section A, (Demographic data) was analysed and presented quantitatively. The analysis included simple calculations such as

sums and percentages. The findings on analysis are presented in tables and graphs.

Information gathered for Section B (interviews/FGDs) was analysed qualitatively in line with the current study research design. Qualitative data analysis was performed simultaneously with data collection to monitor data saturation. The researcher ensured that data from all interviews and FGD were analysed immediately, on the same day or before collecting more data from additional participants. This ensured a better comprehension of the information gathered while the interview session was still fresh in the mind of the researcher as well as for the researcher to check for further questions to ask from the next participant. The researcher acknowledges that, as alluded to by Polit and Beck (2021), there are no universal rules for analysing qualitative data. This makes it difficult to explain how to do such analyses, and how to present findings in a way as to make their validity apparent. Fortunately, many seasoned researchers, including Creswell and Creswell (2023) and Tesch (1992), have guided researchers on how best to analyse qualitative data. Polit and Beck (2021) state that in qualitative studies analysis of the content of narrative data is done to identify prominent themes and patterns among the themes. Thus, in the current study, all data was thematically analysed guided by the six steps as described by Creswell and Creswell (2023).

1. *Organising and preparing data for analysis*

This step involves transcribing the interviews, typing up the field notes and arranging the data into different types depending on the source of information (Creswell and Creswell 2023). The researcher read and re-read the transcribed data, looking to gain a general sense of the information and to secure the opportunity to reflect on its overall meaning.

2. *Reading or looking at all data*

This step provides a general sense of the information and an opportunity to reflect on its overall meaning (Creswell and Creswell 2023).

In this step, the researcher had field notes and started recording general thoughts about the data where the general ideas of the participants were analysed and listening to the tone of their voices when sharing ideas. The impression of the overall depth, credibility, and use of the information was also noted. The researcher organised the collected data by categorising the text and then labelling the categories with themes.

3. *Coding all of the data*

Creswell and Creswell (2023) define data analysis as the process of organising data by bracketing text and writing a word representing a category in the margin. It involves taking text data, which was gathered during data collection, segmenting sentences into categories, and labelling those categories with a term. The researcher utilised this coding process to come up with a description of themes.

4. *Generating a description and themes*

According to Creswell and Creswell (2023), the researchers use the coding process to generate descriptions of the people and themes for analysis. Description involves a detailed rendering of information about people, places, or events in a setting. Researchers can generate codes for this description. In this study, the researcher generated codes for the people and themes and sub-themes from the collected data. Furthermore, Creswell and Creswell (2023) state that this analysis is useful in designing detailed descriptions for case studies, ethnographies, and narrative research projects; this study is a narrative since the participants were sharing their perceptions on the collaboration in their district. The generated themes appeared as major findings in this study, and are used as headings in Chapter 6 where discussion of the findings occurs. These findings displayed multiple perspectives from the participants' data and were supported by the literature. Beyond identifying the themes during the coding process, the researcher analysed the themes for each case and across different cases since this is a case study.

5. *Representing the description and themes*

This step advances how the description and themes are represented in the qualitative narrative (Creswell and Creswell 2023). The researcher used narrative passages to share the findings of the analysis including detailed discussions of several themes with sub-themes, multiple perspectives from individuals, or interconnecting themes.

4.13 DATA MANAGEMENT AND STORAGE

Data management and storage are the two critical steps in any research project where the researcher as the manager of the research project needs to have a plan developed of how to organise and store the data (Grove, Gray and Burns 2017). Records and data that were required to be managed and stored in this study included signed consent forms by participants, completed preselection forms, field notes and transcriptions of interviews and FGDs.

4.13.1 Data management

Data collected in this qualitative inquiry included field notes and transcriptions from interviews and FGDs. Management of the data included safe storage during and post-completion of the study and preparation for the data for analysis. Preparation of data for analyses is discussed in Section 4.12.1 (1).

During the interviews/FGD sessions, the participants' personal details were not recorded on any of the interview sheets, field notes or audio recordings. Instead, codes assigned to the study sites and participants were used. The only documents with true personal information for the participants were the consent forms. The researcher ensured that the consent forms were removed immediately from the rest of the research documents and placed in a sealed envelope which was placed in a locked cupboard. The recorded information was removed from the audio tape onto a dedicated flash drive immediately after transcription before the next interview. This flash drive was kept in a locked cupboard and only used during data analysis. The flash drive was used solely to store the study information and all electronic information was collated in this

one flash drive. However, in line with the recommendation by Grove, Gray and Burns (2017), the researcher ensured that all electronic and hardcopy files were correctly and consistently labelled with the date and code number of the participant, and made copies of electronic files on another external device for back up before storage.

4.13.2 Data storage

The researcher used both a voice recorder and field notes to capture and store data with verbal consent from the study participants. Thus, the research documents stored for the audit trail included the recorded information, the field notes, and the signed consent forms. Data were collected and stored in a manner that ensured that participants' confidentiality was maintained throughout the research and the dissertation writing process and until five years. Research supports that the data should be kept safe during the study and for a reasonable period of 5-10 years with five years recommended on completion of the study after which all data should be discarded safely so that it does not fall into the hands of other researchers who might misuse it (Creswell and Creswell 2023).

The hard copies which included scanned electronic copies, field notes, consent forms etc. were first filed in order in a waterproof and fireproofed storage box and placed in a locked cupboard. The researcher used only one personal computer when working on research data and did not use any other computer. For additional security, the personal computer was secured by a secret code that was only known to the researcher. The hard copies will be destroyed by shredding and the soft copies will be wiped after five years by the researcher.

4.14 DEVELOPMENT OF GUIDELINES TO FACILITATE COLLABORATION BETWEEN MIDWIVES AND TRADITIONAL BIRTH ATTENDANTS

The findings from data analysis were used to develop guidelines to facilitate collaboration between midwives and TBAs. The guidelines were reviewed and approved by experts from the field of maternal and childcare who included midwifery specialists from the healthcare facility (experienced midwives and

advanced midwives), obstetricians and a Maternal Child and Women Health (MCWH) manager from the district office.

This was the last objective of the study which followed the 12 steps as described by Vermeulen *et al.* (2019) which informed the development of guidelines for this study. The process that was followed was topic selection, forming a guideline development group, scope of guidelines, forming relevant key questions, evidence search, evidence synthesis, recommendations, writing draft, stakeholder review, approval, publication and updating/revising. These guidelines were reviewed and approved by relevant experts from the health sector which included experienced midwives, advanced midwives, an obstetrician and a senior from MCWH.

4.15 RESEARCH RIGOUR

In qualitative research, subjectivity may be an element that could render research findings open to criticism. As an alternative to validity and reliability, Lincoln and Guba developed a framework of criteria for quality researchers that would establish evidence for trustworthiness (Botma *et al.* 2015; Polit and Beck 2021). The strengths and weaknesses of the study are determined by appraising credibility and trustworthiness, which lies in the unspoken meanings emerging from the totality of data (Grove, Gray and Burns 2017). Trustworthiness refers to the degree of confidence qualitative researchers have in their collected data and data analysis. In qualitative studies, the researcher demonstrates transparency by providing true findings after the data has been made meaningful (Grove, Gray and Burns 2017). To ensure trustworthiness, Polit and Beck (2021) suggest four criteria: credibility, dependability, confirmability, and transferability, with authenticity added as a fifth criterion by Guba and Lincoln at a later stage (Polit and Beck 2021). These criteria are discussed below.

4.15.1 Credibility

Credibility refers to the confidence of the truth of the data and interpretation (Polit and Beck 2021). In this study credibility was ensured by ensuring trust with

the participants throughout the data collection process by the way the researcher presented herself during all the contact sessions with the participants and how the information-giving sessions and interview sessions were conducted. The researcher ensured that the participants were approached with respect, self-introduction and a full explanation of the reason for recruitment. The researcher answered all the questions asked for clarity truthfully until all participants were satisfied. The researcher also ensured honesty and was truthful in reporting data without manipulating it. To clarify the obtained data, member checking was done after each interview session to confirm with the participant that the information was captured correctly. Conversations were audio recorded with permission from the participants for clarification of data. The researcher repeatedly listened to the audiotaped interviews comparing it with the written notes.

4.15.2 Dependability

Dependability refers to the stability/reliability of data over time and conditions so that it is consistent and stable (Polit and Beck 2021). In this study, dependability was ensured by adhering to the research principles and documentary evidence. All the interviews were conducted in the same manner which was face-to-face using the interview guides for the TBAs and women, and the midwives' focus group interviews. The interviews for this study were recorded with the permission of the participants and the researcher also took field notes during data collection which assisted during data analysis. Both the recorded responses and the field notes were used to confirm the accuracy of the data report when confirmation was necessary at a later stage. To ensure an audit trail data collected was stored under lock and key and will be kept there for five years as evidence. The researcher also ensured consistency and reliability of the research findings and the degree to which research procedures were documented so that someone outside the research could follow, audit, and critique the research process.

4.15.3 Confirmability

Confirmability is another important aspect of qualitative research and is defined by Polit and Beck (2021) as objectivity, which is the potential similarity between two or more independent people regarding data accuracy. Grove, Gray and Burns (2017) described confirmability as accurate reporting of the real meaning of data as provided by the participants so that other researchers can review the findings and agree that the researchers' conclusions are logical. The researcher, therefore, checked and double-checked data throughout data collection and data analysis to ensure that the results would be repeatable by other researchers. Themes and sub-themes were identified during data analysis.

4.15.4 Transferability

Transferability is explained by Polit and Beck (2021) as the extent to which data can be practically applied to other settings. The researcher provided enough information for readers to be able to determine for themselves the degree to which findings are applicable or transferable. Rich descriptions whereby the widest possible range of information was provided, allowing for judgement of transferability. For this study, the researcher ensured that a clear description of the research setting and research processes was provided. Presentation of the findings, together with appropriate quotations by participants, have been provided to ensure the authenticity of the study, making it possible to build on the findings when performing further research. The researcher provided readers with evidence that the findings could apply to other contexts, situations, times, and populations.

4.15.5 Authenticity

Polit and Beck (2021) added authenticity which is the extent to which the researcher honestly and authentically shows various realities in a study. During the interviews, the researcher ensured authenticity by accurately capturing and transcribing all information shared including the descriptions and emotions portrayed by the participants. The direct narrative of the participant's voice,

feeling, and tone were conveyed as they shared their perspectives. The researcher captured the multiple perspectives and values of participants in this study and fostered change across participants and systems during data analysis.

4.16 ETHICAL CONSIDERATIONS

When humans are used as participants in a study, care must be exercised to ensure their rights are always protected ensuring that there will be no risks and no harm throughout the research process (Polit and Beck 2021). Ethical considerations are extensive and should be applicable during all phases of the study (Cresswell and Cresswell 2018). The following ethical principles were followed to ensure the protection of all the study participants.

4.16.1 Permission

The research proposal was submitted to the Faculty Research Committee (FRC) for review and approval and then to the Institutional Research Committee (IREC 307/22) at the Durban University of Technology (DUT) for ethical clearance (Appendix 1) before commencing the data collection. A letter requesting permission to conduct a study at the KZN Department of Health Research Committee (Appendices 2a and 2b), District manager (Appendices 3a and 3b), to request for the district health facilities were sent. Permission was also sought from the mother hospital from the CEO (Appendices 4a and 4b) and the deputy nursing manager of the hospital (Appendices 5a and 5b). Community leaders such as the Chief, Izinduna and Councillors were approached as gatekeepers for data collection for the TBAs. The Induna allowed the researcher to commence data collection, but did not write a permission letter – he wrote on the request letter and signed that (Appendix 6a) and the councillor did write a permission letter (Appendix 6a).

4.16.2 Informed consent

Complete information regarding the research purpose and objectives was provided to all the participants in meetings which were held before commencement of data collection. Letters of information (Appendices 8a, 8b, 8c, 8d and 8e) were given to the participants which were in English for the midwives and English and isiZulu for the women and TBAs to ensure understanding for those who do not understand English. After the information session, all the participants who indicated their willingness to take part in the study were given informed consent forms which were explained to them. Only those who agreed to participate in the study signed consent forms after an explanation about the content of the study was given to them. All participants were informed that they could pull out from the study at any time if they felt uncomfortable with no questions asked even when they had signed consent.

4.16.3 Right to anonymity and confidentiality

All research participants have the right to anonymity throughout research, and all data collected must be kept confidential throughout the data collection process. Codes were used for the identification of all participants e.g. "001". Names of facilities were not used in order to maintain anonymity, but they were also given codes e.g. ("00" for healthcare facilities and "H" for TBA houses). The researcher ensured that the consent forms were collected first and placed in sealed envelopes so that they were not linked to the data and were stored under lock and key, and ensured that recorded data were stored in a password-locked computer with only the researcher having access. All these records will be kept confidential for five years as per DUT policy and protocol, and they will be deleted and shredded by the researcher at the end of five years.

4.16.4 Right to self-determination

The right to self-determination is based on the ethical principle of respect for a person. Participants were informed that participation was voluntary and that they could withdraw from the study at any stage of the research without any

consequences. Participants were assured of autonomy and that no harm would be inflicted on them whether deliberate or not. Participants were given respect by calling them by their preferred titles or names. Anonymity, privacy, and confidentiality of the participants and data that was ensured. The participants were requested to give permission for the interviews to be recorded, and they agreed, which made it easy for the researcher to analyse the data. The recordings were kept safe and confidential in a locked cupboard where only the researcher had access.

4.16.5 Justice

The right to fair treatment is based on the ethical principle of justice. This principle holds that each person should be treated fairly and should be treated with dignity. The researcher ensured justice by approaching and treating all participants equally regardless of race, colour, creed, socio-economic status and/or level of education. The study population was not coerced to take part in the study, but all were allowed to join voluntarily after they had received full information about the study and signed informed consent. Participants were allowed to withdraw at any point in the study if they wanted to do so. The researcher ensured the protection of all participants by treating all data and research records with strict privacy to ensure anonymity and confidentiality. This was ensured by using codes instead of participants' personal information on all records and safe keeping of all research records (soft and hard copies) to ensure that these are accessible to the right persons only such as a researcher and supervisors.

4.17 CHAPTER SUMMARY

This chapter describes the methodology that was used in this study. The methodology covered the aims and objectives which were met as well as the research questions which were answered following a qualitative approach. Sampling methods, data collection tools and methods and the data analysis method were discussed. Ethical considerations were presented.

CHAPTER 5: PRESENTATION OF FINDINGS

5.1 INTRODUCTION

Chapter 5 presents the findings from data analysis. The chapter begins with a brief overview regarding data collection and analysis. Sample realisation, the findings on demographic characteristics of the study participants, the themes and sub-themes derived from data analysis (including findings on triangulation) are presented.

5.2 OVERVIEW OF DATA COLLECTION

Data collection commenced immediately on receipt of full ethics approval (IREC 307/22 Appendix 1) and gatekeeper permissions from relevant gatekeepers (Appendices 2b, 3b, 4b, 5b, and 6). Data was collected between April and August 2023. The data collection sites were all the public healthcare facilities in the Inkosi Langalibalele Local Municipality, Estcourt sub-district, in the uThukela District Municipality, that were providing comprehensive maternity healthcare services (ANC, intrapartum and postnatal care) and the homes where TBAs that were included in the study resided. Data collection was conducted by the researcher guided by the interview guides for women and TBAs (Appendices 9b, 9c, 9d and 9e) which were in isiZulu and English and focus discussion group discussions with the midwives (Appendix 9a). The researcher had to answer six research questions to achieve the aim and objectives of the study. Data collected at this point was intended to answer the first five research questions as presented in Table 5.1.

Data collection and its analysis typically progressed concurrently. While this process allowed the researcher monitor data saturation for this qualitative study, it also assisted the researcher, as she moved from one interview/FGD to the next, to sift through information and gain insight about the problem under study, bring in new questions during probing, and seek further evidence to amplify or confirm the insights (Polit and Beck 2017). In line with the qualitative nature of

the study, data analysis included mainly thematic analysis as guided by the six steps described by Creswell (2014). Selected findings such as demographic characteristics were quantified using simple statistics such as sums and percentages to allow interpretation. Tables and/or graphs are used to present quantification findings under relevant sections. During qualitative data analysis, the researcher was able to organise, provide structure and elicit meaning from the collected data (Polit and Beck 2021).

Table 5.1: Alignment of research questions to collected data

Research Question	Population	Data Collection Method
What strategies exist toward collaboration of TBAs and midwifery care exist in KZN?	Midwives, TBAs and women	FGD and interviews
What are the perceptions of TBAs and midwives regarding collaboration between midwives and TBAs?	Midwives and TBAs	Interviews
What are the views of women regarding the collaboration of midwives and TBAs?	Women	FGD and interviews
Which factors and how do these factors influence collaboration between midwives and TBAs?	Midwives, TBAs and women	FGD and interviews
How would these collaborations be benefiting you and other women in this area?	Women	Interviews

5.3 SAMPLE REALISATION

5.3.1 Study sites

Census sampling of healthcare facilities that were providing comprehensive maternity healthcare services (ANC, intrapartum and PNC) resulted in one district hospital and six PHC clinics being included in the study. The health facilities were used to collect data from midwives who were working in these facilities who had been involved in the provision of ANC, intrapartum and PNC health services for more than six months. Similar facilities were used to collect data from women who were attending healthcare services in the selected clinics who were either pregnant or in the postpartum period and had attended TBAs during current or the previous latest pregnancy. All ten TBAs who were offering maternity care to the women of uThukela District opted for being interviewed from their homes. Thus, ten TBA homes were included as data collection sites

(seven homes prior to data saturation and three from data saturation point to confirm data saturation). Therefore, 16 different study sites were used for data collection as follows six health care facilities (one hospital and five PHC clinics) and 10 TBA homes. Table 5.2 presents the 16 study sites used for data collection.

Table 5.2: Total number of data collection sites included in the study per sub-district

Study site	Number at Data Saturation		Total
	Point	Confirmation	
Healthcare facilities	N/A Census sample used		6
TBA homes	7	3	10
Total study site for the entire study			16

5.3.2 Sample realisation for study participants

The sample for the study included registered midwives who had been involved in the provision of ANC, intrapartum and PNC health services for more than six months, TBAs who were offering maternity care to the women of uThukela District and women who were either pregnant or were in the postpartum period and had attended TBAs during pregnancy. Sample realisation for all these participant groups is presented in sections below.

5.3.2.1 Registered midwives

Midwives were purposively sampled. The targeted midwife population were registered midwives who have been involved in the provision of ANC, intrapartum and PNC health services for more than six months. In line with the original plan to have a minimum of four and maximum of 12 midwives in each group, the minimum sample size was four and the maximum size was five. The number of midwives in the healthcare institution who agreed to take part in the study determined the number of participants in each FGD. Table 5.3 presents the sample realisation for the registered midwife participants.

Staff establishment and availability of midwives who met the inclusion criteria reduced the pool of possible participants. All midwives who met the inclusion

criteria and were available were keen to participate in the study. Thirty-eight midwives were included. In general, on average, one focus group discussion session was conducted in each health facility except in two healthcare facilities where more than one session was conducted. In H2, two sessions were conducted, the second one being to confirm data saturation. In H5 three sessions were conducted because ANC, PNC and intrapartum services were offered as vertical programmes. The third session in this healthcare facility was used to confirm data saturation.

Table 5.3: Total number of registered midwives included in the study (n = 38)

Healthcare Facility	Number of midwives					
	Until saturation point		To confirm data saturation		Total	
	Midwives	Focus Group sessions	Midwives	Focus Group sessions	Midwives	Focus Group sessions
H1	10	2	4	1	14	3
H2	4	1	Nil	Nil	4	1
H3	4	1	4	1	8	2
H4	4	1	Nil	Nil	4	1
H5	4	1	Nil	Nil	4	1
H6	4	1	Nil	Nil	4	1
6	30	7	8	2	38	9

5.3.2.2 Traditional birth attendants

The TBAs (n = 10) offering maternity care to the women of uThukela District were identified with the assistance of the women, other TBAs taking part in the study and the community care givers from the clinics (Table 5.4). Data saturation was reached after seven interviews but because the researcher had planned to have a minimum of ten (10) TBAs irrespective of data saturation, three additional TBAs were sampled and interviewed to confirm data saturation.

Table 5.4: Total number of TBAs included in the study (n = 10)

Home	Number of TBAs		
	Untill saturation	To confirm data saturation	Total
H1-H7	7	NIL	7
H8-H10	NIL	3	3
Total	7	3	10

5.3.2.3 Women

Women (n = 18) who were either pregnant or were in the postpartum period and had attended TBAs during pregnancy were recruited from the ANC, PNC, family planning and well-baby clinics within the healthcare institutions. Table 5.5 presents the sample realisation for women. Eighteen women were purposively sampled and included in the study. A minimum of two and maximum of six women were sampled per PHC clinic. Data saturation was reached after 15 women were interviewed. Three women from two clinics (one and two in each) were sampled and interviewed to confirm data saturation. Eighteen women in total were interviewed.

Table 5.5: Total number of women included in the study (n = 18)

Healthcare Facility	Number to data saturation		Total
	Point	Confirmation	
H1	4	2	6
H2	2	Nil	2
H3	1	1	2
H4	3	Nil	3
H5	2	Nil	2
H6	3	Nil	3
6	15	3	18

5.4 DEMOGRAPHIC CHARACTERISTICS OF STUDY PARTICIPANTS

Selected demographic characteristics of the participants were determined to assist with establishing inclusion criteria, assist with the better understanding of the phenomenon under study, and to assist the readers to comprehend the

sources of the given information. The participants were registered midwives, pregnant and delivered women and TBAs who met the inclusion criteria for participating in this study. The demographic characteristics of all three categories are presented below. In order to ensure better understanding of the demographic characteristics, the findings on analysis of demographic data were quantified and presented in either a table or a graph form. Quantifying qualitative data is the process of coding and analysing qualitative data quantitatively (Polit and Beck 2021). Although some researchers believe that transforming data is inappropriate, Polit and Beck (2021) support this process and propose that converting data of one type to another (qualitative to quantitative or vice versa) sometimes offers benefits and also serves as a critical function to encourage researchers to think about and interact with their data. Polit and Beck (2021) further explain that transforming data can be used to achieve two important goals which are generating meaning, and documenting and confirming conclusions. This is why the researcher in the current study decided to to analyse and interpret data on demographic characteristics quantitatively even though the study used a qualitative approach.

5.4.1 Common demographic characteristics of all three participant groups

The study comprised 66 participants of whom 38 were midwives, 10 were TBAs and 18 were women. The common characteristics across all three participant groups included age, gender and ethnicity. The findings regarding age group ranges revealed the following:

- In the **20-29 years age group** range there were 13% (n = 5) midwives, no (0%; n = 0) TBAs and 33% (n = 6) women.
- In the **30-39 years age group range** there were 31.5% (n = 12) midwives, 20% (n = 2) TBAs and 67% (n = 12) women.
- In the **40-49 years age group range** there were 31.5% (n = 12) midwives, 50% (n = 5) TBAs and no women.
- In the **50-60 years age group** range there were 16% (n = 6) midwives, 30% (n = 3) TBAs and no women.

- In the **60-65 years age group range** there were 8% (n = 3) midwives, no TBAs and no women.

These findings for the age reflect that:

- The majority of midwives were in the 30-39 and 40-49 year age ranges with 12 in each category, while the least number of midwives were in the 60-65 years age range where there were n = 3.
- Half (n = 5) of the TBAs were in the 40-49 years age range followed by 30% (n = 3) in the 50-59 range and 20% (n = 2) in the 30-39 range with none in the 20-29 and 60-65 ranges.
- The majority of women participants 67% (n = 12) were in the 30-39 years age range followed by 33% (n = 6) in the 20-29 years age range with none in the 50-59 and 60-65 years age ranges.

The study findings on **gender** of the participants revealed that all participants were females except for three male midwives (auchouchers) in the midwives population. Both male (accouchers) and female midwives are collectively referred to as midwives in the context of this study.

The findings regarding **ethnicity** indicated that all study participants were black Africans.

Table 5.6 reflects the summary of findings on age gender and ethnicity for the three participant groups included in the study.

Table 5.6: Summary of findings on age, gender and ethnicity

Demographic Charecteristic		Midwives (n = 38)	TBA's (n = 10)	WOMEN (n = 18)	TOTAL
AGE	20-29	13% (n = 5)	0%(n = 0)	33%(n = 6)	16.7%(n = 11)
	30-39	31.5%(n = 12)	20%(n = 2)	67%(n = 12)	39.4%(n = 26)
	40-49	31.5%(n = 12)	50%(n = 5)	0%(n = 0)	25.8%(n = 17)
	50-59	16%(n = 6)	30%(n = 3)	0%(n = 0)	13.6%(n = 9)
	60-65	8%(n = 3)	0%(n = 0)	0%(n = 0)	4.5 %(n = 3)
	TOTAL	100%(n = 38)	100%(n = 10)	100%(n = 18)	100%(n = 66)
GENDER	Male	8%(n = 3)	0%(n = 0)	0%(n = 0)	4.5%(n = 3)

	Female	92%(n = 35)	100%(n = 10)	100%(n = 18)	95.5%(n = 63)
	Total	100%(n = 38)	100%(n = 18)	100%(n = 18)	100%(n = 18)
Ethnicity		100%(n = 38)	100%(n = 18)	100%(n = 18)	100%(n = 66)
	Total	100%(n = 38)	100%(n = 18)	100%(n = 18)	100%(n = 66)

5.4.2 Specific demographic characteristics for each participant group

Selected characteristics differed for each group. These were specific characteristics for each group that were deemed necessary to better understand the phenomenon under study so were gathered as part of data collection. These together with the findings on the analysis of each are presented in the sections below.

5.4.2.1 Midwives

Additional demographic characteristics gathered for the midwives included the category of midwifery qualification, years of experience, and duration in the current facility.

Category of midwifery qualification: All midwives interviewed (100%; n = 38) were registered midwives. 32% (n = 12) had advanced qualification in midwifery and 62% (n = 26) had a general/basic midwifery qualification. There were no participants who were staff midwives. Table 5.7 presents findings on midwifery qualification.

Table 5.7: Information on category of midwifery qualification

Information: Years of experience as a midwife			
Advanced Midwife	General/Basic Midwife	Staff Midwife	Total
32% (n = 12)	62% (n = 26)	0% (n = 0)	100% (n = 38)

Years of experience: The findings of the study revealed that the majority (32%; n = 12) had 6 – 10 years of experience. The proportion of midwives with the most number of years of experience (16 – 20 years) was 13.2% (n = 5), while the least (6 – 11months) was 10.5% (n = 4). Findings on years of experience are reflected in Table 5.8.

Table 5.8: Information on years of experience as a midwife

Information: Years of experience as a midwife				
6 – 11 months	1 – 5 years	6 – 10 years	11 – 15 years	16 – 20 years
10.5% (n = 4)	23.6% (n = 09)	31.5% (n = 12)	21.2% (n = 08)	13.2 (n = 05)

Duration in the current facility: The findings revealed that 34.2%(n = 13) had spent the longest period (1 – 5 years) in the current facility. The proportion of midwives with the most number of years of years working in the current facility (16 – 20 years) was 13.2% (n = 5) and those with the least (6 – 11months) was 7.9% (n = 3). Findings on years of experience are refected in Table 5.9.

Table 5.9: Duration in the current facility as a midwife

Duration in the current facility as a midwife				
6 – 11 months	1 – 5 years	6 – 10 years	11 – 15 years	16 – 20 years
7.9% (n = 3)	34.2% (n = 13)	26.3% (n = 10)	18.4 % (n = 07)	13.2% (n = 05)

5.4.2.2 Traditional birth attendants

Extra demographic characteristics gathered for the TBAs included the category of number of years as a traditional attendant, and their qualifications.

Years as a traditional birth attendant: The findings of the study regarding the duration of experience for TBAs reflected that the majority of the TBAs 40% (n = 4) had 11 – 15 years of experience as TBAs. The proportion of TBAs that had the longest experience 16 or more years was 20% (n = 2) while the least experience of 1 – 5 years was 30% (n = 3). Findings on years of experience are refected in Table 5.10.

Table 5.10: Years of experience as a TBA

Information: Years of experience as TBA			
1 – 5 years	6 – 14years	11 – 15 years	16 –or more years
20%(n = 3)	10% (n = 1)	40 %(n = 04)	20%(n = 02)

Traditional birth attendant qualifications: The finding of the study reflected that 90% (n = 9) of the TBAs did not have any medical qualification. One of the TBAs (10%) had previously worked as a professional midwife.

5.4.2.3 Women

Additional demographic characteristics for the women included the number of pregnancies, number of deliveries, Number of child deaths below 1-year, marital status, highest educational level, employment status and provision of care during pregnancy, labour, delivery and post-delivery.

Number of pregnancies: The majority of the women 38% (n = 7) had two pregnancies. The proportion of women with the highest number of pregnancies (5) was 11% (n = 1), and with the lowest number (1) was 17% (n = 3). Findings on number of pregnancies are reflected in Table 5.9

Number of deliveries: There were two groups who had the largest number of women 33% (n = 6). One group had had one delivery and the other group had had two deliveries. The proportion of women with the highest number of deliveries (4) was 11% (n = 1), and the lowest number of deliveries (1) was 33% (n = 6), while one woman who was still pregnant for the first time and thus have had no previous delivery. The findings on number of deliveries are reflected in Table 5.9.

Table 5.11: Information on number of pregnancies and deliveries

	0	1	2	3	4	5	Total
No of Pregnancies	n/a	17% (n = 3)	38% (n = 7)	28% (n = 5)	11%(n = 2)	6%(n = 1)	100% (n = 18)
No of deliveries	6% (n = 1)	33% (n = 6)	33% (n = 6)	22% (n = 4)	6% (n = 1)	0% (n = 0)	100% (n = 18)

Number of child deaths below one year: This section focused on child deaths that occurred during pregnancy and post-delivery but before the age of 1 year.

The findings showed that among the 18 women who participated in the study, 33% (n = 6) had previously lost a child

Of the six women, one lost two children (one as a fresh stillborn and one as a miscarriage) while the other five women lost their children through miscarriages/abortions. None of the women had neonatal/infant deaths. Table 5.12 presents the findings.

Table 5.12: Findings on death of a child below one year

Viable Death			Abortion/miscariages			Total deaths	Number of women
Stillbirth	Neonatal/Infant Death	Total	Miscariage	Therapeutic abortion (TOP)	Total		
1	0	1	1	4	5	6	5

Marital status: Of the 18 women surveyed, the majority of the women (83%;n = 15) were not married and 17% (n = 3) reported being married.

Highest Education Level: Out of the 18 women who participated in this study, 28% (n = 5) of women reported having achieved a tertiary education level. The majority of the women who participated in the study, 72% (n = 13) reported having achieved a secondary education level. This findings show that all women 100% (n = 18) had had some form of education whether secondary or tertiary.

Employment status: Of the 18 women who participated, the majority of the women (72%; n = 13) reported to be unemployed. Of the other women who were employed 22.2% (n = 4) were employed by someone else and 5.6% (n = 1) was self-employed. Table 5.13 presents the findings on the marital, education and employment statuses of women participants.

Table 5.13: Summary of findings on marital, education and employment status

Characteristic	Single	Married/ Co-habiting	Divorced/ Seperated	Widowed	Total
1. Marital status	72.2 % (n = 13)	16.7%(n = 3)	11.1% (n = 2)	0% (n = 0)	100% (n = 18)
2. Education	None	Primary	Secondary	Tertiary	
	0% (n = 0)	0% (n = 0)	72% (n = 13)	28% (n = 5)	100% (n = 18)
3 Employment	Schooling	Unemployed	Employed	Self Employed	
	0% (n = 0)	72.2%; (n = 13)	22.2% (n = 4)	5.6% (n = 1)	100% (n = 18)

Provision of care during pregnancy, labour, delivery and post-delivery:

All study participants agreed that they were utilising the services of both the midwives and TBAs. However, their responses differed with regard to which maternity care aspects (pregnancy, labour, delivery and post-delivery) they were using with of these providers. The findings below relate to who mostly provided care to women during pregnancy, labour, delivery or post-delivery between TBAs and midwives.

- **Provision of care during pregnancy:** Based on the information collected regarding who took care of the women during pregnancy, the findings were that 33.3% (n = 6) of women were mostly cared for by midwives, 55.56% (n = 10) were mostly cared for by TBAs and 11.1% (n = 1) equally used both TBAs and midwives during pregnancy.
- **Provision of care during labour:** Findings regarding who mostly provided care to women during labour based on the total of 18, there were 87.10% (n = 14) who were mostly cared for by midwives, 3.22% (n = 1) were mostly cared by TBAs and 9.68% (n = 3) equally used both TBAs and midwives during labour.
- **Provision of care during delivery:** Findings regarding who mostly provided care to women during delivery were that 55.6% (n = 10) were mostly cared for by midwives, 44.4% (n = 8) were mostly cared for by TBAs and none (0%) were equally cared by both TBAs and midwives during labour.
- **Provision of care post-delivery:** Findings regarding the care attended by women after delivery shows that of the total of 18 women 6.45% (n = 2) were mostly cared for by midwives, 58.07% (n = 9) were mostly cared

by TBAs, and 35.48% (n = 7) equally used both TBAs and midwives for post-delivery services.

In conclusion, these findings indicate that the majority of women used midwifery services for labour (87.10%, n = 14) and delivery (44.10%, n = 8) compared to those who used TBA services for labour (3.22%, n = 1) and delivery (22.58%, n = 7). However, the majority of women used TBA services for pregnancy (55.56%, n = 10) and post-delivery (58.07%, n = 9), compared to those who utilised midwifery services for pregnancy (33.3%, n = 6), and post-delivery (6.45%, n = 2). The findings indicate that out of 18 women, on average 51.61% (n = 16) utilised the services of midwives for all maternity care services, and 33.87% (n = 10.5) used the TBAs for all maternity care services, and 14.52% (n = 5) used the services from both groups equally.

Table 5.14 presents a summary of findings regarding provision of care during pregnancy, labour, delivery and post-delivery.

Table 5.14: Provision of care during pregnancy, labour, delivery and post-delivery

Period	Midwives	TBAs	Both	Total
Pregnancy	6 (33.3%)	10 (55.56%)	2 (11.1)	18(100%)
Labour	14 (87.10%)	1(3.22%)	3 (9.68%)	18(100%)
Delivery	10 (55.6%)	8 (44.4%)	0 (0%)	18(100%)
Post-delivery	2 (6.45%)	9(58.07%)	7(35.48)	18(100%)
AVERAGE	8 (44.4%)	7 (38.9%)	3 (16.7%)	18(100%)

5.5 THEMES AND SUB-THEMES

The four themes that emerged from data analysis were: 1) Existence of midwifery and TBA services in the area, 2) Collaboration between midwifery and TBA services, 3) Practices in the absence of collaboration, and 4) Feasibility of collaboration. Several sub-themes corresponding to each theme emerged. Table 5.15 presents the four themes and corresponding sub-themes.

Table 5.15: The four themes and corresponding sub-themes

Themes	Sub-Themes
1. Traditional birth attendants services in the area	<ul style="list-style-type: none"> • Awareness of midwifery and traditional birth attendant services in the area. • Utilisation of midwifery and/or traditional birth attendant services • Factors influencing utilisation of midwifery and traditional birth attendant services
2. Collaboration between midwives and traditional birth attendants	<ul style="list-style-type: none"> • Non-existence of collaboration between midwifery and traditional birth attendant services. • Factors influencing non-existence of collaboration between midwifery and traditional birth attendant services. • Teamwork between midwifery and traditional birth attendant services
1. Practices in the absence of collaboration	<ul style="list-style-type: none"> • Acknowledgement of each other's existence. • Attitudes and respect towards each other. • Influences of current practices on patient care outcomes. • Communications.
2. Feasibility of collaboration	<ul style="list-style-type: none"> • Benefits of collaboration. • Requirements for successful and sustained collaboration.

5.5.1 Theme 1: Midwifery and traditional birth attendant services in the area

The availability of healthcare services for pregnant women differs from area to area, with some areas having both the service of skilled healthcare providers such as midwives and of TBAs while others have just one of the two available (Shimpuku *et al.* 2021). The availability of healthcare services has an influence on access and utilisation of such services. Levesque, Harris and Russell (2013) explain that the factors to consider could pertain to supply-side features of health systems and organisations, the demand-side features of populations, and process factors describing how access is realised. The first theme that emerged from data analysis was the existence of midwifery and TBA services in the study area. The three sub-themes that emerged in relation to this theme were awareness of midwifery and TBA services in the area, utilisation of midwifery and/or TBA services, and the factors influencing utilisation of midwifery and TBA services.

5.5.1.1 Sub-theme 1.1: Awareness of midwifery and traditional birth attendant services in the area

Brizuela *et al.* (2019) state that awareness is either described as a precursor to action, or as having heard of a specific issue. Women need to be aware of the existence of midwifery and TBA services in the area for them to utilise. In addition, the midwives and the TBAs need to be aware of each other's existence to be able to collaborate. The findings confirmed that all study participants were aware of availability of midwifery and TBA services in the area since it was an expectation in the inclusion criteria.

"I have a long history with TBAs for childbirth since my whole family believes in traditional assistance but I also attend ANC at the clinic, but I prefer TBAs more because I trust them and I am familiar with how they work. So, if the TBAs and midwives can work together, there should be respect amongst them and traditional practices should be incorporated into modern midwifery". (1/H1/W1)

I attend the clinic more since I have always had positive experiences with the midwives and what I like about them is to know that they have learnt for what they are doing. I only started using TBAs with this pregnancy because of problems I have been experiencing caused by the other baby mama. (4/H1/W4)

The problem with attending clinics all the time is the distance in this area where there is no transport and TBAs are close to me so for me it is easy to go to them. (5/H1/W5)

I attend both because of different reasons during pregnancy and what you are trying to do, sister, will work well because if they work together, they can educate each other and maybe TBAs will be allowed in the clinics and hospitals since we sometimes need them during delivery when there are delays and they can make decisions together (2/H1/W2 & 11/H4/W11)

Similarly, both the TBAs and the midwives were aware of each other's existence. Nonetheless, there was no collaboration between these two groups.

My sister, being aware that there are TBAs who are still functioning in the area means we have to train them formally because the complications women come

with here are worrying and they can also contribute their expertise for safer childbirth practices and better outcomes. (F1/H1/M1)

TBAs are here to stay and I think there is a lot of research to do and I think the guidelines you want to develop will assist in improving maternal and neonatal health. (F1/H1/M4)

As much as we see women at this clinic, but in most cases they use TBAs and only come to us when they have problems and sometimes it is too late. Maybe we should plan community education campaigns among women about the benefits of midwifery services. They can suggest educational campaigns to inform women about their options. (F3/H1/M4)

Collaboration with TBAs will work well since most women prefer to visit them but the most important thing is mutual respect and recognition of each other's roles and I think a coordinated approach will help us here. (F1/H1/M2 & F4/H2/M2)

They are here to stay as my colleagues are saying, so we need guidance to enhance the skills and knowledge of TBAs, ensuring that they are better prepared to handle uncomplicated deliveries and identify when to refer high-risk cases to us. (F3/H1/M2 & F6/H3/M7)

Midwives also discussed the legal and regulatory aspects of their profession, including licensure and certification requirements where they were emphasising the importance of adherence to these standards.

I think we need to engage with local communities to build trust and awareness of midwifery services, maybe have community outreach programmes and involvement in local health initiatives. (F3/H1/M6)

Yes the nurses are there and we respect them but we also have deep knowledge of local birthing practices, including traditional remedies and techniques which we learnt from our forefathers. The nurses must respect that and I am sure these practices can somehow be incorporated into modern maternity care. (I1/H1/T1)

My daughter, I have contributed to reducing maternal mortality by providing care when there are no other options available. I have delivered more than thirty

women here; some had no transport to go to hospital, others preferred to be delivered at home because the nurses shout at them and there are lots of other reasons. (I5/H5/T5)

I am happy to collaborate with the midwives particularly in cases of complications or when advanced medical care is needed. If I can be taught when to refer to healthcare facilities. (I1/H1/T1 & I7/H7/T7)

We know the nurses do a great job since they went for training, but they must also train and educate us sister so that we gain skills and knowledge, then we will be better equipped to handle complications or recognise when a referral is necessary. (I3/H3/T3)

We know they are there and do a great job but they must come to the communities and meet with us do some community education programmes that inform women about the existence and benefits of both TBAs and midwives so we work as a team and women can make informed choices. (I6/H6/T6).

5.5.1.2 Sub-theme 1.2: Utilisation of midwifery and/or traditional birth attendant services

There is evidence that in most developing countries particularly in rural and under-resourced settings, women still continue to use the services of TBAs. All women participants in the current study were or had used the services of both the midwives and TBAs during pregnancy and childbirth. Although this was mostly because this was an inclusion criterion for the women participants in the current study, all study participants concurred that most women in the Inkosi Langalibalele Local Municipality use both the services of the midwives and the TBAs as much as their views varied based on their experiences, cultural background, and socio-economic status.

I use both the TBAs and the midwives at the clinics and hospitals because this will ensure a higher level of safety during childbirth since I once lost a baby. I believe that their knowledge combined can provide comprehensive care. (3/H1/W3)

I support collaboration as it blends traditional practices with modern healthcare, addressing cultural and social preferences especially since we believe in both. (12/H4/W12)

I prefer using TBAs during pregnancy then go to the clinic to deliver because with TBAs I don't have to use money for transport since there is no one working at home. This is due to the lower cost, especially if they lack access to affordable healthcare facilities but I use them both. (6/H2/W6)

To tell you the truth, my husband and I prefer to use TBAs due to cultural and spiritual beliefs associated with childbirth. I also use the clinic if I see that whatever is a problem requires medical assistance for the sake of my baby, so I would like to see them collaborate. (8/H3/W8)

I had a terrible experience with my last baby when I only attended a TBA and she asked me to hurry to hospital because of some complications and my baby died while I was waiting for transport. Now I use both because I believe I need them both. (14/H5/W14)

Midwives also raised their views which may have been influenced by their professional experiences, training, and understanding of the healthcare system. Here are some viewpoints:

The way I look at this is that most women use both us and the TBAs and collaboration with TBAs may be an opportunity to combine our clinical training and medical expertise with the TBAs knowledge and experience and a way to provide more holistic care. (F1/H1/M3 & F7/H4/M3)

As a practitioner of both traditional healing and midwifery, I deeply value the contributions of Traditional Birth Attendants (TBAs) in our communities. I believe that through collaboration with TBAs, we can reach and serve underserved populations, especially in remote or culturally isolated areas because most women will only attend ANC in their last trimester preparing to come to the clinic or hospital to deliver but from the beginning they attend TBAs only. (F1/H1/M5)

For the women's sake since they have always been seeing both us and TBAs I support collaboration since it may allow women more choice in childbirth and aligns with their preferences and cultural beliefs. (F3/H1/M1)

For me, as long as there will be clear referral mechanisms and communication channels regarding referral, I support collaboration so that our patients are safe because we cannot stop them from attending TBAs and us. (F4/H2/M1 & F2/H1/M1)

Sister, it is obvious that women attend the hospitals and also come to us for help so we must just work together for their sake. We can combine our traditional birthing knowledge with the modern medical expertise and this collaboration can enhance the quality of care and improve outcomes for expectant mothers and infants. (I8/H8/T8)

Women believed in both us and the midwives, the problem with us is that we do not have resources to work so we can really appreciate the collaboration as it may provide better access to medical supplies, equipment, and facilities through midwifery services. (I2/H2/T2)

Sister as much as women come to us and hospitals, they have trust in us but we need training, updates on best practices, and modern healthcare knowledge, so that we can improve our skills and capabilities. When working together with nurses they will trust us more. (I6/H6/T6)

What I can say is, we are indirectly working together with the nurses because our clients visit us both and they tell us what they said about their illnesses and they do the same when they go to them as well, we just need to formalise this and discuss referral systems when there are complications. (I7/H7/T7)

5.5.1.3 Sub-theme 1.3: Factors influencing utilisation of midwifery and traditional birth attendant services

The research shows that utilisation of health services improves the health status of the population. However, the presence of health facilities alone is not enough to guarantee their use as other socio-economic factors such as high cost of drugs and service charges, easy access to traditional healers, and difficulty in getting transport to a health facility could influence access and thus utilisation. In most cases, low health facility utilisation is often a reflection of poor quality of services and poor attitude of staff. The finding from this study reflected that several factors were influencing utilisation of midwifery and TBA services. Women participants in the current study highlighted several factors responsible

for them opting to use the services of a TBA. These included traditional and cultural beliefs, lack of trust in modern medicine, poor access to healthcare services, costs, and attitude of midwives.

My sister, nurses do not understand our traditional practices instead they just shout at us and force us to only use modern healthcare. Due to cultural beliefs and the trust for the TBAs I prefer to use them than nurses. I am only here because my traditional healer said I must also come here for help. (9/H3/W9)

My one problem with the clinics and hospitals is that I stay in a place where there is poor transportation so it is difficult to come for ANC all the time but the traditional healer I use when I am pregnant is a walking distance from home. I use her because she is always available and accessible to me and other women from our community. The cost of transportation to reach a hospital is also much for us. (16/H6/W16)

Sister some of the problems are language and communication with me since I am Sotho sometimes the nurses do not understand what I am saying and they get irritated, the other problem they are rude they shout at us each time we come for ANC and that is demoralising. The TBAs in our different areas respects us, they are patient with us and they try to understand what we are saying so I prefer them than nurses but I have to come here so I can get my treatment. (17/H6/W17)

My sister, I have lost babies before so this time I went to a traditional healer who gave me traditional medicine to hold the current pregnancy and I will be able to deliver a live baby when the hospital could not help me. I will continue with the TBA because he understood my problem and I believe he will help me. He insisted I also attend ANC so that the nurses may watch me closely and I can deliver in hospital. (7/H2/W7)

My traditional healer offers me personalised and culturally sensitive care and privacy is ensured. He follows spiritual aspects needed for both me and the baby, he also understands our family customs and my preferences, which is very appealing to me and my husband's family. (15/H5/W15)

I don't like to deliver in hospital, they like to operate on people the moment they struggle to deliver but the traditional healers will give you time and try. I am scared of medical interventions I prefer more natural approach. (10/H3/W10)

5.5.2 Theme 2: Collaboration between midwives and traditional birth attendants

There is research evidence that integration of TBAs within the country's healthcare system, particularly in the field of maternal and child healthcare, would be a helpful strategy to curb maternal and child mortality and other untoward pregnancy outcomes in developing countries (Kassie *et al.* 2022). The two sub-themes that emerged regarding collaboration were non-existence of collaboration between midwifery and TBA services and the factors influencing non-existence of collaboration between midwifery and TBA services.

5.5.2.1 Sub-theme 2.1: Non-existence of collaboration between midwifery and traditional birth attendant services

Non-existence of collaboration between midwives and TBAs in this district was reported by all study participants. Musie *et al.* (2022) state that the lack of collaboration between midwifery and TBAs can have significant implications for maternal and neonatal health in a given country by undermining the country's ability to progress in fighting against maternal mortality as indicated by the Sustainable Development Goals (SDG 3) to reduce maternal mortality rates.

Therefore, it is generally recognised that the lack of collaboration between midwives and TBAs impacts a country's ability to curb perinatal and neonatal deaths and morbidities (Musie *et al.* 2022). The views and perspectives of women, midwives, and TBAs are crucial in understanding the reasons behind the lack of collaboration and how it can be improved. The views of the participants in the current study were based on their different experiences, cultural contexts, and perspectives. Here are some common views from each group:

The safety of my child is my priority so delivering in the absence of skilled midwives when the TBA is assisting me worries me so the fact that they are not collaborating is a problem when we need them both. (12/H4/W12)

Sister, I personally prefer to use the services of TBAs due to traditional reasons, but I also acknowledge their limitations in handling complications hence I end up using the hospital as well. If there was a facility where there was collaboration between TBAs and midwives, I would go there but I end up confused on where to go for assistance (13/H4/W13)

I feel like I have limited choices and I rely mostly on TBAs due to a lack of access to healthcare facilities, our area has no transport at all. When TBAs have problems they don't know how to communicate with the hospital for help. (18/H6/W18)

Women may feel like utilising us and TBAs but I still emphasise the importance of a midwife during childbirth to ensure patient safety due to the potential risks associated with relying solely on TBAs. (F3/H1/M5)

Non-existence of collaboration causes many problems like neonatal deaths so I see it as an opportunity to build the capacity of TBAs and enhance their skills to provide safer care. (F2/H1/M3)

My sister as a traditional healer and a midwife, I told you that these barriers to collaboration are frustrating because we end up attending mothers with complications which should have been prevented by having a transfer system between us and the TBAs. Therefore, we need to try and work with the TBAs which will assist improve overall maternal and neonatal health outcomes. (F1/H1/M5)

Sister, it is no lie that we have a deep understanding of local cultural practices and traditions, making us more culturally competent than midwives so we can be able to communicate with them in case of emergency. (I10/H10/T10)

As traditional healers, we have trust and good relationships with our clients that is long built within our communities which is important in providing care during childbirth. This helps us convince women to go to the hospital when we see that there will be a problem during delivery. (I4/H4/T4)

Collaboration will help maybe we will be recognised by the midwives and we can now work together, otherwise they see us as people who perform witchcraft and shout at women who use our services. (I9/H9/T9)

5.5.2.2 Sub-theme 2.2: Factors influencing non-existence of collaboration between midwifery and traditional birth attendant services

The participants also shared several factors that according to them were influencing the lack of collaboration between midwifery and TBA services. Musie *et al.* (2022) found in their study that non-existing collaboration between midwifery and TBAs impedes pregnant women's ability to receive the holistic care they need. They also highlighted the benefits of collaboration contributing to the global reduction of maternal mortality rates.

The collaboration between midwives, women, and TBAs in the context of maternal and child health is a complex and multifaceted issue. The perspectives and views of these stakeholders can vary significantly, and the factors influencing the non-existence of collaboration is shaped by a range of social, cultural, economic, and policy-related factors, as reflected in the participant contributions below.

I am worried about safety and quality of care provided by TBAs since they lack formal training and can't provide the same level of care and expertise in handling complications during childbirth, I think that's one of the reasons we never thought we can work collaboratively. (F5/H3/M3)

My sister I am hesitant to collaborate with TBAs remember their methods are based on traditional or cultural beliefs rather than scientific, when working with them are we going to be expected to practice that as well? (F8/H5/M1)

I have never thought of it since we are professionals and they operate outside the formal healthcare system, working with them will undermine the credibility of our profession. (F9/H6/M2)

I believe in TBAs and I trust them fully because of family cultural and traditional beliefs and I think I prefer them than nurses because they do not have any

knowledge of our local customs and practices. I only come to the clinic because I have high blood pressure otherwise I won't be coming here. (F9/H6/M4)

Sister I believe and respect my traditions especially related to childbirth, I don't believe they can be shared with non-believers. Our roles as TBAs is culturally and spiritually significant and should be preserved well. (I10/H10/T10)

We have longstanding relationships within our communities and we are trusted by almost all families, what you should know is that we provide a crucial service that women prefer and trust so forcing the collaboration may be a problem but we can try. (I9/H9/T9)

The nurses are stigmatising us, and they perceive themselves as marginalised within the healthcare system. This perception may result in some of our colleagues we are partnering with showing resistance to collaboration. (I1/H1/T1)

5.5.2.3 Sub-theme 2.3: Teamwork between midwifery and traditional birth attendant services

The interviews with registered midwives revealed a strong desire for collaboration with TBAs, although some expressed uncertainty about its feasibility. While there are opportunities for integration, the absence of a formal framework for sustained cooperation and teamwork has resulted in distrust and fragile relationships between midwives and TBAs, as noted in Mutale *et al.* (2020). It was apparent that TBAs often faced negative experiences in many communities due to the lack of support from the healthcare system. Consequently, fostering teamwork between midwives and TBAs is essential to ensure the continuity and quality of postnatal care, thereby reducing preventable factors contributing to maternal mortality and morbidity (as discussed by (Ngunyulu, Mulaudzi and Peu 2020). Candidates had varying perspectives on the idea of collaborative teamwork.

Sister, I think we work well alone, working with TBAs will complicate things in our system, like how are we supposed to know this patient needs Western help and this one needs traditional help. (F5/H3/M1)

I think this will work well if we work together as a team my sister, I am sure that the guidelines will make things easier for both us and the TBAs. (F8/H5/M4)

As long as the guidelines you will be developing will be clear, I think working as a team with TBAs will work well if we put our patients needs first and our differences aside. (F9/H6/M1)

All TBAs were positive about working as a team with the midwives and were looking forward to the guidelines and meeting with the nurses.

Nurse, I am sure if we work with respect all will be well and our clients will be happy. The main thing is to know who you are and you work from there and respect other people's boundaries. (I4/H4/T4)

Sister bring the guideline and see our place change, we need things like this where we will work as a team with the Department of Health to help our women in the community. (I10/H10/T10)

Women were also happy about the idea of midwives working together with the TBAs.

My sister seeing the TBAs working together with midwives will help us use them both freely without being scared of being shouted at. (14/H5/W14)

I don't know if working as a team between the two can work but it is a good idea since they are both helping us in different ways. (7/H2/W7)

I hope the TBAs and midwives will work as a team, work harmoniously to provide safe and respectful care that aligns with our preferences and needs. (14/H5/W14)

5.5.3 Theme 3: Practices in the absence of collaboration

Collaboration between midwives and TBAs is generally encouraged as it assists in the global reduction of the perinatal and neonatal mortality rates (Musie *et al.* 2022). Fragmented patient care without collaboration between the two groups can vary depending on the specific context and healthcare system.

The sub-themes that emerged related to this included acknowledgement of each other's existence, attitudes towards each other, influences of current practices to patient care outcomes and communications.

In the absence of collaboration between midwives and TBAs, common practices among women during childbirth may vary depending on their cultural, economic, and geographical contexts. The following are the common practices women shared during their views:

With my other babies I preferred home births and I was assisted by my grandmother who helps all women in the community. In such cases, traditional practices and customs often play a significant role in the birthing process. (11/H4/W11)

My family believe in herbal remedies and traditional techniques and my grandfather passed this down to my mother so she knows everything even when it comes to pain relief and assisting in the birthing process. The practices she does include massages, herbal teas, and specific rituals believed to ensure a safe delivery so she also has many pregnant people coming to her. (5/H1/W5)

I only come for healthcare assistance in cases of complications or when it becomes clear that the birth is not progressing well like today. For me it is the last resort to come to the clinic but if they work together I think it will be easy for us women to use both TBAs and the nurses freely. (16/H6/W16)

Sister I like coming to the clinic and I believe in the nurses but I also attend the traditional healer even though I have to hide it because the nurses shout at us. (13/H4/W13)

I usually deliver at home where my family will be there to support me and they will do cultural rights for my babies then come to hospital to check if everything is fine with me and my newborn baby even though the nurses shout at me. (9/H3/W9)

5.5.3.1 Sub-theme 3.1: Acknowledgement of each other's existence

It was evident from the responses by the midwives and TBAs that they acknowledge each other's existence during the interviews, which was at least a

starting point. This acknowledgement involves recognising and valuing the roles, skills, and contributions of both midwives and TBAs within the context of maternal and child healthcare. To promote effective collaboration, it's essential to understand and appreciate the perspectives and strengths of each group. The following are the views of midwives:

Efforts should be made to establish platforms for collaboration, promote mutual respect, and bridge the gap between formal training and traditional practices to ensure the best possible care for pregnant women and their newborn babies. (F6/H3/M6)

I feel it is important that we try and meet with them (TBAs) so we can combine ideas on how to assist women because this is about them. (F7/H4/M2)

They (TBAs) are continuing in communities and they are not going anywhere, so for the sake of our patients, let's try and work together, I think collaboration is needed and we appreciate that they exist and they are doing what they were called for as well. (F8/H5/M3)

These (TBAs) are the people they go to first before us in most cases throughout the pregnancy as much as they come to us as well for different reasons especially since they are close by in their communities. We need to appreciate that and work with them for the benefit of the women in our community. (F5/H3/M1)

The TBAs echoed the same sentiments about the midwives where they felt the need to work together, putting women's health first.

My child, I would like to work closely with the nurses because they know the Western part of treatment which can help when I work with my clients. So if they can teach me one or two things, I will be a pro. (I4/H4/T4)

You know; the nurses think we don't know what we are doing which is what was done by our ancestors before this nursing started. They must ask and we teach them, I am willing to teach them as much as I know their experience is also good but they need to know cultural things. (I10/H10/T10)

I am happy to work with them because they need to help us by teaching us some of the first aid things so we do not panic when we see new things. If they

can also give us some protective equipment like gloves, masks and aprons.
(19/H9/T9)

5.5.3.2 Sub-theme 3.2: Attitudes and respect towards each other

It was evident that TBAs and midwives do have respect for each other and each other's jobs and spaces. This was clear from their responses during the interviews.

We need to respect what they do because it's their calling too and it is their jobs as much as we have to work hard when we receive women they have seen with complications. (F2/H1/M2)

The TBAs are also working hard and we know very well that they are not going anywhere and women will continue to see them so let us work with them.
(F4/H2/M1)

Hmmmmm my sister the nurses are our sisters and we respect what they do especially because they went to college and studied nursing, that is why they have to teach us so that we can do the right thing. Beside jokes I would like to work with them and I am sure we will work well together with respect. (I1/H1/T1)

If we work together with respect we will work well, I respect them a lot because they do a great job and they help where we are stuck and send our clients to them. (I7/H7/T7)

5.5.3.3 Sub-theme 3.3: Influences of current practices on patient care outcomes

It is crucial to understand the perspectives and views of women, midwives, and TBAs on the influence of current practices on patient care outcomes. Collaboration can have a significant impact on maternal and neonatal health, particularly in areas with limited access to professional healthcare services. It was evident in this study during data collection that there are different influences of current practices, as reflected in the responses below:

Sister I believe more in culture and TBAs because of how I was raised in a home with traditional healers. In my family it is important to be protected by the

ancestors when you are pregnant because people can destroy your pregnancy for different reasons. (18/H6/W18)

I have always used the clinics and hospitals because at home we are Christians. I only went to a spiritual healer because I became sick and nearly died with this pregnancy and a friend directed me to her. (8/H3/W8)

With all my pregnancies I attend TBAs because I have to protect myself and the baby until delivery. Yes, I also attend antenatal care at the clinic because we are encouraged to, so if the two parties can collaborate it will be much better. (12/H4/W12)

I prefer using the hospital and clinics because I know the nurses went to college to learn for what they are doing and if there are any complications, they will manage them quickly, but I go to a spiritual healer for a rope and water. (14/H5/W14)

I prefer to deliver at home or at the TBAs place because it is comfortable no shouting and there is more privacy since it is me alone delivering there. The only problem is that I know they do not have the resources like gloves and cleaning solutions used in hospitals and I am not sure what they use. I always pray for my safety and for my baby. (2/H1/W2)

I prefer to attend both midwives and TBAs as long as I will receive skilled care when complications arise and I believe to a combined approach. (15/H5/W15)

I am not sure I like the idea of working with TBAs I am concerned about the qualifications and training of TBAs, as it can impact the safety and quality of care provided. As long as your guideline will have standardised practices and training for TBAs maybe I will be ok. (F2/H1/M4)

While listening to my colleagues, I see collaboration as an opportunity to provide mentorship and guidance to TBAs where their skills and knowledge will be enhanced. (F3/H1/M3)

The fact that our goal is reducing maternal and neonatal mortality I see this collaboration with TBAs as a way to reach women who might otherwise not have access to professional care. (F4/H2/M3)

My daughter only if the nurses can recognise us all will be well, but we are continuing with our work because of the calling by our ancestors. (I4/H4/T4)

Women in this community prefers us because of the traditional and cultural knowledge that we have. If the nurses can be open minded and be willing to learn from us since we are also willing to learn from the, our community will be saved and women will be relieved. (I10/H10/T10)

If I can talk for myself, I am continuing to work with women in this community because they prefer us compared to nurses because they don't give them respect but I still encourage them to go for antenatal care at the clinics as well so that if I miss something the sisters will be able to pick it up. I also wish that with the collaboration we can at least gain access to essential medical resources, like clean birthing kits and medications, which can improve patient care outcomes. (I2/H2/T2)

5.5.3.4 Sub-theme 3.4: Communication

Improving collaboration and communication between midwives, TBAs and women is crucial to ensuring safe and effective care of pregnant women and unborn babies.

Mutale *et al.* (2020) stated that formalising links between traditional healers and their counterparts providing allopathic healthcare require a need for recognition of traditional healers in the healthcare system through good communication, relationship building, and identification of areas for collaboration between the two parties. Communication can encourage bi-directional referral systems as well as improved information sharing systems and the continuous training of healers on new treatment guidelines.

Under this sub-theme, participants spoke strongly about the communication barriers between the midwives and TBAs where one was hoping the other would initiate communication and integration.

Nurse, I don't want to sound rude but the nurses think they are in power, they are superior than us, they are more knowledgeable than us and they don't want to come down to our level and understand what we do so we can work together and learn that what we are doing is not the same. (I1/H1/T1)

I think the problem my sister is the acceptance of different practices we all think we are the best in what we do and we need each other for these women and the unborn child, so lack of acceptance of different practices is a problem and that is why there is no effective communication and collaboration between us and the nurses. (I5/H5/T5)

Nurse I think cultural differences is one of the problems which impedes effective communication between us where there may be misinterpretation or miscommunication due to cultural differences and exchange of information is hindered which will block collaborations. We both need to be open minded when it comes to these issues because we are not doing it for ourselves but for our clients. (I8/H8/T8)

The midwives shared the same perception as the TBAs, and identified gaps which are hindering communication amongst them.

Sister, there are limited opportunities for interaction between us and TBAs since we work in different healthcare systems and settings leading to direct interaction, they are there, we are here and we don't even know how to reach them. (F9/H6/M3)

Lack of communication channels or platform may also hinder the beginning of a good working relationships between us but we need to work on it, how? I don't know but we have to save our babies and women. (F7/H4/M1)

I think the problem is that we don't know who they are, where they are or how to reach them because only the women know them and they don't want to tell us who they are. (F6/H3/M8)

This is a difficult issue mam as you know there is always resistance to change, I hear my colleagues encouraging to change and acceptance of differences but there will be resistance since not everyone will agree to work with TBAs, so there is a lot still to be done. (F7/H4/M4)

The participants also came up with the need for facilitation of communication which might assist with improving communication.

Sister I think one of the things that will help us here is shared decision-making where we can meet with the TBAs and discuss how we assist different women with different problems to improve and promote effective communication between us and them. I am sure this will benefit women and their unborn babies. (F8/H5/M2)

My colleagues here are correct with what they are saying, this may happen with engaging in joint discussions and considering each other's perspectives which will enable the development of comprehensive care plans that incorporate the expertise of both groups. (F8/H5/M3)

Remember that documentation is another form of communication, so including spaces in a maternity care record where we will space and write if a woman is attending TBA or not, if yes we then write type of TBA and their contact details and area can help a lot for us to reach out to them. (F7/H4/M3)

Midwives and TBAs also raised their views on how to enhance communication between them as well as the platforms where they can meet in order to work together and provide comprehensive care throughout pregnancy, delivery and post-partum periods:

I think we need to organise regular meetings, forums, or workshop which will bring us together as midwives and TBAs and even invite them in the perinatal meetings so we can discuss the issues together and see how we can work together. (F6/H3/M4)

We can try and develop clear communication systems between us which may include standardised protocols for when the pregnant woman can be referred from a midwife to a TBA and vice versa so there is a record which will have clear communications. (F4/H2/M4)

Offering the TBAs first aid on delivery will also help a lot and they can also be taught about the dangers that may arise during delivery like post-partum haemorrhage and others. (F4/H2/M4)

Even dangers they should watch for during ANC so they can send women to the clinics when they experience them immediately. Yes, I think educating them will really help my sister that is a very good idea. (F5/H3/M2)

The TBAs had the same ideas as midwives, recognising that they can benefit from receiving education.

My child, I think the Department of Health should provide us with training of simple things that they feel we need to know about women during pregnancy and delivery to reduce the problems they think are caused by us. (I10/H10/T10)

I am talking for myself, if they can give me gloves because I use plastics when delivering these women, I know what to do because I have delivered over 30 women in this community. If they invite us to meetings to discuss the problems which arise when women go to hospital, I will go because we need to work together and not fight. (I3/H3/T3)

The nurses should attend the war rooms and we can share ideas and problems there because those are meetings where most people are there and we discuss community issues affecting us. (I4/H4/T4)

5.5.4 Theme 4: Feasibility of collaboration

Collaboration between midwives and TBAs can be a complex and nuanced issue, and the feasibility largely depends on various factors, including the context in which they are working, and it has both advantages and challenges. Both midwives and TBAs play a crucial role in maternal and newborn healthcare, particularly in rural areas. Collaboration between midwives and TBAs can be feasible, but they require careful planning, training, and integration into the healthcare system. Success largely depends on the local context, available resources, and the willingness of all stakeholders to work together to improve maternal and neonatal health outcomes while respecting local customs and traditions. The feasibility of collaboration between midwives and TBAs depends on many factors, some of which came up during the interviews.

For me my sister, I am sure collaboration can happen we just need to ensure it is feasible by conducting comprehensive training programmes for TBAs, focusing on essential medical skills, infection control, and emergency response

and this training could be conducted in collaboration with local healthcare authorities. (F5/H3/M5)

It is also important that we work closely with the TBAs so we can ensure continuous supervision and oversight of their activities. Regular review and evaluation of TBA practices can help ensure adherence to healthcare standards so we are not in trouble with the law. (F3/H1/M4)

The other thing that we can incorporate in their training is designing communication tools for quick referrals in case of complications, as well as strengthening established relationships with healthcare facilities. (F3/H1/M2)

If we start collaboration, it is important to promote awareness and education programmes to inform women about the benefits of collaborating with both midwives and TBAs, ensuring informed choices and for them to know that we are a team now. (F4/H2/M2)

The other important thing is for the department to issue more resources so we can share with the TBAs, things like aprons, gloves, visors, masks, sanitisers etc. for them to maintain quality care. (F2/H1/M4)

The TBAs also shared their views and emphasised the need for collaboration and how to sustain it:

If this collaboration will happen, it is important that we are recognised and respected for our cultural role in childbirth so that this benefits us all. (I1/H1/T1)

I support collaboration even though I am not sure if the nurses will allow it since they look down at us, but if it happens and for it to not die on our hands nurses should train us and give us resources to work with. We will also share our traditional knowledge so they can send women to us if the notice that they have a traditional problem that needs a healer. (I3/H3/T3)

When we do this collaboration my daughter, it is important that we involve the community leaders and community health workers to build trust and good relationships. (I9/H9/T9)

Collaboration will work but we will be complementing each other's skills where we can focus on our cultural practices, supporting women and family emotionally and the midwives continue with their medical aspect. (I5/H5/T5)

I support collaboration because when the TBAs and midwives work together, we will get help easily whenever there are complications because the TBAs will know who to contact for guidance. (17/H6/W17)

I think collaboration will work since we use both TBAs and the nurses, I can only suggest that both midwives and TBAs should be trained to respect and incorporate local customs and traditions. (6/H2/W6)

I would like to see TBAs and midwives work collaboratively but the community leaders should be involved so that they are aware of what is happening in their area and that will ensure respect and continuous support between the two parties. (10/H3/W10)

I would like to see the midwives and TBAs work together maybe the nurses will stop undermining and shouting at us but, they must teach the TBAs about things like potential risks and management during pregnancy. (3/H1/W3)

5.5.4.1 Sub-theme 4.1: Benefits of collaboration

Collaboration between midwives and TBAs can bring together the clinical expertise of midwives and the cultural understanding of TBAs to provide holistic, culturally sensitive, and cost-effective maternal healthcare in communities with limited access to formal healthcare facilities. Such collaboration can save lives, improve health outcomes, and empower communities to take control of their maternal health. These partnerships can contribute to safer childbirth practices, enhanced community trust, and cost-effective solutions for underserved populations. This collaborative approach also leverages the strengths of both groups to provide safe, culturally sensitive, and accessible care, ultimately improving the well-being of women and their newborns. Below are the views of the participants under this sub-theme.

This collaboration will be appreciated my sister as it can lead to improved clinical outcomes since our involvement as midwives will ensure that that complications are recognised and managed more effectively, ultimately reducing maternal and neonatal morbidity and mortality. (F5/H3/M3)

My sister I see what my colleagues are saying and I agree with them. I see this collaboration can elevate the professionalism of childbirth care in the community. Midwives may see it as an opportunity to ensure that childbirth practices are based on sound medical knowledge and adhere to established healthcare standards. (F1/H1/M3)

True and I think it will help if we start by training and capacitating TBAs, and help them in enhancing their skills and knowledge. This will benefit the entire community by improving the quality of care provided to women in this district. (F3/H1/M3)

Collaboration will benefit us all and it will assist us to monitor and provide supervision and oversight to ensure safe practices by TBAs and they will benefit knowledge from us. This is particularly important in managing complications and ensuring proper hygiene and infection control. (F1/H1/M4)

Sister I think if the midwives agree to work collaboratively with us we will gain more knowledge through training and support from midwives which will lead to improved skills and knowledge and we will have confidence in providing safe care to women in our communities. (I8/H8/T8)

You know if the midwives agree to collaborate with us, we will gain recognition and respect within our communities as we work alongside formally trained healthcare professionals, this will elevate our status even those who do not believe in us they will see that we are real and the trust they already have for us will be maintained. (I9/H9/T9)

With me when collaboration starts I will be expecting access to resources such as clean delivery packs, medications, and transportation support for referrals. (I9/H9/T9)

When the Department of Health agrees that we work with them I will be happy because I will continue performing culturally significant roles in childbirth, while integrating safer healthcare practices, striking a balance between tradition and modernity. (I4/H4/T4)

Women also spoke about preferring collaboration that respects and incorporates local customs and traditions in the birthing process.

I will be happy if they agree to collaborate because we will be safe and our newborn babies will be safe as well. Also, if there are any complications there will be quick response and access to medical care will be faster. (10/H3/W10)

5.5.4.2 Sub-theme: 4.2 Requirements for successful and sustained collaboration

Registered midwives were positive about collaboration, and they had hoped that it would work well.

You know, maybe we can facilitate health education initiatives as it has been said in this interview, I am sure the TBAs will also appreciate us teaching them new things and they can be empowered with some new knowledge and skills related to antenatal, intrapartum, and postnatal care. (F1/H1/M2)

Sister I think the one that you want to do of developing the guidelines will help us a lot because there will be consistency and quality of care and there will be integrated expertise from us and the cultural knowledge from the TBAs. (F2/H1/M2)

If we agree on this, each party should understand their scope of practice, the specific tasks each is responsible for, and how we complement and support each other's work so that we cannot step on each other's toes. (F3/H1/M1)

Someone will have to monitor this though when the guidelines are now developed where there will be feedback mechanisms to gather input from both us and TBAs, for continuous quality improvement and any challenges that may arise are addressed timeously. (F2/H1/M1)

One of the women was worried about collaboration; as much as she appreciated it she said:

Sister I think when they agree to work together, which I doubt, clearly defining the roles and responsibilities will be very important so that we are not caught in the middle of their fights. (I1/H1/T1)

Some TBAs also voiced their views related to this sub-theme and they seemed positive about the whole collaboration issue as long as there is respect and support between them and the midwives.

Communication is very important, so if we communicate well it will be easy for us to check with them whenever we come across problems and be able to ask for the solutions. (I1/H1/T1)

The nurses went to school to learn how to care for these women, we didn't but we are following what we are taught by our elders, so they can provide us with formal training and mentorship programmes which can enabling us to enhance our skills and knowledge in a structured manner. (I5/H5/T5)

Effective collaboration relies on open and respectful communication between us and the midwives. Therefore, both parties should actively listen, share their perspectives, and acknowledge each other's expertise and contributions. (I6/H6/T6)

You know the people who makes policies, they should recognise and acknowledge our role as TBAs, and maybe you can also help with the guideline that you want to develop and provide avenues for this integration into the formal healthcare system. (I3/H3/T3)

This collaboration between us and the nurses should be embedded within the community, with active engagement and support from local stakeholders so it should be introduced to all so they understand that we are now working together and know how it works. (I10/H10/T10)

5.6 CHAPTER SUMMARY

Chapter 5 presented the findings from data analysed in Chapter 4. The chapter began with a brief overview regarding data collection and analysis. Sample realisation, the findings on demographic characteristics of the study participants, the themes and sub-themes derived from data analysis including findings on triangulation were presented. Chapter 6 discusses the findings and triangulation of the study findings assisting the researcher to develop guidelines to facilitate collaboration between midwives and TBAs in KZN, South Africa.

CHAPTER 6: DISCUSSION OF FINDINGS

6.1 INTRODUCTION

Chapter 6 presents the discussion of findings. The first section of this chapter provides a brief overview on the significance of selected study sites and participants in the study, followed by a discussion of the findings on demographic characteristics of the study participants with particular emphasis on how these could influence collaboration between midwives and TBAs. The rest of the chapter focuses on discussion of the main study findings where each of the themes and sub-themes that emerged from data analysis are discussed in detail and supported with relevant literature.

6.2 DEMOGRAPHIC CHARACTERISTICS OF STUDY PARTICIPANTS

Selected demographic characteristics were deemed necessary for better interpretation and understanding of the study findings. Some demographic characteristics assessed such as age, ethnicity and gender were common across all study participant groups while others differed and were specific for each group. The specific demographic characteristics for the midwives included years of experience as a midwife, duration in the current facility as a midwife as well as qualifications. For the TBAs these were their years of experience as TBAs as well as if they had any medical qualification while for the women these were the number of pregnancies, deliveries and child deaths below one year.

6.2.1 Common demographic characteristics across the participant groups

The common demographic characteristics assessed across all participants groups included age, ethnicity and gender. The majority of the participants in all three participant groups were black African females aged between 20 and 47 years. A number of factors were attributed to these findings. Firstly, especially for the women participant group, these findings corresponded with the

population demographics of the area under study which were mostly black African. Furthermore, these findings corresponded with the uThukela demographic profile, which shows that approximately 53% of the population were females, and 96.22% were black Africans between 15 and 35 years old followed by 2.17% Indians, 1.07% Whites and 0.54% Coloureds (Uthukela District Municipality Profile 2020).

The age range of between 20-39 years for the women aligns with the reproductive age which, according to the WHO, is 15-49 years. The age range for the midwives of between 20-65 years aligns with the the average working age for females in South Africa. These findings concur with the Statistics South Africa (2024) report for the year with the largest age group (72.7%) being 35-44 years.

All the midwife participants were females which corresponds with midwifery being a feminised profession where patients and service providers are largely females (WHO 2017; International Confederation of Midwives [ICM] 2021). Similarly for the TBA group, there is research evidence that the majority of TBAs are black females (Garces *et al.* 2019). These findings particularly for the midwives and TBAs were crucial for the researcher as they signified the feasibility of successful collaboration between the two groups who happened to be from the same racial, gender and age group. DiBenigno and Kellogg (2014) explain that while differences in occupational status rules, emotional scripts, meanings, and expertise can make it difficult for members of different occupations to collaborate with one another even when the organisation provides collaboration tools, these differences can be overcome in social structures where cross-cutting demographics facilitate cross-occupational dyads' with use of shared, non-occupational social identities in their interactions with one another. According to DiBenigno and Kellogg (2014), using shared social identities expands the dyadic toolkit of available status rules, meanings, emotional scripts, and expertise, guides their interactions, and allows groups to work successfully with one another across occupational differences.

6.2.2 Specific demographics characteristics for midwives

All midwives interviewed except three had been working at the selected healthcare facilities for more than a year and all except four had between 6 and 20 years experiences as midwives. There is research evidence that duration of exposure to an environment and experience familiarises individuals with a setting and allows the person to determine/decide what could work. Mahapatra (2022) concurs that environment, skills and experience influences decision making. Thus, the midwives in this study had enough exposure to midwifery practice and the environment where they were working to be aware whether there were TBAs in the area or not, the services provided by the TBAs if any, and existing collaboration and the factors that could facilitate improved collaboration between midwives and TBAs. This was evident in the findings from the study where the midwives confirmed that that they were aware that were TBAs in the area and highlighted some of the TBA practices and services provided to women and children which they claimed impacted negatively on midwifery healthcare services and also indicated a number of factors which, according to them, could facilitate improved collaboration between midwives and TBAs.

6.2.3 Specific demographic characteristics of traditional birth attendants

The two specific demographics characteristics of the TBAs included years of experience as a TBA and whether the TBA had any medical qualification. The majority (45%) of TBA participants had experience of 11 to 15 years. Only one (10%) TBA participant was a retired nurse and midwife while the majority (90%) had no medical qualification. This indicates that they mostly rely on traditional knowledge and practices. These findings concur with the WHO, ICM and FIGO (2014) who defined 'TBAs' as traditionally independent, non-formally trained and community-based providers of care during pregnancy, childbirth and the postnatal period. Similarly, Miller and Smith (2017) define TBAs as non-professional people who conduct home births but lack the technical skills and training to manage obstetric complications although some of them may have received training for client referrals. The one woman participant who was a

midwife before becoming a TBA is supported by the WHO (2014) findings that retired community nurses in some communities also render TBA services.

6.2.4 Specific demographic characteristics of women

The demographic characteristics of women included number of deliveries, number of child deaths below 1 year, marital status, highest education level and employment. The majority of the participants (77%) had more than one pregnancy and one woman who happened to be still pregnant had given birth before. Five women participants (19%) had experienced loss of a child either as a miscarriage, a stillborn or early neonatal death. The majority of the women (10%) married which means they had support of their husbands and in-laws especially in utilising TBAs. All had had some form of education either the secondary or tertiary level. The majority (87%) were employed, which is one the characteristics that, according to some authors, helps women to be autonomous regarding healthcare decisions. Khuzaiyah *et al.* (2023) highlighted age, marital status, number of pregnancies, and employment status as some of the factors that influence health-seeking behaviour among women. According to Azuh, Fayomi and Ajayi (2015) people's socio-cultural background plays a vital role in seeking and acceptance of healthcare. Several factors including the socio-cultural dimensions, husband's perception of pregnancy complications, age at marriage, who pays antenatal bills, family type, treatment place decision, are significant regarding healthcare facility utilisation, and influence maternal morbidity (Azuh, Fayomi and Ajayi 2015). In line with this research evidence, the study explored selected demographic characteristics including previous pregnancy outcomes, service providers utilised between midwives and TBAs. Tshuma *et al.* (2014) attest that patient satisfaction or dissatisfaction is an indication of other patient behaviours such as choice of practitioners or programmes, use of services, complaints etc.

6.3 DISCUSSION OF FINDINGS BASED ON THEMES AND SUB-THEMES THAT EMERGED FROM DATA ANALYSIS

The discussion below focuses on the four themes and sub-themes that emerged from data analysis as presented in the previous chapter. The four themes that emerged from data analysis were: 1) Existence of midwifery and TBA services in the area 2) Collaboration between midwifery and TBA services 3) Practices in the absence of collaboration and 4) Feasibility of collaboration. Several sub-themes corresponded to each theme.

6.3.1 Existence of midwifery and traditional birth attendant services in the area

The first theme that emerged from the study was existence of midwifery and TBA services in the area. The three sub-themes that emerged from this theme were: awareness of midwifery and TBA services availability in the area, utilisation of midwifery and/or TBA services by women in the area, and factors influencing the utilisation of midwifery and TBA services. The study findings confirmed that both TBAs and midwifery services were available in the area; all study participants were aware of this, and both services were being utilised by women in the area. Several factors were highlighted as influencing utilisation of midwifery and TBA services in the study area. Confirmation that both services were available in the area was one of the important findings for the study especially because collaboration can only happen if both services exist. However, more importantly, confirmation that the midwifery services were available in the area was one of the reassuring findings from the study because one of the factors highlighted in research is that the community, particularly in underdeveloped countries and disadvantaged settings, opt to utilise TBA services due to shortage of SBAs in different areas.

Behruzi *et al.* (2017) highlight a number of factors that could impede inter-professional collaboration which include, but are not limited to, conflict in scope of practice, myths about each other, pre-judgement, and lack of communication between group members. Furthermore, Behruzi *et al.* (2017) advise that

because having collaborative and multidisciplinary teamwork is a goal of maternity care systems, inter-professional collaborative work between midwives and other maternity care services providers is crucial to improve access and women's choices for maternity care even though collaboration is hard to achieve.

Access and utilisation of healthcare services is crucial for the health of women and their babies so they can be well monitored during pregnancy, delivery and the postnatal period. SBA provided by midwives and/or obstetricians play a crucial role in ensuring care and safe delivery (Yaya *et al.* 2018). Healthcare services ensure that childbirth is safe and attended by skilled professionals, reducing maternal and infant mortality rates. Midwives play a crucial role in stabilising and facilitating the childbirth process because they are trained healthcare professionals that are able to handle various aspects of prenatal, delivery, and postnatal care (Mwoma, Kituku and Gitome 2021; Hajaratu and Sunday 2022).

In addition to the above, it was also crucial to confirm that TBA services were available in this area being a rural setting which aligns with evidence from research that, in rural areas where access to formal healthcare may be limited, TBAs provide a more accessible option for pregnant women as they constitute the greater number of childbirth care providers due to the unavailability or shortage of midwives and doctors (Mhlongo 2016; Fantaye, Gunawardena and Yaya (2019); Adongo, Atanga and Yakong (2020). One of the factors that makes availability of TBAs important for healthcare services is that they are often preferred by women over the services of the midwives Adatara and Amooba (2020) attributes this to the fact that TBAs often have deep roots in the community and are well-integrated into local cultural practices. There is research evidence that if integrated and utilised appropriately TBAs can bridge the gap between traditional beliefs and modern healthcare practices (Ohaja, Murphy-Lawless, Dunlea 2020; MacDonald 2022; Sarmiento 2014; Miller and Smith 2017; Chi and Urdal 2018).

The findings of this study confirm that the majority of women utilise both TBAs and midwifery services at different stages of pregnancy and child birth. While services provided by midwives and obstetricians play a crucial role in ensuring care and safe delivery, TBA services are accessible and sometimes preferred by women, therefore researchers recommend that TBAs and midwifery services must continue to coexist to provide safe maternal and child care in vulnerable and rural communities (Mwoma, Kituku and Gitome 2021; Yaya *et al.* 2018).

The current study found that the majority of women participants were utilising TBAs more than the healthcare facilities especially since they reside in the rural areas. This situation not only prevails in South Africa but in other developing countries such as Bangladesh where 41% of women from the rural areas do not utilise healthcare facilities during pregnancy; they utilise TBAs since they feel comfortable with them instead of the health practitioners (Sarker *et al.* 2016), and in Ethiopia, where more than 70% of births are conducted by unskilled birth attendants (Gurara *et al.* 2020). In order to reduce deliveries by unskilled deliveries, Hajaratu and Sunday (2022) state that enhanced accessibility to SBAs is one of the core strategies of the Safe Motherhood Initiative of the WHO to ensure safety of mother and the neonate.

The findings of the current study that women use TBAs more for ANC at healthcare facilities are concerning, considering that ANC is regarded as a cornerstone for reducing maternal and child deaths (Sibiya, Ngxongo and Bhengu 2018). Women who have utilised healthcare during pregnancy have decreased health problems resulting from prevention strategies, early diagnosis and management of pregnancy related problems, whereas women who do not attend ANC usually come when they have complications and are usually women who utilise TBAs (Taye *et al.* 2022). The findings from the current study confirmed that although the majority of women utilised TBAs for ANC and PNC, the majority of them attended SBAs for delivery. These were relatively positive findings considering that the proportion of births attended by SBAs was one of the indicators of goal 5 of the MDGs (Onambele, *et. al.* 2022). Maternal mortality in Africa: regional trends (2000-2017). Furthermore, Sarmiento (2014), Adataru,

Strumpher and Ricks (2018) and Gurara *et al.* (2020) concur that, irrespective of the reason for home delivery, evidence has shown that home delivery is associated with a significantly higher risk of maternal death.

Participants from all participant groups highlighted several factors that, according to them, were influencing women's choice between utilisation of midwifery and TBA services. Some of these factors included disrespect by the midwives especially when they learn that they utilise TBAs, lack of transport, lack of funds to go to the healthcare facilities, lack of privacy at the healthcare facilities. Some recommended utilising both since midwives have knowledge of what they are doing since they were trained, they are able to attend to emergencies and complications promptly, they are able to refer to other healthcare practitioners whenever needed. Those that preferred TBAs more was because they even come to your home to attend to you, they have privacy since they attend to one person at a time, and they know relevant cultural practices during pregnancy and delivery.

6.3.2 Collaboration between midwives and traditional birth attendant services

This is the second theme that emerged from this study, with three sub-themes: non-existence of collaboration, factors influencing non-existence of collaboration, and team work between midwifery and TBA services. Participants in this study confirmed that there is no collaboration between the midwives and the TBAs. This was an important finding in this study since it justified the development of guidelines to facilitate collaboration between midwives and TBAs. Women participants reported that they would appreciate collaboration between midwives and TBAs in order to be accepted and served by both. The study by Ngotie, Kaura and Mash (2022) concur that TBAs continue to provide their maternity services in the community on their own and there is no formal collaboration between them and the midwives. Although the WHO recommended collaboration between midwives and TBAs to improve women's access to maternal healthcare, many countries including SA have not recognised

TBAs nor integrated them into the healthcare system (WHO 2015; Musie *et al.* 2022).

Participants who were TBAs in this study verbalised that collaboration would address their educational and resource needs such as dealing with complications like bleeding, and also being provided with personal protection equipment like gloves. Several researchers support collaboration between midwives and TBAs as a positive mechanism for identifying high-risk pregnancies, and therefore reducing maternal and neonatal mortality rate (Ngotie, Kaura and Mash 2022; Hulsbergen and van der Kwaak 2020); Musie *et al.* 2022). The TBAs suggested that collaboration must also involve the community since they (TBAs) are preferred by women and the community because their services are more accessible and readily available. Hajaratu and Sunday (2019) stated that TBAs were the most preferred by women since they were from the same community and the healthcare facilities are also far from them with no transport especially at night. Involving the community in the collaboration process will ensure that the community members including women and TBAs are also involved in decision-making related to maternal healthcare which is crucial for addressing the absence of collaboration. Community involvement will also put women at ease and they will know that the healthcare workers understand their cultural needs. Hajaratu and Sunday (2019) also encourage community involvement, especially in reproductive health issues where TBAs serve as birth companions, supporting households in birth preparedness and complication readiness, and encouraging community participation in developing and maintaining the continuum of care.

This study found that the midwives had a negative attitude towards culture with some participants reporting that midwives shout at them if they are utilising TBA services. The TBAs also felt undermined by the midwives but wish to work closely with them so that they can teach each other. They are aware that midwives call them names like "witches" which made them request that the healthcare practitioners be trained and educated about their practices so they can acknowledge what they are doing (Musie *et al.* 2022). There is a need for

healthcare workers to be taught about culture and TBA practice to ensure that they are aware of the cultural illnesses that are common in maternity (Musie *et al.* 2022). Midwives acknowledging the importance of cultural awareness will increase their cultural sensitivity, therefore ensuring women are more comfortable with their care. Women appreciate care that preserves their cultural identity while being clinically safe (Ngotie, Kaura and Mash 2022).

It was evident that TBAs also need training in early identification and prompt referral of at-risk pregnancies as well as first aid management while waiting for an ambulance. They were aware that they do not know how to manage complications, hence requested training. Several researchers support the fact that training will also assist TBAs to receive certificates of competency; at the moment in South Africa there is no training or certification for TBAs (Musie *et al.* 2022, Kassie *et al.* 2022; Udenigwe *et al.* 2021).

To facilitate collaboration there needs to be a buy-in from the DoH and district services. Unfortunately, the recommendation from WHO (2015) regarding the integration of TBAs into the healthcare system has not been implemented in South Africa and therefore there is a lack of policies and guidelines to support collaboration. Mutale *et al.* (2020) confirm that the lack of formal policy direction and guidelines is a huge problem that has made it difficult for the healthcare facilities to integrate with TBAs since they provide parallel services to the same patients and the same communities. The other reason mentioned by a few of the midwife participants, is a concern that if they are working with TBAs and TBAs make errors, they (midwives) will be the ones in trouble since they are guided by a regulatory body. Midwives are regulated by the SANC which prescribes their directives and scope of practice and they receive policies and guidelines from the DoH so they are accountable for their actions. Also, since they are regulated, they cannot contravene these two bodies, therefore cannot accept collaboration without proper guidelines. The nursing profession is guided by standards of practice and codes of ethics while the TBAs have no regulatory body to hold them accountable during their practice. This makes the midwives accountable for their acts and omissions and subject to oversight and discipline

by their regulatory bodies. The midwives suggested that the TBAs must also register with a body which will make it easier for them to assess who they are collaborating with. The development of guidelines will also put the midwives at ease since there will be guidance.

One of the factors influencing the non-existence of collaboration raised by participants was that both midwives and TBAs were not aware that they can collaborate and they never thought of contacting each other when there were problems. Most women in this study encouraged collaboration because they really trust and want to continue utilising both TBAs and healthcare professionals; they want to use midwives because they are trained for what they are doing, and they want to use TBAs because they can provide them with companionship and they practice the cultural rituals of the community which is not done in the healthcare facilities (Gurara *et al.* 2020). TBAs support women holistically which is taking care of self, body, spiritually, as well as the and this holistic approach includes the values, beliefs, norms, and spiritual beings that satisfies women and the community (Mutale *et al.* 2020).

Lack of knowledge and understanding may also contribute to the non-existence of collaboration because if the midwives and TBAs have different levels of understanding either of culture or health, this may impact their ability to understand and appreciate each other's contributions. To address these barriers to collaboration, healthcare organisations should provide training and support to midwives, prioritise collaboration through ongoing discussions, promote equal partnerships and mutual respect, and actively engage with TBAs through invitations to meetings and involvement in decision-making processes.

Teamwork between midwifery and TBA services is the other sub-theme that emerged during data analysis where midwives verbalised that if collaboration is allowed it will work well if there is teamwork amongst them so that there can be peace. TBAs also appreciated the suggestion of collaboration since they have the same goal as the midwives of ensuring that mother and child are safe from pregnancy to delivery; teamwork will assist them both to attain their goal. Musie

et al. (2022) recommend that teams need to be formed between community health workers, midwives, physicians, traditional health practitioners, and TBAs for the provision of maternal healthcare services at primary healthcare level which emphasises the importance of teamwork.

As much as some midwives support working as a team with the TBAs, some still had uncertainty about the feasibility of collaboration since they were not sure how the collaboration would work. Mutale *et al.* (2020) confirm that some healthcare workers are suspicious of traditional practices and are unwilling to engage meaningfully because of different reasons like protecting themselves. Ngunyulu, Mulaudzi and Peu (2020) encourage teamwork to ensure continuity and quality of maternal care, thereby reducing preventable factors contributing to maternal mortality and morbidity as discussed. Encouraging teamwork between midwives and TBAs within the framework of structural functionalism theory can yield numerous benefits for maternal and child health outcomes. Musie *et al.* (2022) found that TBAs are very keen to work as a team with midwives so that the midwives can refer patients who appear to have illnesses that require their expertise and they will also refer those who need medical assistance and encourage women to attend ANC throughout their pregnancy. The TBAs saw this as a win-win situation for all parties – midwives, TBAs and women who need both types of assistance and attention. In maternal and child healthcare, midwives and TBAs can be recognised for their complementary roles since the midwives possess medical expertise and formal training and TBAs possess deep cultural knowledge and they also have a sound community relationship. Thus, encouraging teamwork between the two groups involves acknowledging and leveraging their strengths.

This study found that there was no collaboration in the district in which the study took place since there was no channels of communication between midwives and TBAs. Clear communication channels between midwives and TBAs can facilitate effective collaboration and teamwork for smooth collaboration. This can be done through community engagements which can be organised by the community leaders, workshops, and training sessions where midwives and

TBAs can share knowledge, experiences, and concerns so as to foster mutual understanding which will strengthen teamwork. Mutale *et al.* (2020) in their study on integrating traditional healers into the healthcare system found that despite the collaborative efforts have been made, mistrust and reported lack of respect for traditional healer's practices by healthcare practitioners has made formal collaboration difficult. With that being said, formalising links between traditional healers and their counterparts providing allopathic health services requires recognition of healers in the healthcare system through good communication, relationship building, and identification of areas for collaboration between the two parties.

Proper communication will assist with development of mutual respect and trust between the two parties because trust and respect are vital for the smooth functioning of social systems. Ngotie, Kaura and Mash (2024) suggest the importance of trust and understanding between midwives and TBAs should be based on women's needs and respect between the midwives and TBAs.

6.3.3 Practices in the absence of collaboration

The third theme that emerged from this study during data analysis is practices in the absence of collaboration, with four sub-themes which emerged under this theme, namely: acknowledgement of each other's existence, attitudes and respect towards each other, influences of current practices to patient care outcomes and communications. The findings of this study revealed that there was role fragmentation between the midwives and TBAs since there was no collaboration of any kind which led to women being stuck in the middle and not knowing what to do. Some women hid from midwives the fact that they were utilising TBAs with the current pregnancies since midwives generally discouraged them from utilising TBAs, but they use them both anyway because of different problems they are facing as well as their cultural beliefs. Some midwives complained that women utilise TBAs then come to the healthcare facilities when they have complications which TBAs cannot handle, leading to increased maternal and neonatal mortality rate. This problem needs to be

addressed with women and communities for prevention purposes (Gurara *et al.* 2020; Taye *et al.* 2022). It was evident that the midwives from two of the selected healthcare facilities were not acknowledging the existence of TBAs and their roles since they voiced that they do not want women to utilise TBAs because of the complications thereafter. TBAs on the other hand acknowledge midwives and their roles since they want to learn from them even though midwives appear to have less interest in learning from them (Mutale *et al.* 2020).

Some midwives verbalised acknowledgement of TBA existence and their roles even though they did not believe in cultural remedies and practices but worried that there was no communication between the two groups which led them to work in silos. They also acknowledged that this is because no one thought of starting communicating about the women they were caring for. Acknowledgement will therefore be facilitated through communication between midwives and TBAs where clear and respectful communication channels contribute to recognising each other's existence, fostering understanding, and potentially laying the foundation for collaboration. When there is acknowledgement, midwives and TBAs will be able to find common objectives and work towards shared outcomes.

During interviews, the midwife participants mentioned the importance of having policies supporting collaboration for them to be able to start communicating and collaborating with TBAs. Therefore, it is crucial that the DoH develops policies and guidelines which support collaboration where both parties can learn to understand and appreciate the perspectives and strengths of each group. These policies will assist in guiding both parties on collaboration, where to start and how to move forward (South Africa. Department of Health 2012). When the facilities have policies and both TBAs and midwives are acknowledging each other regarding the different work they do with women, it will be easy for the women and communities to also acknowledge their roles.

Acknowledgement was the other aspect that was evidently not present and requires inclusive practices and the policies so that both services are

recognised. The midwives did not acknowledge TBAs presence in the community and their role with women, but TBAs acknowledged the midwives and their role even though there was no formal communication or collaboration. TBAs' views were that there should be policies enabling training where midwives will train the TBAs on the most important aspects, especially obstetrical emergencies and referral, as well as TBAs teaching the midwives to identify any problem requiring traditional assistance. It is acknowledged that TBAs do attend to women from ANC to delivery and post-delivery, especially those with normal pregnancies or low risk conditions (Musie and Mulaudzi 2024). There could also be referral programmes where midwives and TBAs are exposed to each other's skills and expertise, fostering mutual acknowledgement which will contribute to acknowledging each other's strengths which can then inform collaborative strategies. Acknowledgement can also be facilitated through community engagement programmes that will actively acknowledge the presence and contributions of both midwives and TBAs. Involving communities in decision-making processes and recognising the diversity of maternal healthcare providers is essential for social integration.

It was evident that there was no respect between midwives and TBAs and the midwives mainly had a negative attitude towards TBAs. Women stated that midwives shout at them when they learn that they utilise TBAs since they do not believe in their practices, and TBAs also have a negative attitude because they know that midwives do not respect their work. This may lead to hidden conflicts and disrespect for each other that might affect collaborative efforts between them. This mistrust and disrespect stem from lack of communication and lack of recognition of each other's professional competence. The responses by the midwives confirmed that they are not happy with women utilising TBAs because most of them do not believe in cultural or traditional illnesses and treatment. The main worry is that women come to the clinic or hospital when they already have complications when they started with the TBAs, but the TBAs could not manage. However, TBAs are aware of mistrust by the midwives and are willing to learn from them especially on how to prevent or manage complications.

Community approaches to promote mutual respect and collaboration can enhance cultural safety as well as positive birthing experiences and outcomes (Ngotie, Kaura and Mash 2022). The participants provided reasons why they use TBAs, and their reasons ranged from the notion that modern medicine is not affordable or accessible, to the attitude of health providers. Some participants provided examples of maternal morbidities that are best treated with traditional medicine such as placenta-related problems which they believed should be treated culturally and be buried at home. The belief that modern medicine cannot cure all ailments is a major driver of the common maternal health-seeking behaviour of utilising both hospital and TBAs for maternal care in the study communities (Ntoimo *et al.* 2022). One of the main reasons why TBA services are utilised is their friendly attitude to clients. The TBAs are willing to deliver women in their homes and are available at any time (Ntoimo *et al.* 2022). Collaboration between midwives and TBAs can significantly improve maternal and newborn health outcomes, particularly in regions with limited access to professional healthcare services. However, fostering effective collaboration requires addressing attitudes and respect towards each other.

Midwives and TBAs often have distinct roles, with midwives typically receiving formal training and TBAs relying on traditional knowledge and experience. It is crucial for both parties to understand and respect the expertise and limitations of each other's roles. This understanding can help mitigate conflicts and foster a sense of mutual respect. The current study showed that the midwives did not respect the TBAs and their roles but the TBAs did respect the roles of the midwives, and the women would like to see both groups work together. If both groups respect each other's roles it will be easy for both to educate each other. The systematic review study by Miller and Smith (2017) reported that TBAs and other healthcare workers developed mutually respectful working relationships where TBAs were given access to call the healthcare facilities to arrange transport and report when they were sending a client that needed immediate attention.

TBAs possess valuable traditional knowledge and skills that have been passed down through generations. Midwives should recognise and respect the importance of this knowledge, incorporating it into collaborative practices where appropriate. This acknowledgement can enhance trust and collaboration between the two groups. Providing training and capacity-building opportunities for both midwives and TBAs can improve their skills and knowledge, leading to more effective collaboration. By investing in continuing education programmes, both groups can remain updated on best practices and evidence-based approaches, contributing to better maternal and newborn health outcomes.

When there is respect between the midwives and TBAs, it will be easy for them to communicate about their clients. Establishing channels for open communication and mutual learning is essential for building trust and respect between midwives and TBAs. Regular meetings, workshops, and peer-to-peer learning sessions can create opportunities for sharing experiences, discussing challenges, and finding common ground. This collaborative learning environment fosters a sense of equality and respect among participants. When they have found common ground, collaboration between midwives and TBAs should be culturally sensitive and community driven. Engaging local communities in the collaborative process promotes acceptance and support for the partnership. It is essential to involve community leaders, elders, and other stakeholders in discussions about maternal and newborn health, ensuring that interventions are culturally appropriate and respectful of local customs and traditions. Recognising the contributions of midwives and TBAs to maternal and newborn healthcare is crucial for fostering respect and appreciation within the healthcare system and the wider community. Providing incentives, such as formal recognition, financial support, or access to resources, can motivate both groups to actively participate in collaborative efforts. Therefore, attitudes and respect towards each other play a pivotal role in developing effective collaboration between midwives and TBAs. By understanding each other's roles, acknowledging traditional knowledge, investing in training and capacity building, fostering open communication, engaging communities, and providing recognition and support, healthcare systems can create an environment

conducive to collaborative practice, ultimately improving maternal and newborn health outcomes.

The current study findings revealed that TBAs often serve communities where healthcare facilities are scarce or not easily accessible, but by collaborating with midwives TBAs can facilitate better access to skilled care during childbirth, which can reduce maternal and neonatal mortality rates. Adatara, Strumpher and Ricks (2018) found that TBAs are involved with their clients to the extent of finding transport for them to reach the healthcare facilities and they accompany them. In the district under research, healthcare facilities are sufficient but women and their families still rely on cultural management in different illnesses and the other problem that was raised was transport which makes it difficult especially at night and holidays to access healthcare facilities.

Midwives can bring formal medical training and evidence-based practices to their collaboration with TBAs since they do not trust what the TBAs are doing, and in this way equip them with the appropriate knowledge and skills, since it was evident that women are willing to continue utilising both for different reasons. Therefore, sharing of knowledge and skills between midwives and TBAs can improve the quality of care provided during childbirth, and reduce the risk of complications, thereby improving trust between them and women as well as improving patient outcomes. Midwives are trained to identify high-risk pregnancies and childbirth complications then provide appropriate interventions or referrals. Collaborating with TBAs can enhance the early detection of complications and ensure timely referrals to healthcare facilities, thus reducing adverse outcomes and the TBAs will be free to consult the midwives whenever they suspect any problems while doing their work.

When collaboration has been accepted by all and has started, implementation of monitoring and evaluation mechanisms will be essential to assess the effectiveness of the collaboration in improving patient care outcomes. This involves tracking indicators such as maternal mortality rates, neonatal mortality rates, incidence of complications during childbirth, and patient satisfaction

levels. Feedback from the communities will also assist since they will be involved from the beginning of the collaboration. Of course, all this will require supportive policy frameworks and regulatory guidelines to ensure standardisation of practices, protection of patient rights, and accountability. Clear policies can help streamline the collaboration process and ensure adherence to quality standards. By examining these influences within the context of the collaboration between midwives and TBAs, researchers can better understand how current practices impact patient care outcomes and identify areas for improvement to enhance the quality and effectiveness of maternal healthcare services.

The current study revealed that there was no communication between midwives and TBAs since they had never tried to contact each other to discuss the women they were caring for. All participants reported lack of communication between the midwives and the TBAs concerning the pregnant women, and some midwives even mentioned that they do not know where to find the TBAs in the community so it is not easy to communicate with them regarding working together. On the other hand, the TBAs reported that they could not communicate with the midwives since they usually look down on them and they do not trust what TBAs do. Effective communication is crucial for collaboration; without collaboration there will be communication challenges between midwives and TBAs leading to misunderstanding and inadequate sharing of important information regarding women. Findings in a study by Okala *et al.* (2020), on factors associated with the utilisation of TBAs among pregnant women in Nigerian rural communities, concluded that trainings and collaboration and regular involvement of TBAs in the clinic duties increased the number of referrals and improved communication between midwives and TBAs. Effective continuous feedback mechanisms are crucial with effective communication for adapting strategies, addressing challenges, and improving the overall quality of maternal healthcare services. Cross-training initiatives may be developed and encouraged which will involve communication about sharing skills and knowledge between midwives and TBAs. The two groups need to keep checking on how well communication occurs in cross-training programmes, ensuring that

they are both exposed to each other's expertise by ensuring open communication which is vital for fostering a collaborative learning environment. Midwives verbalised the need for proper communication especially in case of emergencies, in order to save mother and child. Therefore, there should be communication channels within healthcare institutions involving midwives and TBAs. Effective communication within and between institutions is vital for the success of collaborative efforts and requires transparent and culturally sensitive communication to align with societal expectations and values. In a study by Jara *et al.* (2020) TBAs were included in communicating with the ambulance services in case of emergency where they were given radio services to communicate for prompt referral of clients. Education is a means of social integration so it is important that it is utilised in educational and training programmes for midwives and TBAs where there will be clear communication about collaborative practices and the benefits of working together which can contribute to a shared understanding and mutual respect. Thus, examining communication between midwives and TBAs involves analysing role clarity, institutional communication channels, community engagement, education and training communication, feedback mechanisms, cross-training programmes, cultural sensitivity, collaborative decision-making processes, conflict resolution communication, and the role of technology. Effective communication in these areas is fundamental for building and sustaining a collaborative environment that contributes to the stability and success of maternal healthcare services.

6.3.4 Feasibility of collaboration

Feasibility of collaboration was the fourth theme that emerged from this study with two sub-themes under it, namely: benefits of collaboration and requirements for successful and sustained collaboration. The feasibility of collaboration between midwives and TBAs involves assessing the practicality, viability, and likelihood of successful cooperation between these two groups within the broader context of maternal healthcare. The study findings revealed that all groups of participants verbalised that collaboration between midwives and TBAs is crucial and has to be encouraged. However, there should be well

defined roles for midwives and TBAs; their roles should complement each other for the benefit of women who attend healthcare clinics and traditional services. The findings further indicated that smooth integration of these responsibilities would ensure efficient and coordinated maternal healthcare. The midwives further stated that support would be needed in the whole process of collaboration through the provision of the necessary support, resources such as surgical supplies, policies and standard operating procedures for midwives and TBAs to work together effectively since women still prefer to utilise TBAs. These findings are similar to those by Adatara, Strumpher and Ricks (2018) in their study who found that labouring women still prefer TBA services because they are available and easily accessible in the communities. Musie *et al.* (2024) concurred by revealing that most communities in rural areas prefer to consult with traditional healers before seeking Western medical care. These findings are in line with the current findings in that participants (women and TBAs) verbalised that they prefer to consult with TBAs and only attend clinics when experiencing complications. Therefore, for collaboration to be feasible, training and skilling/equipping of TBAs would be ideal for sustainable relationships between TBAs and midwives. Such training could include multicultural sensitivity, values and beliefs. Similar recommendations were made by Kassie (2022), with participants in their study describing the possible benefits of collaboration between TBAs and midwives as follows: enhanced access to safe care either from TBAs or midwives during pregnancy, childbirth, and the post-partum period, early detection of complications by TBAs and prompt referral to clinics, thus reducing maternal and neonatal morbidity and mortality rates. Requirements for successful and sustained collaboration delves into the factors necessary to establish and maintain effective partnerships between the two groups in maternal and newborn healthcare delivery. Effective collaboration relies on clear and open lines of communication which calls for departments to develop protocols for communication between midwives and TBAs, such as regular meetings or designated contact persons, which can facilitate the exchange of information and coordination of care (Helmond *et al.* 2015). Collaboration between midwives and TBAs can yield numerous benefits, especially in regions where both play critical roles in maternal and newborn care.

Collaboration can enhance access to skilled care during pregnancy, childbirth, and the post-partum period and therefore improve maternal and neonatal health outcomes. By leveraging the expertise of midwives and the familiarity and trust that TBAs often have within their communities, guidelines can be developed to ensure that women receive the best possible care, leading to reduced maternal and neonatal morbidity and mortality rates. The study findings revealed that women are happy with collaboration since it will benefit them in many ways such as them attending healthcare facilities freely and being able to inform the midwives about their cultural problems in pregnancy and that they are also utilising TBAs. By so doing there will be a reduction in maternal mortality and morbidity which is the ultimate goal of collaboration. By combining medical expertise with community-based support, collaborative efforts have the potential to enhance overall maternal health. Both midwives and TBAs verbalised willingness to collaborate since this will benefit women they are servicing where collaborative efforts between the two groups can also lead to an increase in antenatal and postnatal care by working together. Midwives and TBAs can encourage more women to seek care during pregnancy and in the post-partum period and TBAs can even accompany women to the healthcare centre freely. This can result in early detection of complications and improved health outcomes for both mothers and infants thus reducing or eliminating maternal and neonatal morbidity and mortality rates. Enhanced collaborative efforts between midwives and TBAs can lead to improved access to maternal healthcare services. By working together, these professionals can ensure that pregnant women have access to a broader range of services, whether in healthcare facilities or through community-based approaches, contributing to enhanced overall accessibility. Evidence has shown the effectiveness of interventions such as training and support of TBAs in improving maternal and newborn health outcomes while reducing perinatal, neonatal, and maternal mortality (Kassie *et al.* 2022).

Collaboration provides opportunities for knowledge exchange and capacity building between midwives and TBAs. Midwives can share evidence-based practices, clinical skills, and medical knowledge with TBAs, while TBAs can

contribute their knowledge of traditional practices, local customs, and community dynamics. This mutual learning fosters professional development and can improve the quality of care provided by both groups. Guidelines developed through collaboration can also establish clear referral pathways between TBAs and midwives where TBAs can be trained to recognise complications early and refer women to midwives or healthcare facilities for appropriate management from ANC up to post-delivery. This will help with timely access to emergency obstetric care, reducing delays that can lead to adverse outcomes.

Collaboration will allow midwives and TBAs to pool their resources, skills, and expertise which can result in more efficient utilisation of healthcare resources, reducing redundancy and ensuring that available resources are maximised for the benefit of pregnant women and their communities. Collaboration can optimise resource utilisation by leveraging the strengths of both midwives and TBAs. Midwives, with their formal training, can focus on providing skilled care for complicated deliveries and managing obstetric emergencies, while TBAs can provide essential care and support for normal deliveries in community settings. This division of tasks ensures that resources are used efficiently and effectively, particularly in resource-constrained settings. Collaborative efforts can enhance the effectiveness and resilience of healthcare systems by promoting teamwork and integration. Collaborating with TBAs allows midwives to gain cultural competence in maternal care which can result in more respectful and patient-centred care that aligns with the cultural practices and preferences of the communities they serve. It will also foster community engagement, aligning with the principles of structural functionalism that emphasise community involvement where everyone will have an idea of what is happening in the district. Therefore, by working together, midwives and TBAs can build trust within communities. This trust is essential for encouraging pregnant women to seek healthcare services and participate in maternal health programmes. Since community collaboration fosters trust and mutual respect between midwives, TBAs, and the communities they serve, all stakeholders will feel a sense of ownership increasing their likelihood of adoption and adherence. This participatory

approach strengthens community engagement in maternal health initiatives and promotes sustainable change. TBAs often possess deep cultural knowledge and practices that are valued within their communities. Collaborative guidelines can incorporate these cultural aspects, ensuring that interventions are culturally sensitive and acceptable to the community. This can lead to increased utilisation of maternal health services and improved health-seeking behaviours among pregnant women.

By demonstrating the effectiveness of collaborative models of care, stakeholders can advocate for supportive policies, regulations, and investments that strengthen the integration of TBAs into the formal healthcare system while ensuring that midwives receive the necessary support and resources to provide quality care. In summary, exploring the benefits of collaboration between midwives and TBAs within the framework of structural functionalism theory involves assessing improved maternal healthcare access, reductions in maternal mortality and morbidity, efficient resource utilisation, role complementarity, cultural competence, community engagement, trust-building, health education, adaptability to local practices, increased antenatal and postnatal care, and the overall strengthening of healthcare systems. Understanding these benefits is crucial for designing effective collaborative strategies that align with the principles of social order and integration. Collaboration between midwives and TBAs in developing guideline will promote synergistic partnerships that enhance maternal and neonatal health outcomes, respect cultural contexts, build capacity, strengthen community engagement, optimise resource allocation, and advocate for supportive policies.

The responses by midwives in this study indicate that effective collaboration relies on clear and open lines of communication which calls for departments to develop protocols for communication between midwives and TBAs, such as regular meetings or designated contact persons, can facilitate the exchange of information and coordination of care. With proper communication there will be mutual respect and recognition of expertise for both since both midwives and TBAs bring unique skills and knowledge to maternal and newborn healthcare

therefore, recognising and respecting each other's expertise fosters a collaborative environment where contributions from both sides are valued. These statements are supported by several authors, for example Adatara, Strumpher and Ricks (2018), Ohaja, Murphy-Lawless, and Dunlea (2020), and Jara *et al.* (2020).

6.4 SUMMARY

Chapter 6 presented discussed the findings in the context of the relevant literature. The discussion assisted the research in identifying critical areas that need to be prioritised when developing guidelines. The next chapter focuses on the steps that were followed to develop the guidelines.

CHAPTER 7: DEVELOPMENT OF GUIDELINES TO FACILITATE COLLABORATION BETWEEN MIDWIVES AND TRADITIONAL BIRTH ATTENDANTS IN KWAZULU-NATAL, SOUTH AFRICA

7.1 INTRODUCTION

Chapter 7 presents the process that was followed to develop the guidelines to facilitate collaboration between midwives and TBAs in KZN, South Africa, and the process of reviewing the guidelines for relevance and acceptance. The guidelines were informed by the findings from analysis and interpretation of data collected in phases 1-3 as discussed in Chapters 5 and 6 which focused on achieving the first five objectives of the study which were; 1) to explore if any strategies exist toward collaboration of TBAs and midwifery care in KZN, 2) describe perceptions of TBAs regarding collaboration with midwives, 3) describe the perceptions of midwives towards collaboration with TBAs, 4) explore the views of women regarding the collaboration of midwives and TBAs and 5) critically analyse the factors that influence collaboration between midwives and TBAs. Development of the guidelines to facilitate collaboration between midwives and TBAs in KZN, South Africa was the sixth and final objective of this study. The guidelines were subsequently reviewed and modified based on the suggestions by experts.

7.2 OVERVIEW AND GENERAL USE OF GUIDELINES

Guidelines are defined as a set of recommendations, principles, or rules established to provide direction or advice in a particular context and serve as a framework to help individuals or organisations make decisions, set standards, or achieve specific goals (Dang *et al.* 2021; Toronto and Remington 2020; Shneiderman 2020). Guidelines can vary widely in scope, ranging from broad principles applicable across various disciplines to specific instructions tailored for a particular task or industry (Page *et al.* 2021; Collins *et al.* 2021; Halken *et*

al. 2021; Wharton *et al.* 2020). Therefore, guidelines play a vital role in guiding decision-making, promoting consistency, and improving outcomes in diverse fields by providing evidence-based recommendations and standards. They help to ensure that actions are informed by the best available knowledge and practices (Collins *et al.* 2021; Wharton *et al.* 2020). The functional nature of guidelines implies that they serve a practical purpose, providing recommendations or instructions to guide decision-making, practice, or behaviour in a specific context. They are designed to address real-world needs and challenges faced by stakeholders, such as healthcare providers, policymakers, educators, or industry professionals (Halcken *et al.* 2021). A functional guideline is one that effectively fulfils its intended purpose which should be relevant, actionable, and applicable to the target audience.

The functionality of a guideline depends on factors such as the clarity of recommendations, the quality of evidence supporting them, and the feasibility of implementation. This emphasises their role as practical tools for guiding decision-making and their need for regular review and updating to remain relevant and effective over time (Halcken *et al.* 2021). Thus, the intention of the researcher in the current study was to develop guidelines which would have specific instructions (strategies to facilitate collaboration) tailored for a particular task or industry which in this case was collaboration of midwives and TBAs (Dang *et al.* 2021).

Pereira, *et al.* (2022) defines clinical practice guidelines as systematically developed statements which contain recommendations that are based on evidence from a rigorous systematic review and synthesis of the published medical literature to assist practitioner and patient decisions about appropriate healthcare for specific clinical circumstances. While the guidelines identify and describe generally recommended courses of intervention, they are not fixed protocols that must be followed, but are intended for healthcare professionals and providers to consider (National Center for Complementary and Integrative Health n.d.). Vermeulen *et al.* (2019) concur that clinical guidelines are systematically developed statements intended to assist care providers and

patient decisions about appropriate healthcare for specific clinical circumstances, and further state that for the guidelines to be helpful in everyday clinical medical decision-making about appropriate and effective care, guidelines should be presented in formats that are easy to interpret. The researcher in the current study followed specific steps that have been verified and approved in developing the guidelines to ensure that the guidelines developed meet these specific criteria as described by the authors stated above. The process/steps followed were those described by Vermeulen *et al.* (2019).

7.3 THE PROCESS OF DEVELOPING GUIDELINES

According to Vermeulen *et al.* (2019), guideline development, implementation, and evaluation is not a linear process, but a cycle of interdependent activities involving 12 steps which include topic selection, forming guideline development group, scoping, key questions, evidence search, evidence synthesis, recommendations, writing draft, stakeholder review, approval, publication and updating/revising. The key steps are topic selection, synthesis of evidence, formulation of recommendations, consultation and review, dissemination and implementation, evaluation and updating (Vermeulen *et al.* 2019). Meyer *et al.* (2023) and Movsisyan, Rehfuess and Norris (2020) attest that the process of guideline development should follow specific rules to avoid disagreement, misunderstanding, misleading recommendations, and confusion. The 12 steps as described by Vermeulen *et al.* (2019) were adhered to in developing the guidelines in this study.

7.3.1 Topic selection

Vermeulen *et al.* (2019) propose topic selection as the first step in the process of developing guidelines which is important to ensure that guidelines are relevant, address priority issues, and are transparent. Vermeulen *et al.* (2019) recommend that coordinators of special interest groups in the field should be invited to propose topics for the guidelines. However, for the current study the topics for the guidelines were determined by the researcher and these

were informed by the findings from the study as discussed in Chapter 6. Thus, the topic selection was informed by the views of persons considered to be the special interest groups in field, the midwives, mothers and the TBAs who were participants in the study. Vermeulen *et al.* (2019) advise that the proposed topics should be reviewed for relevance to the field or specific purpose of the guidelines. The topics were mostly informed by the themes and sub-themes that emerged from data analysis. The use of literature to discuss and support the findings from the study together with the theoretical framework that guided the study assisted in verifying the selected topics to be included in the guidelines. The selected topics were also approved by the study supervisors who guided the researcher during this research project. Furthermore, the topics included in the guidelines were also approved by the experts who were invited to review the developed guidelines for relevance, completeness and acceptance which was done through a Delphi Technique as part of the study. The five factors that influence effective collaboration as described by Rollins (2015) assisted the researcher in structuring the topics for the various guidelines that were developed. The five topics were: recognising and communicating common vulnerabilities, involving everyone who has a personal stake or interest in the outcome of a situation, maintaining an environment of trust, using good problem-solving tools and replacing beliefs with knowledge.

1. Recognising and communicating common vulnerabilities

According to Rollins (2015), recognising and communicating common vulnerabilities enhances a team's ability to form trusting relationships and supports deliberation and problem solving. It was evident from the study findings that because of lack of collaboration the midwives and TBAs were not aware of each other's vulnerabilities, including those that were common between the two groups which could have been a compounding factor to having no collaboration. Thus, the first and foremost topic was to facilitate communication, openness and transparency.

2. Involving everyone who has a personal stake or interest in the outcome of a situation

Rollins (2015) states that group diversity is essential for effective collaboration so everyone associated with the project should be included to enhance collaborative decision-making. The current study findings show that the two groups (midwives and TBAs) were diverse but the problem was that each was working independently with no chance to consolidate their efforts in the management of women and their babies. These findings led to the third topic which was shared vision and sense of responsibility.

3. Maintaining an environment of trust

Rollins (2015) defines trust as the knowledge that each member of the group is dependable and will deliver on expectations, and is vital currency in a collaborative group. Rollins (2015) explains that adaptive planning models rely heavily on negotiation and thus the group must share trust among its members in order to achieve consensus and joint decision-making. Furthermore, Rollins (2015) advises that people in a collaboration need to feel that everyone involved is committed to solving the problem otherwise the group may feel that the uncommitted persons not working hard are a reason for failures and or challenges in a programme. The findings from the study revealed that the two groups had no common environment where they could share successes and challenges experienced during their practices. What was evident from the study was that one group (the midwives) blamed the other group (the TBAs) for problems and challenges experienced in maternity services provisions some of which led to negative pregnancy outcomes. This could be one of the factors that prevented collaboration between these two groups. Thus, the fourth topic became facilitating a sharing and a caring environment for collaboration.

4. Using good problem-solving tools

Rollins (2015) states that problem-solving efforts can be stalled without a set of common tools. The author emphasises that creating a common perspective of the problem, which he describes as the "how" of a problem, is the foremost component of problem solving. The main challenge when working on collaboration between diverse groups is defining the set of tools to use for problem solving and the rules that need to be used to correct power imbalances and resolve conflicting values among members. Therefore, collaboration initiatives should identify factors in the complex adaptive environment that surround the problem and create a common perspective to interpret and classify the problem. Because the two groups work independently and in isolation, they were not aware of each other's tools of practice and also could not share good problem-solving tools. Thus, the fifth topic became promotion of teamwork and cooperation between midwives and TBAs.

5. Replacing beliefs with knowledge

Rollins (2015) describes belief as a powerful common enemy of successful collaboration; belief is a person's acceptance or faith that something is the truth without the benefit of evidence, unlike knowledge which requires direct observation, experience or evidence that directly supports a given position. The way to overcome the challenges caused by opposing views is to replace beliefs with facts, by providing a body of evidence that confirms the truth. Another finding was that each group had some beliefs about each other, which impacted on the care of women and their babies. The midwives populations had negative beliefs about the TBAs and thus attributed most untoward pregnancy outcomes to mismanagement by the TBA. The TBAs on the other hand believed that the midwives did not approve of their practices and thus TBAs were unable to declare that they were attending to the women and or babies since there was no communication. The one topic that emanated from this was the need to develop a guideline to facilitate a paradigm shift and values clarification between midwives and TBAs. Table 7.1 presents the alignment of the five proposed guideline topics in line with

the five factors that influence effective collaboration as described by Rollins (2015).

7.3.2 Forming the guideline development group

Convening an effective guideline development group is a crucial stage in producing guidelines and participation by representatives of all key groups and disciplines affected by a guideline topic should be ensured (Vermeulen *et al.* 2019). This needs to be a multidisciplinary group of experts including clinicians, researchers, methodologists, and relevant stakeholders. The group assists in guiding the guideline development process and they should have the necessary expertise in the subject matter. The multidisciplinary team in the current study included the researcher as the convener, the study supervisors and the experts who were invited to review the guidelines. The researcher was herself an expert in the field for which the guidelines were being developed in that she was an experienced midwife who was working as a lecturer for the midwifery programme. The study supervisors were also experts in the field of maternal and childcare as they were both experienced midwives with one of them being an advanced midwife. The experts who reviewed the guidelines included experienced midwives (n = 2), advanced midwives (n = 2), obstetrician (n = 1) and a manager from MCWH.

7.3.3 Scope of the guidelines

The aim of a scoping process is to define the overall objectives of the guidelines such as potential impact and benefits, the target users to whom the guideline is meant to apply and its relation to other relevant documents (Vermeulen *et al.* 2019). The scoping process was guided by the findings on data analysis and interpretation, literature review and the theoretical framework used for the entire research project. Vermeulen *et al.* (2019) advise that the scoping should include a preliminary literature search and/or a survey of potential users to provide input for the scope of the guidelines. The research project commenced with a preliminary literature review as presented in Chapter 2 of this thesis followed by another literature review in relation to the discussion of the findings in the

context of the problem at hand, which was no collaboration between the midwives and TBAs and all resultant effects thereof. The researcher ensured that all relevant parties to the problem (midwives, TBAs and women) were included as study participants and provided this input during the interviews including asking them to propose possible strategies that could enhance collaboration between midwives and TBAs.

7.3.4 Forming relevant key questions:

According to Vermeulen *et al.* (2019), effective and efficient guideline development involves asking and answering key questions developed from the guideline's scope. These questions should be clear, focused and closely define the boundaries of the topic. Thus, the researcher developed relevant key questions based on the scope of the guidelines, the study findings and supporting literature. Table 7.1 presents the key questions that were developed for each of the guideline topics in line with the factors that were identified as influencing effective collaboration.

Table 7.1: Key questions that were developed for each of the guideline topics in line with the factors influencing effective collaboration

Factors influencing effective collaboration	Suggested Topics	Main Question
Recognising and communicating common vulnerabilities	Facilitating communication, openness and transparency	How could communication, openness and transparency between midwives and TBAs be encouraged?
Involving everyone who has a personal stake or interest in the outcome of a situation	Shared vision and sense of responsibility	What strategies could facilitate shared vision and sense of responsibility between midwives and TBAs?
Using good problem-solving tools	Sharing and caring environment	What are the possible ways that could promote sharing and caring between midwives and TBAs?
Maintaining an environment of trust	Promotion of teamwork and cooperation between midwives and TBAs	What factors could promote a trusting relationship between midwives and the TBAs?
Replacing beliefs with knowledge	Facilitating paradigm shift and values clarification	How values clarification and paradigm shift could be encouraged between midwives and TBAs?

7.3.5 Evidence search

Comprehensive searching of relevant literature based on explicit criteria is the key step in developing valid guidelines because incomplete or biased literature evaluation can lead to inappropriate recommendations (Vermeulen *et al.* 2019). At the point of developing guidelines, the researcher had already explored relevant literature related to the area of the study. The evidence search included the preliminary literature reviewed at the onset of the research project, which assisted the researcher to confirm the gap and decide on the approach to the study. Subsequently the literature used to discuss the study findings was also useful in confirming the need for collaboration between the TBAs and midwives and therefore developing the guidelines to facilitate these indicating areas of focus when developing the guidelines. Nonetheless, the selected areas in the development of guidelines, the scope and identified topics necessitated additional literature review. The questions as presented in Table 7.1 guided the further search for literature:

7.3.6 Evidence synthesis

After a step-by-step search of relevant literature, there is a need to prioritise the most relevant data which will then help to provide answers to the specific questions and help to make recommendations based on the most appropriate evidence available (Vermeulen *et al.* 2019). Evidence synthesis is also referred to as qualitative evidence synthesis which is an umbrella term for the methodologies associated with the systematic review of qualitative research evidence (Flemming and Noyes 2021; Carmona, Baxter and Carroll 2021). The evidence synthesis process can be conducted either as a stand-alone review or as part of a review of complex interventions, systems, or guideline development. It aims to bring together findings from qualitative research to establish a greater understanding of issues, often of a subtle or sensitive nature, that primary qualitative research frequently addresses. In the context of guideline development, evidence synthesis plays a key role in addressing questions related to an intervention or system complexity. It helps establish an understanding and explanation of complexity in both interventions and systems,

contributing valuable evidence for decision guidelines (Movsisyan, Rehfues and Norris, 2020; Flemming *et al.* 2018). For the purpose of this study, attempts were made to evaluate all the evidence obtained from the current study findings through supporting these with relevant literature. Some of the key findings from this process are presented below.

Musie *et al.* (2024) concur with many authors that collaboration between midwives and TBAs is a useful strategy for integration of TBAs within the formal healthcare system. For collaboration to be successful there is a need for policy improvement to promote collaboration between midwives and TBAs. Egal *et al.* (2023) highlighted that TBAs need to consider their approaches to meet the needs of women under their care by activating their cultural awareness so they can identify problems that need TBAs and be able to refer when required. They further stated that their cultural positioning, personal cultural affiliation, professional identity and the amount of work experience they have in the community influence women expectations about their culture. This would assist in achieving culturally appropriate goals for women and professionally and ethically acceptable goals for SBAs (Ngotie, Kaura and Mash 2022). Those midwives working closely with TBAs and accepting women's cultural beliefs can also assist by ensuring community awareness of complications occurring during pregnancy which can be done through community engagements, workshops and involving community care workers. This would assist in empowering women in decision-making concerning their health (Hulsbergen and van der Kwaak 2020). Egal *et al.* (2023) found in their study that there were no health awareness programmes specifically for maternal child healthcare, thus some TBAs lacked knowledge about the warning signs in pregnancy and labour and there was a failure to recognise which signs were potentially life-threatening.

It is crucial that the referral system is strengthened through TBAs since they are the community resource supporting community facilities (Egal *et al.* 2023). The TBAs in Ghana are integrated into the community health worker system where they are trained and equipped to perform uncomplicated deliveries and identify obstetric complications. They can then refer women early to the closest

healthcare facility for further management (.). Furthermore, healthcare institutions need to work closely with the communities and community leaders to safeguard women's respect while maintaining maternal safety (Ngotie, Kaura and Mash 2022). Collaboration and teamwork between midwives and TBAs as well as the care recipients is recommended to reduce child and maternal morbidity and mortality rates (Hulsbergen and van der Kwaak 2020). With collaboration, it is important to build trust, share power and ensure integration by adopting flexible protective approaches to cultural practices to achieve women-centred care for positive childbearing outcomes (Ngotie, Kaura and Mash 2022). According to WHO (2018) and the International Council of Nurses (2019), respect for culture and traditions is recommended in the maternal and child health guidelines drawn up by the UN, ICM, and WHO which call for community-based interventions like health education on obstetric danger signs, by giving more emphasis on the benefits of using ANC so that women know the importance of utilisation of healthcare facilities (Taye *et al.* 2022; Haruna, Kansanga and Bagah 2019b).

Gurara *et al.* (2020) suggest interventions such as educating the TBAs, integration of TBAs in the healthcare system, providing them with communicative possibilities, and ensuring that training is renewed yearly to keep them updated with new guidelines. These trainings will also assist the SBAs get training in cultural competencies and support them in building constructive interpersonal relationships (Gurara *et al.* 2020). Participation and involvement of other stakeholders from the national government to the community level is vital since this will create ownership and sustainability in the development of programmes and implementation thereof (Hulsbergen and van der Kwaak 2020). This statement is supported by Ohaja, Murphy-Lawless and Dunlea (2020) who assert that community leaders should be involved which will assist in achieving a smooth integration of TBAs into formal healthcare.

Several authors such as Ohaja, Murphy-Lawless and Dunlea (2017), Ngotie, Kaura and Mash (2022), and Egal *et al.* (2023) support the need for change of policies in order to favour collaboration between midwives and TBAs. Ngotie,

Kaura and Mash (2022) emphasise the need for paying attention to modifying education in midwifery, health sector practice policies, and community empowerment for collaboration to work well. This can only happen through trust, power and information sharing, with collaborative engagements adopting flexible protective approaches to cultural practices to achieve woman-centred care for positive childbearing outcomes and experiences (Ngotie, Kaura and Mash 2022). Policymakers in the health sector should ensure that women are empowered with information on the benefits of maternal health services and improve their decision-making in seeking such services (Rizkianti *et al.* 2020). When women are well informed and familiar with the healthcare system, the TBAs can even potentially act as doulas, who make women feel more comfortable in an unknown environment through providing companionship and support (Graces *et al.* 2019). Therefore, there is the need for policy makers to reconsider the roles of TBAs which should involve their integration into formal healthcare whereby both groups complement each other through fostering a healthcare environment where equal respect and recognition of each practitioner's skill is paramount (Ohaja, Murphy-Lawless and Dunlea 2020).

7.3.7 Recommendations

Once the selection and summary of evidence was complete, the researcher combined the available evidence and condensed it into statements proposing a course of action. The recommendations made from the study are presented in Chapter 9 Section 9.5 where the researcher proposed the following recommendations:

- **Policy formulation, implementation and review:** This will support both midwives and TBAs in the proposed collaboration by providing guidance for them as they continue collaborating.
- **Midwifery and TBA practices:** The two parties have to start respecting each other and ensure that they learn from each other's practices.
- **Education and training:** TBAs have to be trained so that the midwives are able to work with them knowing that they have learnt some skill including referring clients to healthcare facilities as needed.

7.3.8 Writing a draft

The researcher was able to write the first draft of the guidelines based on findings from the study. The key questions presented in Table 7.1 and the recommendations presented in Chapter 9 Section 9.5 assisted the researcher to structure the guidelines. Vermeulen *et al.* (2019) advise that guidelines be written in a language that is clearly understood by all parties with all terminology well defined and should be comprehensive and flexible to allow adaptation to diverse settings and circumstances of clinical practice. When the researcher was developing the guidelines, English was chosen since it is a universal language that many readers easily understand. However, considering that some of the TBAs use isiZulu rather than English. the guidelines were also made available in isiZulu (Appendix 14). The English version of the final guidelines are presented in the next chapter (Chapter 8) and the preliminary guidelines (first draft) are presented in an English version in Appendix 13.

7.3.9 Stakeholder review

This is the final stage of guideline development and involves a review by the future users and approval by all the parties involved (Vermeulen *et al.* 2019). For this study, the researcher identified experts from the maternal and childcare section who are specialists in midwifery or maternal and childcare services in general, from the different healthcare institutions which were part of the study. The identified specialists were experienced basic midwives, advanced midwives, obstetricians, operational managers and district managers. The TBAs and women (two from each group) from this district were part of the panel that reviewed the guidelines.

Two meetings were held with the panel to review the guidelines. For both review meetings the researcher had a summary sheet where all comments that were raised were recorded. The summary sheets were read at the end of each meeting to ensure that the researcher had captured all comments correctly. The guideline checklist was included in the minutes of the meetings and were

shared with all experts after the meeting (Appendix 12). The summary sheets assisted the researcher to effect all the recommended amendments and corrections after verifying these with the study supervisors. The researcher sought verbal consent from the reviewers to record the discussion at both meetings. Availability of the recorded information made things easy to keep track of all decisions made during this review process as well as the rationale behind all.

The first meeting was to review and comment on the guidelines and propose amendments to improve the guidelines. The second meeting was to review the corrected guidelines to verify that all the proposed amendments were factored in correctly and to confirm if the guidelines were in an acceptable state after the amendments. The researcher, who was the chairperson in both meetings, ensured that all stakeholders understood the purpose and the goals of the review process, which was discussed with them. The researcher communicated what needed to be achieved and the criteria that was to be employed in reviewing the guidelines.

Copies of the preliminary guidelines (Appendix 13) were delivered to all identified experts either via email or via hand delivery (depending on the choice) two weeks before the first meeting to allow them sufficient time to go through the guidelines in order to identify areas that required amendment or clarity. All experts were invited to a face-to-face meeting. On the day of the first meeting, the experts were requested to sign a statement of confidentiality before the meeting started (Appendix 11). The researcher presented the guidelines to the whole expert team. The experts had a robust discussion about the guidelines focusing on their relevance, comprehensiveness, and possibility of acceptance by intended users. There was consensus among the reviewers regarding the need, the relevance and the comprehensiveness of the guidelines. However, there were a few proposals regarding the language in selected aspects of the guidelines considering these were meant to be used by professional and non-professional people some of whom were less educated. Other proposals for

amendments included logical sequence, too wordy, and suggestions on change of structure by adding main points and sub-points on the guidelines.

The reviewers were tasked to take the guidelines home for further analysis based on the discussion that took place in the first meeting and to submit their comments by email within six weeks. The researcher send the TBAs and the women a soft copy of the guidelines and the comments sheet. The TBAs and the women were allowed to submit their comments via WhatsApp message, or to send a message to the researcher to come and collect comments from them.

An agreement was made that the researcher would convene another meeting as soon as all comments have been received from all reviewers. Even those that did not have any further comments were requested to submit a nil response in order for the researcher to be assured that she was not missing any comments. Comments from all reviewers were received within the next two weeks. The researcher captured all the comments to ensure that there were no contradicting comments. Thereafter, the guidelines were revised accordingly (Vermeulen *et al.* 2019). The revised guidelines were circulated back to all the panel members a week before the next meeting to allow that they could go through them before the next meeting. At the second meeting the panel reached consensus regarding the accuracy of the guidelines.

7.3.10 Approval

This is the final approval and authorisation of the guidelines by the same stakeholders who were consulted to review the draft, based on the input and recommendations by this reviewing team. The final approval process ensured that there was consensus among the reviewing team (Vermeulen *et al.* 2019). Consensus among the reviewing team was ensured by effective communication and collaborative decision-making. Openness and transparency during the discussions were encouraged, which required a good listening ear, a clear record of the views and perspectives of the reviewing team. This ensured that everyone was heard and valued. There were productive discussions especially

during the first meeting and different viewpoints were debated constructively and new ideas and solutions were generated.

A few disagreements arose but the researcher found solutions to address the concerns raised in order to ensure that no group was favoured since they all had valid points; it was important to find common ground and areas of agreement to build and ensure consensus. Consensus assists with accountability of all stakeholders.

All the reviewers at the second meeting were happy with the guidelines and consensus was reached therefore no further meetings were scheduled. The reviewers were thanked for their contribution and were promised that a copy of the thesis containing the final guidelines would be made available to them and any other interested parties on completion of the project. The final approved guidelines were translated from English to isiZulu and back by an English language translator who is proficient in both languages (Appendix 15)

7.3.10.1 Publication

Vermeulen *et al.* (2019) explained that dissemination of guidelines is a way of making guidelines accessible. Advertising their availability and ensuring that they are distributed widely ensure that they are easily accessible to all. There are different strategies that can be used to publicise guidelines, such as: dissemination of short summaries, promotion of guidelines development, publication in professional journals and on the internet, and links on related websites. The researcher will ensure that the developed guidelines are shared with relevant stakeholders through presentation at relevant conferences and midwifery workshops, and publication in professional journals and on the internet. In addition, the copy of the guidelines will be made available to the KZN Provincial and uThukela District offices.

7.3.10.2 Updating / revising

According to Vermeulen *et al.* (2019) updating guidelines is an essential part of guideline development which assists in ensuring that quality is maintained and that they remain current. This final step did not form part of the current study but the researcher included this as a recommendation should the guidelines be implemented.

The development of guidelines is a complex, challenging and time consuming process that typically involves collaboration among experts, stakeholders, and relevant organisations (Peleg and Haug 2023; Johansson, Guyatt and Montori 2023). While guidelines provide a framework for decision-making, they must be responsive to new evidence, emerging trends, and feedback from stakeholders. Thus, Keepers *et al.* (2020) advise that well-developed guidelines are never a static document and should never be treated as a fixed document that remains unchanged indefinitely but should be functional and dynamic in nature. Treating guidelines as static documents can lead to outdated recommendations, missed opportunities for improvement, and suboptimal outcomes. It can also undermine the credibility and usefulness of guidelines among end-users. By recognising that guidelines are dynamic documents, stakeholders are encouraged to engage in ongoing dialogue, collaboration, and continuous improvement processes. This fosters a culture of learning, adaptation, and innovation in the use of guidelines to promote better outcomes and quality of care. Guidelines are dynamic documents that evolve over time in response to changes in evidence, technology, regulations, best practices, and societal needs. They are not fixed in stone but are subject to revision and updating as new knowledge emerges or circumstances change (Keepers *et al.* 2020).

7.4 SUMMARY

Chapter 7 discussed the development of the guidelines and the processes that were followed in developing the guidelines, as guided by Vermeulen *et al.* (2019). Chapter 8 presents the guidelines to facilitate collaboration between midwives and TBAs in KwaZulu-Natal, South Africa.

CHAPTER 8: GUIDELINES TO FACILITATE COLLABORATION BETWEEN MIDWIVES AND TRADITIONAL BIRTH ATTENDANTS IN KWAZULU-NATAL, SOUTH AFRICA

8.1 INTRODUCTION

Chapter 8 presents the proposed guidelines including recommendations for implementation. The guidelines considered the findings and recommendations from the first phases of the current study which were achieved in the first five objectives of the study. The guidelines were developed following the 12 steps described by Vermeulen *et al.* (2019) as presented in the previous chapter. Six sets of guidelines were identified as essential to facilitate collaboration between midwives and TBAs and were decided upon based on the five factors that influence effective collaboration as described by Rollins (2015). The guidelines presented in this chapter are the final version that was reviewed, verified and approved by the relevant experts as presented in the previous chapter. The guidelines are available in the two main languages used in the area of the study (English and isiZulu). The English version is presented in this chapter and the isiZulu version is available as Appendix 15.

8.2 PRESENTATION OF THE GUIDELINES

I. Title of the guidelines

Guidelines to facilitate collaboration between midwives and traditional birth attendants (TBAs).

II. Author

These guidelines were prepared by Ms Nompumelelo Pearl Ndaba as part of her research study in fulfilment of the requirements for the Doctoral Degree in Nursing in the Faculty of Health Sciences at the Durban University of Technology, Durban, South Africa.

III. Purpose of the guidelines

The purpose of the guidelines is to facilitate collaboration between midwives and TBAs with the aim of being able to work together in providing services to mothers and their infants during the antenatal, intrapartum and post-natal periods with the ultimate aim of reducing maternal and child deaths in the area.

IV. Guideline Objectives

The objectives of these guidelines are to:

- Facilitate collaboration between midwives and TBAs.
- Address factors that can possibly hinder successful collaboration.
- Facilitate partnership and teamwork when providing services to women and their children.
- Ensure that collaboration between midwives and TBAs is sustained.

V. Target Audience

The target audience for these guidelines include the following

- Healthcare institutions in KwaZulu-Natal offering maternal women's and child healthcare services.
- Healthcare staff within different healthcare institutions particularly the midwives.
- Communities and TBAs in uThukela District and surrounding areas.
- Any other settings where services of TBAs prevail.

VI. Scope and applicability of guidelines

These guidelines aim to provide recommendations for facilitating and sustaining collaboration between TBAs and midwives as two essential service providers of maternal, child and newborn care in the area under study. Development of these guidelines emanated from anecdotal evidence as reported by midwives and the researcher that a number of pregnant women, especially from rural communities, either do not attend ANC, do not come on time for delivery, and

do not attend postnatal care services, but present at the clinic late when they already have complications related to pregnancy, birth or postpartum. In most cases, these women were reported to have been under the care of either traditional healers or TBAs in their communities. It was envisioned that this problem could be eliminated through strengthening collaboration between the midwives and the TBAs. The developed guidelines will be applicable to the KwaZulu-Natal Department of Health maternity staff (especially the midwives), TBAs, women and their families as the persons who could affect or be affected by the collaboration between the midwives and TBAs.

VII. Legislative framework

The following are some of the acts that are critical and should be considered during implementation of the proposed guidelines:

- South Africa Department of Health 2005. The Nursing Act, 2005 (Act 33 of 2005).
- South Africa National Department of Health (2020) The National Strategic Direction for Nursing and Midwifery Education and Practice (2020/21-2025/26).
- South Africa National Department of Health (2016) Guidelines for Maternity Care in South Africa.

VIII. Acronyms

KZN:	KwaZulu-Natal
iMMR:	Maternal Mortality Rate
MNCWH:	Maternal, Neonatal, Child and Women's Health
PPEs:	Personal Protective Equipment
WIL:	Work Integrated Learning
SA:	South Africa
SANC:	South African Nursing Council
SDG:	Sustainable Development Goal
TBA:	Traditional Birth Attendant
WHO:	World Health Organization

IX. Glossary of Terms

- Antenatal care: According to the guidelines for maternity care in South African (2016), antenatal care is designed to ensure the best possible pregnancy outcome for women and their babies.
- Collaboration: The process of two or more people, entities, or organisations, working together to complete a task or to achieve a goal.
- Community health worker: A community member chosen by community members and trained to provide basic health and maternal care services in community households within the preventive, promotional and rehabilitative scope.
- Community participation: A process that involves community members in problem solving or decision making using their resources or inputs to identify their problems.
- Foetus: An unborn offspring, from the embryo stage (the end of the eighth week after conception, when the major structures have formed) until birth.
- Healthcare facility: A place that provides healthcare both in public and in private settings. This includes hospitals, clinics, outpatient care centres and specialised care centres like birthing centres and psychiatric care centres.
- Healthcare unit: A health division of the health establishment.
- Maternal mortality: this is the death of a woman while pregnant or within 42 days of pregnancy termination, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes. Institutional maternal mortality relates to maternal deaths that occur within a health institution.
- Midwife: According to the South African Nursing Council (SANC), a midwife is a person who is enrolled and licensed by the SANC as an independent practitioner who is permitted to practice as a midwife in the jurisdiction of South Africa.

- Neonate: Any newborn with signs of life regardless of the gestational age (SANC).
- Traditional birth attendant: A person who assists a mother during childbirth and who initially acquired her/his skills by delivering babies herself/himself or through apprenticeship to other TBAs.
- Scope of practice: According to SANC these are the parameters within which a category of nurse or midwife may practice

X. Foreword from the author

Collaboration between midwives and TBA services holds significant potential to enhance access to skilled care during childbirth and improve health outcomes for mothers and babies. This notion is supported by Behruzi *et al.* (2017) who state that to meet women's preferences and their choice of midwifery care, and to serve the needs of women and their families, it is required that the maternity care providers work at the highest level of collaboration. The International Council of Midwives (ICM) (2023) supports the notion of collaboration when they state that although midwives work in partnership with women, families and communities to achieve the best outcomes for pregnancy and birth, effective health promotion and disease prevention within maternity and newborn care cannot be accomplished by a single professional, community or policy-making group. Thus, they emphasise that multi-professional collaboration plays a vital role in the provision of high-quality sexual, reproductive, maternity and newborn care. Although in principle the ICM is referring to health professionals, the TBAs cannot be excluded as they also take part in the management of women during pregnancy, labour and puerperium. This is supported by the findings from this study and supported by several authors including Kassie *et al.* (2022), and Musie *et al.* (2022), who affirm that TBAs in underdeveloped countries including India, Bangladesh and South Africa, to name just a few, function as service providers to women and young infants during pregnancy labour, child birth, the postpartum and early neonatal period, especially in rural areas. The ICM supports the demand for continuity of care through pregnancy, childbirth and post-partum, and collaboration with any other roleplayers as needed to ensure that care is quality, timely and

accessible. According to ICM, a collaborative chain links community health workers to family and community-based primary care. They further state that many women, gender diverse people, and newborns, continue to suffer unnecessary mortality and morbidity because there is delay in seeking midwifery care, or have no access to the next level of health services when complications arise (ICM 2023). Thus, midwives must work in partnership with other health professionals, policy makers and global agencies to ensure quality, timely and accessible reproductive, maternal and infant healthcare globally.

These guidelines aim to provide recommendations for facilitating and sustaining collaboration between the TBAs and midwives in the area under study, both being essential service providers of maternal, child and newborn care. The current study supported the literature which indicates that while they both provide services to the same audience, they each work independently with no form of engagement or collaboration between them. As a result, negative pregnancy outcomes can be experienced by mothers and their infants which, according to literature, could be minimised or overcome through collaboration between the two parties. The ultimate aim of developing these guidelines is to improve maternal and newborn health outcomes through engagement, good communication, and sharing of best practices. Morley and Cashell (2017) attest that exceptional healthcare is facilitated by a collaborative approach. According to these authors, the members of a multifunctional team bring together a range of functional expertise to the task at hand, and can be more efficient, effective, innovative, and better at-risk management compared with purely functional teams. As they collaborate, they are able to create opportunities for a broad range of ideas, considerations, and compromises to be worked out as early as possible to avoid costly errors, rework, and miscommunication. Morley and Cashell (2017) emphasise that this is particularly important when the goals and values of different team members may be very different, as was evident with the midwives and TBAs in the current study.

The guidelines are multifaceted, aiming to improve maternal and newborn health outcomes, ensure safe and culturally sensitive care, and integrate traditional practices with modern medical standards. With these guidelines in place, it is envisaged that maternal and infant mortality can be reduced through the resulting collaboration between midwives and TBAs. This could facilitate a number of intervention strategies towards reduction of maternal and infant mortality such as timeous identification of complications and early referral to the midwives, which will reduce complications caused by delays in seeking, accessing and receiving care as specified in the three delays model (Thaddeus and Maine 1994). In addition, interventions to enhance collaboration and partnerships between TBAs and SBAs have been found to create good relationships and facilitate the integration of TBAs into midwifery training in Indonesia (Mwoma, Kituku and Gitome 2021).

Benchmarking and sharing of good practices can facilitate provision of training, particularly to the TBAs, on critical aspects of maternal and child care such as on identifying abnormalities early and managing maternal emergencies in the absence of or while awaiting skilled service providers. Adatara *et al.* (2019) cited by Musie *et al.* (2022) emphasised the importance of the healthcare system acknowledging the significance of TBAs and the importance of up-skilling them since they serve as the initial point of contact for women during pregnancy until childbirth. Their recognition can positively impact the country's ability to curb perinatal and neonatal deaths and morbidities.

There is research evidence that some of the practices by TBAs and some of the herbal medicinal supplies issued to mothers and babies may not be safe because they are not scientifically proven (Aziato and Omenyo *et al.* 2018; Scina 2017; Boltman-Binkowski 2016). Therefore, it is envisaged that as the TBAs and midwives collaborate, this will create an opportunity for them to get to know each other's practices, strengths and weaknesses better. This will facilitate awareness of practices or omissions that impact negatively on pregnancy outcomes and patients' health and create opportunities for discussion of these and together identify strategies to overcome these. It will also create

opportunities for education and training in order to ensure safe practices by both parties. Ohaja, Murphy-Lawless, and Dunlea (2020) attests that collaboration between TBAs and midwives is a useful strategy for integrating TBAs within the formal healthcare system. Training, supervision, and collaboration between TBAs and midwives enhances their skills thereby increasing the number of SBAs and thus access to SBA services. This is of particular importance because unlike midwives who have undergone formal training and are thus able to provide skills-based healthcare, the majority of TBAs do not have any formal training. Adatara, Strumpher and Ricks (2018) attest to this and advise that SBAs should foster collaboration with TBAs in rural communities to ensure that some refresher training is offered to all.

It is also envisaged that collaboration between midwives and TBAs will strengthen referral between these two groups. Referral will assist and ensure that TBAs are able to refer to healthcare facilities and the midwives are able to refer back to the TBAs in a timely fashion. This will minimise delays and facilitate continuity of care including tracking of patients for follow up and monitoring of progress. The Rwandan Maternal Newborn and Child Strategic Plan 2018-2024 highlighted that the majority of maternal and infant deaths in this country were related to the delay in referral, poor case management and delays in recognising complications (Rwanda Ministry of Health 2018). Collaboration with midwives and training will assist in ensuring TBAs work within their limits when caring for patients and those cases that are beyond their skill level are promptly referred to healthcare facilities for further management (Adatara, Strumpher and Ricks 2018).

It is clear from the findings of this study and literature from previous research studies that developing guidelines for the facilitation of collaboration between midwives and TBAs is essential for the improvement of maternal and newborn health outcomes, ensuring culturally sensitive and safe care, and optimising healthcare resources. Such guidelines will help in bridging the gap between traditional practices and modern healthcare, ensuring that all women have access to high-quality maternal care.

XI. Summary of guideline development process

These guidelines were developed to facilitate collaboration between midwives and TBAs which was one of the objectives of this study from the findings and recommendations from the current study which was conducted at uThukela District with midwives, TBAs and women in different maternity units. The guidelines were informed by the finding of a study conducted in uThukela District in KwaZulu-Natal, South Africa. The study looked at strategies that existed in the area regarding collaboration between TBAs and midwifery care in uThukela District but discovered that collaboration did not exist. However, the perceptions of TBAs and midwives and the views of women regarding the collaboration of midwives and TBAs was positive, with the majority of participants from all three groups in favour of collaboration. The factors that influence collaboration between midwives and TBAs have all been considered in the process of drawing up the guidelines. The final guidelines were verified by the experts from maternity, women and the TBAs for relevance and acceptance by potential users.

XII. LIST OF GUIDELINES

NO	Guideline
A	Guideline to facilitate communication, openness, and transparency
B	Guideline to facilitate shared vision and sense of responsibility
C	Guideline to foster a sharing and caring environment for collaboration
D	Guideline to promote teamwork and cooperation between midwives and TBAs
E	Guideline to facilitate a paradigm shift and values clarification between midwives and TBAs

GUIDELINE A:
**GUIDELINE TO FACILITATE COMMUNICATION, OPENNESS, AND
TRANSPARENCY AMONGST MIDWIVES AND TBAS**

Rationale for implementation of this guideline

Women in this province, especially those living in the rural communities utilising both healthcare facilities and TBAs, require quality care from both midwives and TBAs for different problems. This is not easy when there is no proper communication between the two parties. Both midwives and TBAs need to ensure communication, openness and transparency for them to be able to collaborate well and sustain the collaboration. Transparency builds trust and credibility, as stakeholders, perceive organisations like healthcare facilities as being reliable and honest. This trust is crucial for maintaining strong, positive relationships, especially between the caregivers, in this case, the midwives and TBAs. In crises, clear and open communication is vital for effective management and minimising reputational damage, which will be helpful between midwives and TBAs since they come from different backgrounds. A culture of transparency will encourage improvement and innovation by maintaining open feedback channels, ensuring that collaboration is sustainable. Overall, these guidelines will create a foundation that will be effective and ethical.

Recommendations for implementation of this guideline

- Establishment of clear communication channels and mechanisms for information sharing between midwives and TBAs by ensuring there are regular meetings between the two parties including community meetings where challenges, successes, and ongoing cases can be discussed.
- Ensuring effective teamwork and coordination of care to ensure seamless continuity of care and to ensure challenges are overcome easily.

- Developing and agreeing on communication tools such as phones for urgent information and referral, and documents for detailed client information on referral, while ensuring privacy and confidentiality.
- Ensuring and building mutual respect and understanding between the midwives and TBAs.
- Having joint training programmes where midwives and TBAs can shadow each other, observing each other's practices for better understanding and recognising each other's roles.
- Involvement of both midwives and TBAs in the decision-making of a client who utilises both practitioners.
- There should be training on conflict resolutions since the two parties are not used to working together and mediators should be selected from both parties.

GUIDELINE B:

GUIDELINE TO FACILITATE SHARED VISION AND SENSE OF RESPONSIBILITY

Rationale for implementation of this guideline

This guideline will enhance collaboration and improve maternal and newborn health outcomes ensuring that midwives and TBAs bring their unique skills and knowledge to maternal care. With midwives having formal training in obstetrics and gynaecology, and TBAs offering traditional wisdom and experience that resonates with local cultural practices, such collaboration is likely to work well. By fostering sharing and collaboration, these guidelines can help integrate the strengths of both approaches, leading to more comprehensive and culturally sensitive care. This guideline will also ensure that patients receive consistent care across different providers which is particularly important in areas where access to healthcare facilities is limited. Shared care models will address both physical and emotional needs of women since midwives provide clinical care, TBAs offer emotional support and guidance based on cultural practices, leading to a more holistic approach to maternal care. When midwives and TBAs work together this demonstrates commitment to respecting and valuing local traditions while providing high-quality care and this can build trust within communities, encouraging more individuals to seek professional help when needed.

Recommendations for implementation of this guideline

- Outline the roles and responsibilities of midwives and TBAs participating in the collaboration framework by clearly specifying how each role complements the other.
- Engage all stakeholders (Department of Health, midwives, TBAs, community leaders, and health authorities) in the development and implementation of the collaboration process to ensure that the guidelines are practical and culturally appropriate.

- Organise regular meetings with involved stakeholders to discuss progress, address challenges, and gather feedback on the implementation of the guidelines.
- Organise training sessions that include both midwives and TBAs which will focus on areas such as communication skills, cultural competence, and clinical updates. These training sessions can ensure that the specific needs and practices of both groups are met.
- Promote mutual respect and recognition of each other's expertise and acknowledge the value of traditional practices and integrate them with modern medical approaches.
- Ensure development of systems to monitor, implement and evaluate the guidelines, including tracking adherence, effectiveness and identifying areas for improvement of collaboration.
- Evaluate the impact of the collaboration by using data to ensure that the guidelines are achieving their intended goals and adjust strategies as necessary.
- Offer support services to midwives and TBAs such as administrative assistance for the implementation of the guidelines effectively.

**GUIDELINE C:
GUIDELINE TO FACILITATE A SHARING AND CARING ENVIRONMENT FOR
COLLABORATION**

Rationale for implementation of this guideline

Implementing this guideline is essential since it will assist in enhancing communication, resolving conflicts, and increasing productivity amongst the midwives and TBAs during collaboration. It will promote inclusivity and diversity, ensuring that all team members feel valued and heard. Consistent practices foster accountability and provide a stable, supportive culture, boosting morale and job satisfaction. This guideline will also serve to stimulate innovation and creativity by creating a safe space for new ideas and will streamline the onboarding process of the midwives and TBAs. Overall, clear guidelines enable teams to adapt to changes more effectively, leading to a more cohesive, efficient, and innovative collaboration.

Recommendations for implementation of this guideline

- Plan review meetings to discuss progress and develop action plans based on feedback and evaluation results to continuously improve the collaborative environment.
- Hold continuous education and professional development workshops with feedback sessions on maternal and child health and cultural competency.
- Facilitate and encourage the sharing of best practices and successful strategies between midwives and TBAs.
- Establish clear procedures for addressing and resolving conflicts should they arise.
- Ensure that both midwives and TBAs have equal opportunities to contribute to discussions and decision-making processes.
- Promote an understanding and respect for cultural differences and traditional practices.

- Implement programmes to recognise and celebrate the contributions and successes of both midwives and TBAs during the collaboration.
- Provide constructive feedback in a supportive and respectful manner, focusing on strengths and areas for improvement.
- Develop tools such as messaging apps, emails, and online platforms to maintain continuous communication and strengthen the referral system.
- Create a non-judgemental space where all team members feel comfortable expressing their thoughts and concerns.
- Clearly define and communicate the roles and responsibilities of both midwives and TBAs to avoid misunderstandings.

**GUIDELINE D:
GUIDELINE TO FACILITATE TEAMWORK AND COOPERATION BETWEEN
MIDWIVES AND TBAS**

Rationale for implementation of this guideline

This guideline aims to improve maternal and neonatal health outcomes and enhance teamwork and cooperation between midwives and TBAs. Effective collaboration between the two groups is essential for improving maternal and child health outcomes and it will ensure that both groups can effectively share knowledge, skills, and resources, enhancing the quality of care provided and it will bridge the gap between modern practices and traditional practices ensuring comprehensive care. There are usually positive outcomes when there is teamwork and cooperation between groups especially if both groups have common goals, it becomes easy for them to work as a team to ensure reduced MMR and improve maternal and neonatal health outcomes. Moreover, this guideline will establish clear roles and responsibilities and reduce misunderstandings, it will also assist in promoting a collaborative approach to address common challenges arising along the way leading to safer and more effective maternal health services.

Recommendations for implementation of this guideline

- Conduct trainings which will involve both midwives and TBAs for knowledge sharing and mutual respect.
- Training of TBAs which will include simulation to ensure their skills are upgraded in line with the modern obstetric practices and identify tasks that can be safely managed by TBAs. TBAs can be paired with midwives for mentorship as part of their training.
- Clearly defining roles and responsibilities of midwives and TBAs to ensure that there is no overlapping of work and highlight work requiring the expertise of midwives.
- Organise and hold meetings where midwives and TBAs will discuss different cases, share their experiences and resolve any conflicts.

- Establish reliable communication channels to ensure continuous communication (e.g. for emergencies, for clarification, for referral and feedback).
- Ensure respect between midwives and TBAs; build trust and respect for traditional knowledge and cultural practices of TBAs and vice versa.
- Provide TBAs with resources such as personal protective equipment, cord scissors, sterilising solutions, and referral forms to ensure that they are effective in what they are doing.
- Involve the community and the leaders in ensuring collaboration is sustained by conducting awareness campaigns to educate them about the need for and benefits of integrating TBAs into the healthcare system.
- Improve and implement policies and protocols that will support the integration of TBAs into the formal healthcare system.
- Establish mechanisms for referral and feedback from both midwives and TBAs to improve and sustain collaboration.
- Evaluate and assess the effectiveness of teamwork and cooperation initiatives between midwives and TBAs.

GUIDELINE E:
**GUIDELINE TO FACILITATE PARADIGM SHIFT AND VALUES CLARIFICATION
BETWEEN MIDWIVES AND TBAs**

Rationale for implementation of this guideline

This guideline is essential for aligning the approaches of the midwives and TBAs, and improving maternal and child health outcomes by encouraging both groups to understand and appreciate each other's roles, perspectives, and expertise, fostering mutual respect and cooperation. By clarifying values, midwives and TBAs can find common ground in their shared goal and vision of providing the best possible care for mothers and infants. This paradigm shift can really lead to more effective collaboration, where both practices are integrated and as a result, this alignment reduces conflicts, enhances trust within the community, and ensures a more holistic approach to maternal and neonatal healthcare, ultimately leading to better health outcomes and increased satisfaction among patients. Therefore, implementing this guideline requires a multifaceted approach that focuses on education, good communication, and collaborative practices.

Recommendations for implementation of this guideline

- Develop and conduct workshops that include both midwives and TBAs, focusing on shared goals, best practices, and mutual respect which will incorporate cultural competency training to help midwives understand the cultural significance of TBAs and vice versa, fostering mutual respect.
- Establish regular meetings where midwives and TBAs can discuss cases, share experiences, and resolve conflicts, which will also improve teamwork.
- Implement structured feedback mechanisms that allow both groups to voice their concerns and suggestions in a constructive manner.
- Involve both midwives and TBAs when developing care protocols that respect traditional practices while ensuring patient safety.

- Develop standardised procedures that integrate traditional and modern medical practices, ensuring a cohesive approach to maternal and child healthcare.
- Conduct community education campaigns, which will assist in highlighting the importance of both midwives and TBAs, promoting respect and cooperation between them.
- Engage community leaders to introduce the guidelines and for them to support and endorse the guidelines, ensuring community buy-in and adherence.
- Use of feedback from evaluations to continuously refine and improve the guidelines and their implementation.
- Ensure that healthcare institutions adopt policies that support and enforce the guidelines, providing the necessary resources and infrastructure.

8.3 CONCLUDING REMARKS

Smooth collaboration between midwives and TBAs can ensure the best community relationships and facilitate collaborative efforts in working towards reduction of MMR. Mutale *et al.* (2020) highlighted the need to formalise links between traditional healers and their counterparts by providing allopathic health services which will assist in recognising healers in the healthcare system through good communication, relationship building, and identification of areas for collaboration between the two parties. Developing these guidelines to facilitate collaboration between midwives and TBAs in this province is seen as a good move and an important contribution to maternal, women's and child care services in the country. These guidelines, if implemented could also promote mutual respect and understanding between midwives and TBAs, ensuring clear communication channels, and providing joint training programmes. The collaborative approach can also allow for the integration of culturally accepted practices with scientifically validated medical procedures, fostering trust and cooperation. Sharing roles and responsibilities, establishing formalised protocols for referral and emergency situations, and creating room for continuous education can leverage the strengths of both midwives and TBAs, ensuring that mothers and babies receive the best possible care throughout pregnancy, childbirth, and the postnatal period. Developing these guidelines involves fostering an environment of mutual respect and is a contribution that can benefit not just uThukela District but other districts and provinces, as well as South Africa and beyond as a number of other settings worldwide also have TBAs and midwives working in the same area without communication or collaboration.

8.4 CHAPTER SUMMARY

This study presented the developed guidelines, which will assist in collaboration between midwives and TBAs in KwaZulu-Natal. Developing guidelines for collaboration took into account the strengths and limitations of both midwifery and TBA services. The goal was to create a system where these services complement each other, ultimately benefiting the health and well-being of

pregnant women in the rural area under study. It is anticipated that the guidelines, if implemented, will address issues such as training, communication, referral mechanisms, and the integration of traditional practices with modern healthcare standards. These guidelines will be beneficial to the community which will involve husbands and families who will also ensure support by encouraging women to also utilise the healthcare system. Midwives will learn new ways to deal with women and be able to identify women who need the attention of the TBAs and refer them in that direction, and TBAs will also benefit by gaining medical information and resources and be able to liaise with healthcare facilities whenever there is a need. Women are the most important party in this study and will benefit by receiving quality care from both midwives and TBAs without fear of being scolded when utilising TBAs.

CHAPTER 9: SUMMARY, LIMITATIONS, RECOMMENDATIONS AND CONCLUSION FROM THE STUDY

9.1 INTRODUCTION

Chapter 9 presents the summary, the findings, the limitations, recommendations, and the conclusion drawn from the entire study. This is the final chapter for this research project, the purpose of which is to wrap up the study, highlight what was done, how it was done, what was achieved, and the contribution made to the field of research which was the improvement of maternal and childcare services in the country through collaboration between midwives and TBAs.

9.2 SUMMARY OF THE STUDY

The study emanated from the anecdotal evidence by the researcher who through her exposure to the maternal and child care units in the uThukela District observed that a number of women presented with problems and complications during pregnancy, labour delivery and postpartum, most of which resulted in untoward pregnancy outcomes that were linked to lack of collaboration between midwives and TBAs in the area. This anecdotal evidence was supported by literature where several authors including Akute *et al.* (2024), Musie *et al.* (2024), and Egal *et al.* (2023), confirmed lack of collaboration between midwives and TBAs and that most women from rural areas prefer to utilise TBAs over SBAs for various reasons such as access to healthcare institutions, fear of caesarean section, disrespect by the SBAs, low quality of care, lack of privacy and trust, etc. These were flagged as part of the reasons for persistently increased perinatal death rates in low-medium-income countries including South Africa (Sarker *et al.* 2016). Reduction of perinatal deaths is one of the priority mandates for the DoH, aimed at achieving Sustainable Development Goals (SDG) number 3, particularly goal numbers 3.1 and 3.2

which are to reduce the global maternal mortality ratio to less than 70 deaths per 100 000 live births and to end preventable newborn and under five children deaths with each country aiming at less than 12 neonatal deaths per thousand (South Africa. Department of Health 2021a). This was a stance for conducting this study whose aim was to develop guidelines to facilitate collaboration between midwives and TBAs in KwaZulu-Natal, South Africa. The study had six objectives which were to:

- Explore if any strategies exist regarding collaboration of TBAs and midwifery care in KZN.
- Describe perceptions of TBAs regarding collaboration with midwives.
- Describe the perceptions of midwives towards collaboration with TBAs.
- Explore the views of women regarding the collaboration of midwives and TBAs.
- Critically analyse the factors that influence collaboration between midwives and TBAs.
- Develop guidelines to facilitate collaboration between midwives and traditional birth attendants.

The structural functionalism theory was used as a theoretical framework to guide the study. The study was approved by the DUT as an academic institution through granting ethical approval (IREC 307/22 Appendix 8). Gatekeeper permission to use the study sites for data collection was received from the KZN Health Research and Knowledge Management Unit and the uThukela District Manager (appendices 2b and 3b). The study took place at uThukela District Healthcare facilities that were providing comprehensive maternity healthcare services (ANC, intrapartum, and PNC). One group of participants were registered midwives who had been involved in the provision of ANC, intrapartum, and PNC healthcare services for more than six months, the second group was women attending the selected healthcare institution who were either pregnant or were in the postpartum period who had attended TBAs during pregnancy, labour and/ or post-delivery, and the third group was TBAs who were offering maternity care to the women of the uThukela District. Data were collected from 6 facilities and 10 TBA homes, between June and July 2023 using

semi-structured interviews with 18 women, 10 TBAs and FGDs with 38 midwives. All data were thematically analysed using the six steps as described by Creswell and Creswell (2018). The summary of findings is presented below, showing mainly the achievement of the study objectives.

9.3 SUMMARY OF FINDINGS

Data collection and analysis occurred concurrently. Four themes and several sub-themes emerged as presented and were discussed in Chapters 5 and 6. The summary of findings presented in this chapter highlights the achievement of the six study objectives.

9.3.1 Existing strategies toward collaboration of traditional birth attendant and midwifery care in KwaZulu-Natal

Achievement of this objective was informed by data from all three groups of participants – midwives, TBAs, and women. All participants reported that there was no collaboration between the midwives and TBAs in this district and they were not aware of any strategies for collaboration between TBAs and midwifery care that existed in the district. These findings concur with those by Musie *et al.* (2022) in a study conducted in Tshwane and Johannesburg metropolitan districts in South Africa, who concluded that the reality is that in South Africa that there is no collaboration between healthcare professionals and the TBAs, despite the recommendations made by the WHO. The reasons for lack of collaboration noted in the study by Musie *et al.* (2022) were lack of formal registration and regulation of TBAs by the DoH, lack of reciprocal knowledge and practice sharing between TBAs and midwives, and a healthcare system that is fragmented with no synergies between traditional and Western practices. Healthcare involves the participation of patients' families, and a diverse team of often highly specialised healthcare professionals, the involvement of whom in a cooperative and coordinated way is essential to providing exceptional care (Morley and Cashell 2017). All participants in the current study attested that the midwives and TBAs worked in isolation. Chi and Urdal (2018) confirmed that there was no sustained engagement between the formal health system and the

TBAs in the Northern Uganda but both TBAs and midwives knew that both groups existed in the area. The findings from the current study revealed that even in cases where a midwife and a TBA attended to the same woman there was no form of communication, compounded by the fact that the formal referral system in the area and KZN as a whole does not cater for a referral system between these two groups. However, both the midwives and the TBAs were aware of each other's existence. Makhavhu, Masala-Chokwe and Ramukumba (2024) concur that although patient referral is a standard procedure, referral patterns between healthcare and allopathic and traditional practitioners are unknown and thus remains a problem yet to be addressed. The midwives stated that they were aware that there were TBAs in the district since some women declared to them that they utilise the services of the TBAs and some of them came to the healthcare facilities wearing certain garments and ropes around the waist and/or limbs received from the TBAs. The midwives also raised the fact that they did not know where the TBAs operated even if they wanted to meet with them since women will not tell them when they ask. Similarly, the TBAs were aware of the existence of the midwives but also attested that there were no strategies regarding collaboration. They stated that they were aware that women were using both the services of the TBAs and the midwives during pregnancy labour and childbirth, however, there was no formal communication related to the care of the women between the two parties. They agreed that they get to know that the women they are attending to have attended a healthcare clinic or hospital for medical care, but will not base their management on that care. Most TBAs also stated that they would like to collaborate with midwives since they have the same goal which is assisting women during pregnancy till post-delivery. Musie *et al.* (2022) stated that the TBAs are ready to collaborate with the formal healthcare system, and all they require is for their services relating to maternal healthcare to be recognised and acknowledged.

Women concurred with midwives and TBAs, declaring that there was no collaboration between midwives and TBAs and that they could not freely declare to midwives that they were using the services of TBAs because, according to their knowledge and experience, midwives and doctors do not approve of the

TBAs and traditional healers. Musie *et al.* (2022) concur when they state that globally and in African countries in particular, although the WHO has recommended collaboration between healthcare professionals and traditional TBAs to improve women's access to maternal healthcare, this is not the reality. In South Africa TBAs are not recognised in the formal healthcare system. Some of the women in the current study stated that they would not inform midwives that they utilise TBAs because midwives do not understand their culture and beliefs and often shout and scold women who utilise TBAs. However, all women participants stated that they would like to see TBAs and midwives work together since they believe they are both helpful. Collaboration of all relevant stakeholders is critical for positive pregnancy outcomes. The DoH emphasises in the national maternal, perinatal and neonatal health policy that achieving positive, perinatal and neonatal health outcomes necessitates community engagement, participation and collaboration that informs the demands for care and access to care for pregnant women, families and the communities (South Africa. Department of Health 2021a).

9.3.2 Perceptions of TBAs regarding collaboration with midwives

This objective targeted the TBAs only. They had to narrate their perceptions regarding collaborating with midwives. All TBAs who were interviewed were happy to collaborate with the midwives for different reasons. These findings concurred with other research studies. A study conducted by Musie *et al.* (2022) entitled "Recognise and Acknowledge Us: Views of Traditional Birth Attendants on Collaboration with Midwives for Maternal Healthcare Services" deduced that the TBAs feel it is pivotal for the healthcare system to recognise them as counterparts. Some wanted collaboration to learn more about pregnant women, and women in labour and delivery since they believed midwives have skills since they studied for many years. Gurara *et al.* (2020) in their study discussed that some of the collaboration interventions were educating TBAs, integrating them in the healthcare system with a new role, providing them with communication tools, and renewing their training yearly. Others stated that collaboration would assist them by enabling them to have access to resources like gloves, aprons,

visors, cord scissors and cord clamps which would make their jobs easier and safer for both them and the women. Others stated that sometimes complications experienced by women during pregnancy labour and childbirth necessitate that they refer the women to midwives or doctors. In the absence of formalised collaboration and acceptance of their services by midwives, they are unable to freely refer women and declare that women have been under their care leading to complications in some women's pregnancies and deliveries. In a study conducted in Nigeria, Hajaratu and Sunday (2022) highlighted that there are efforts there to reduce maternal deaths, one of which was TBAs referring women to healthcare services since delays lead to complications. TBAs also would love to know how the women that they refer to the healthcare institutions are managed so that they know how to proceed with the management of the women or the baby and what to do should a similar situation occur in the future. Although women sometimes provide feedback to them regarding what transpired in the clinic/hospital, the feedback is not comprehensive and thus not very useful. A more formalised feedback written by a doctor or midwife who cares for the women would be more useful. Some participants were concerned that even in their case they were not doing any formal referral with a full report regarding what they have already done or suspect is wrong with the women but, they will simply verbally advise the women or the family to go to a hospital or clinic sometimes advising them not to declare that the women have been managed by a TBA.

The TBAs appeared very proud and convinced regarding the effectiveness and safety of their practice and felt collaboration would create an opportunity for the midwives to get to know and learn several strategies from them that could enhance the safety of the women and their babies. The TBAs stated that they wished that midwives could also learn their cultural roles and respect their existence and practice. One TBA stated that midwives need to also understand where the women come from and their needs because there are spiritual problems that women experience for which they require spiritual help not just medical help. Musie *et al* (2022) found in their study that midwives do not know how TBAs operate and they need to go to them and learn what and how they

work. A good referral system should be developed where both midwives and TBAs share written communication about their clients. This statement is supported by Kassie *et al.* (2022) who encourage the importance of TBAs referring women but it is noted that most healthcare systems have not developed a formal referral mechanism.

9.3.3 Perceptions of midwives regarding collaboration with traditional birth attendants

The midwives were also invited to share their perceptions regarding collaboration with TBAs. This was the third objective of the study. Perceptions of the midwives varied, with some holding the view that collaboration would not work because they regarded TBAs as a type of traditional healer and they were not keen to perform traditional healer duties at the DoH healthcare facilities because they regarded such duties as uncivilised and unsafe. However, one midwife who is also practicing as a traditional healer at home stated that it is important to collaborate because women trust TBAs more than they do nursing staff at healthcare facilities and working closely with TBAs will encourage them to utilise both. Some FGD sessions resulted in a dialogue between midwives with polar opposite opinions, but these dialogues were controlled by the researcher as the convener of the FGD and resulted in the whole group being convinced of the need for, and importance of, collaboration between TBAs and midwives.

It was evident that some midwives were misinformed regarding TBAs and regarded them as traditional healers. In some FGDs there were midwives who were also practicing as traditional healers when not on duty and they were sharing that women preferred TBAs because they know their cultural needs and customs. This was confirmed by a statement in a study by Downe *et al.* (2019), where health professionals acknowledged that women sometimes preferred to be seen by a TBA because of their understanding of community-derived customs and rituals relating to pregnancy. Ngotie, Kaula and Mash (2022) emphasised the importance of collaboration between midwives and TBAs since

they also see women with spiritual and traditional problems during pregnancy, but they encourage them to go for antenatal care and to deliver in the healthcare facilities. TBAs stated that many women have problems during pregnancy which specifically need a spiritual/traditional healer who can conduct rituals to protect their unborn children or themselves, and some women have problems among families or with sister wives. They stated that if there was collaboration with TBAs it would be easy for them to encourage women to attend ANC accordingly until delivery since both they and midwives will be working closely together and understand each other's roles.

9.3.4 Views of women regarding the collaboration of midwives and traditional birth attendants

Women were invited as part of the fourth objective of the study to share their views regarding the collaboration of midwives and TBAs. Almost all women were happy about the initiative since they felt conflicted about who to choose when they needed both midwives and TBAs, and they could not freely discuss with either of the two parties that they were receiving services from both. The participants stated that collaboration would improve this situation as it would facilitate that midwives and TBAs working together. McKellar, Brown and Adelson (2019) observed that a TBA is trusted by the community as a figure who has knowledge and experience for pregnancy, health and safety from pregnancy to puerperium. They continue and state that a midwife is a skilled, caring, supportive and a women-centred person who the society holds in high regard and values as a professional that can provide care to women not just during childbirth but from conception till six weeks post-partum. For most women, the services of both parties were regarded as crucial and complemented each other. However, because of no communication between the two parties, women were unable to comply with treatment and instructions from one or both as sometimes contradicting instructions were received. Most women stated that they would be happy to see midwives and TBAs collaborate since the midwives always shout at them for utilising TBAs. Some shared that they prefer utilising TBAs throughout their pregnancy and only come to the

healthcare facility to give birth because of the midwives' attitude, long waiting times when they come for healthcare institutions, and not having transport money to come to the clinics as often as the midwives want them to.

A few women were not convinced that it would be possible for the collaboration to happen, because midwives look down upon the TBAs and regard them as inferior people who do not know what they were doing. Most women were happy and mentioned that it would help for the two to collaborate because they would be free to utilise both parties.

9.3.5 Factors that influence collaboration between midwives and traditional birth attendants

The fifth objective of the study was to critically analyse the factors that influence collaboration between midwives and TBAs. During the interviews and FGDs all study participants were asked to share their views about the factors which in their opinions could positively or negatively influence collaboration between midwives and TBAs. The majority of the participants were positive about collaboration, thus most of the factors that were shared included factors that could positively influence collaboration. They indicated that collaboration between these two parties was important and that while it would improve the working relationship between the two groups the greatest benefit would be for the women and their babies, because the management and care of women during pregnancy, childbirth and puerperium would be improved. The participants highlighted several factors that if implemented could influence collaboration between midwives and TBAs. A number of these factors are similar to those that were identified in a study by Sherifali *et al.* (2018) conducted in Canada where seven organisational factors that influenced collaboration between PHC and public health were identified. These were: clear mandate vision and goals, strategic coordination and communication between partners, formal organisational leaders as collaboration champions, collaborative organisational culture, optimal use of material and human

resources and collaborative approaches to programmes and service delivery. The factors identified in the current study were the following:

1. **Values clarification** which could enhance team work, cooperation and understanding between the two parties. It was evident from all study participant groups that the midwives did not value the TBAs. They regarded them as inferior and responsible for complications experienced by women. The participants indicated that this lack of respect created a division between the midwives and TBAs and if it is allowed to persist would impact negatively on the collaboration. Thus in order for them to be able to collaborate and work together effectively, it is critical that they respect and value each other including their differences.
2. **Shared vision:** The midwives and TBAs indicated that their vision was similar, this being the health of mothers and babies. With this shared vision, collaboration would be possible. Several participants verbalised this stating that this was a strength that they could built on as they worked on the collaboration.
3. **Open and continuous communication:** The participants from the three groups concurred that there was no communication between the midwives and TBAs and that this lack of communication had a negative impact on the care of women and babies. Almost all participants attested that communication between the two parties is vital and emphasised that it would assist in strengthening the collaboration and would also benefit not just the women and babies but also the midwives and TBAs who through open communication would be able to share ideas and learn from each other.
4. **Transparency,** particularly regarding trends and operations within each discipline, challenging experiences, successes and shortfalls. The midwife participants shared that often TBAs are not transparent, they even advise women and families not to declare to the midwives how they had managed the women or a baby, especially when there were complications. The participants proposed that transparency between midwives and TBAs would assist collaboration. Instead of them criticising each other issues should be discussed openly so that they can guide and

assist each other in resolving issues that they face in the management of women and babies. Also, transparency will assist in the continuity of care for the women and babies if each party is transparent regarding what has already been done, what went well or went wrong, and what still needs to be done. This will enable problems to be identified and managed timeously.

5. **Teamwork:** Women need to see both parties treating each other with respect and communicating and referring to each other, because this will make it easier for them to feel free to utilise both as needed.
6. **Formalised memorandum of understanding:** During data collection, some midwives were not keen on collaborating with the TBAs since there would be no formality. They stated that they are guided by a regulatory body which is the South African Nursing Council (SANC) and they were asking who is guiding the TBAs and what will happen if they make an error. During discussions, one suggestion was for the TBAs to be part of a traditional healer organisation so that the DoH will have a memorandum of understanding with that organisation and there will be a list of TBAs who will be working with the midwives. The signing of a memorandum of understanding could be one of the strategies to ensure proper collaboration between midwives and TBAs.
7. **Recognition of the TBAs by the DoH:** All participants attested that there was no collaboration between midwives, and they were aware that most women prefer to utilise TBAs more than the healthcare facilities in the rural communities during pregnancy. The TBAs stated that the midwives do not recognise the work they are doing in the communities, and they have worked with pregnant women for many years but their contributions are overlooked. Musie *et al.* (2022) recommended that the formal healthcare system should collaborate with the TBAs to try and reduce maternal mortality rates in South Africa. Development of policies that will assist in governing their practice because women in rural communities will continue to consult them.
8. **Visibility of TBA:** The midwife participants verbalised that TBAs were only known to specific people thus identifying them was a challenge. The

proposal was that TBAs need to come out so that they are known by the midwives and other health team members to facilitate them working together. One midwife participant suggested that the TBAs should consider registering with a traditional healer organisation so that it is easy to have a memorandum of understanding and for the healthcare facilities to know them.

The factors listed above emerged from the data collection and analysis process as themes or sub-themes. The participants flagged these factors as being non-existent in the district under study which was contributing to poor management of women during pregnancy, labor and post-partum, thus contributing to the high perinatal death rates in the country. The Saving Mothers reports (South Africa. Department of Health 2017, 2019, 2020, 2021b, 2022) repeatedly reflect potentially avoidable maternal and child deaths that are either healthcare provider, community or patient-related.

9.3.6 Guidelines to facilitate collaboration between midwives and traditional birth attendants

The information generated to achieve the first five objectives as presented above, the literature review and the structural functionalism theory by Talcott Parsons assisted the researcher to achieve the sixth and last objective of the study which was to develop guidelines to facilitate collaboration between midwives and traditional attendants in KZN, South Africa. The process followed in developing the guidelines and evaluating them for relevance and acceptance was presented in Chapter 7. The developed guidelines were presented in Chapter 8 including the implementation strategy.

The guidelines were reviewed by seven experts for relevance and acceptance. The experts were one obstetrician, one senior midwife in charge of the CHC, two advanced midwives (one from the CHC and one from the hospital), two TBAs and two women who were approached in ANC.

The researcher followed the steps recommended by Vermeulen *et al.* (2019) in developing the guidelines, except for step 11, updating/revising of guidelines. This step was beyond the scope of the current study. The researcher recommended in the implementation guide that the guidelines should be reviewed and evaluated annually should they be implemented.

9.4 LIMITATIONS

This study was small scale since it was a case study focusing on one specific district in KZN, thus the findings from the study cannot be generalised to other settings. However, though not generalisable, the recommendations from the study and the guidelines developed from this study finding could be useful in settings with similar challenges as those facing uThukela District. The findings from the current study could be used as a basis for studies on a much larger scale. Thus, the researcher recommends that a larger study covering the same aspects should be considered as literature confirmed that similar situations prevail in most rural settings, particularly in African countries.

Traditional leaders, religious leaders and community leaders were not included in the study; they may have had information that could have enriched the study. One of the findings in this study, as well as from the literature survey, was that traditional and spiritual healers also provide services to pregnant, birthing and post-delivery women. Adatarara, Strumpher and Ricks (2018) observed that because many traditionally valued practices are prohibited in Western healthcare centres, women who strongly value cultural and traditional approaches to healthcare are not keen to use the Western healthcare centres and instead opt for traditional and spiritual healers. The UN (2015b) acknowledges the importance of partnership and proposes a global partnership for sustainable development, focused on the needs of the poorest and most vulnerable with the participation of all countries, all stakeholders and all people. Thus, collaboration will be most effective if all relevant stakeholders are involved. Rollins (2015) calls this involving everyone who has a 'dog in the fight'.

9.5 RECOMMENDATIONS

The recommendations below do not only focus on facilitation of collaboration but also on other aspects of practice that were identified by participants as requiring attention. The recommendations are therefore in relation to policy formulation, implementation and review, midwifery and TBA practices, education and training, and further research. Proposal for implementation of some of the recommendations is already included as part of the guidelines developed as presented in Chapter 8, especially those related to the practices of midwives and TBAs aimed at facilitating, strengthening and sustaining collaboration not just between midwives and TBAs but also between the mothers and the community.

Policy formulation implementation and review

- It was evident from the findings of the study that the policies of MCWH did not recognise the services provided by the TBAs despite their active role in the community. This group of service providers is available in rural communities, and they face challenges due to lack of recognition, thus this study recommends that policies that include TBA integration in the health sector are developed to ensure smooth collaboration between them and the midwives. This integration will assist in bridging the gap in healthcare delivery in KwaZulu-Natal.
- Already the DoH has existing platforms and projects in the current healthcare system where the TBAs could be included as long as policies and guidelines allow for that. Such platforms/projects include community care giver (CCG), and War on Poverty rooms (referred to as war rooms) which draw from different structures including healthcare representatives, members of the community and relevant stakeholders in the healthcare delivery system. It is recommended that TBAs be included in such community projects so that they form part of the activities and dialogues around healthcare issues.

Midwifery and TBA practices

- The study findings revealed that midwives disrespect TBAs, look down on them and discourage women from utilising their services. Women reported that when the midwives learn that they utilise TBAs they shout and criticise the work by the TBAs. The researcher recommends training for the midwives on aspects such as human dignity and effective communication, acceptance of diverse healthcare practices, and cultural sensitivity which will improve collaboration healthcare delivery in KZN rural communities.
- This study also identified that a number of factors including attitude of midwives and being culturally insensitive were some of the factors that made women prefer services of TBAs over those provided by midwives. It is thus recommended that the importance of values clarification be emphasised to the midwives and that they be encouraged to always provide culturally sensitive care which, according to WHO (2016) incorporates and respects all acceptable traditional and cultural practices of care after they have been tested for safety and efficacy so as to facilitate accessibility of care to all mothers and babies.

Education and training

- Part of the problem that led to the current study was anecdotal evidence as reported by the midwives that a number of pregnant women, especially from rural communities, either do not attend ANC, or only come for delivery, or do not attend postnatal care services. Many of them have been under the care of a TBA and present at the clinic late when they already have had complications related to pregnancy, birth or postpartum. However, there was no evidence of what the midwives had been or were doing to resolve this problem. Midwives are skilled professional service providers who should be able to take initiative to find strategies to resolve problems that prevail

in their practice. There should be more emphasis in training of midwives so that they are able to take initiatives to investigate challenges that prevail in their practice through research so that there is concrete evidence regarding sources of problems, and then takes steps and implement strategies to resolve the identified problems.

- The study also confirmed that the majority of the TBAs were unskilled service providers who provided care based on no formal training but just past experience. Therefore this study recommends that the DoH and the midwives conduct formal training workshops for the TBAs particularly on basic safe practices and identification of problems and danger signs as they care for women and babies so that they can refer to the healthcare clinics timeously to avoid delays in care for women and babies.
- The study identified that there were no platforms and opportunities where the two groups could come together to share best practices or benchmark each other. Thus it is recommended that regular workshops, inservice training sessions and seminars be made available where the two groups can come together and workshop each other.

Further research

- A broader study looking at a greater area is recommended involving other Districts which will assist in acquiring more views where more participants in different categories can be included since this study was done on a smaller scale.

9.6 CONCLUSION

This study aimed to develop guidelines to facilitate collaboration between midwives and TBAs in KZN, South Africa. The research was conducted in the uThukela District, within the Langalibalele Municipality, encompassing six healthcare facilities including a district hospital and clinics and PHC facilities.

Participants included midwives with over six months of experience, TBAs, and women from antenatal care, antenatal wards, and postnatal wards. This was a qualitative case study

The findings revealed lack of collaboration between midwives and TBAs in this district. Women expressed their trust in TBAs, partly because midwives often showed mistrust toward TBAs' work and reprimanded women who sought their services, particularly when complications arose. Despite these challenges, both midwives and TBAs expressed a willingness to collaborate, recognising their shared goal of reducing maternal and neonatal mortality rates in KZN.

As a result of this study, guidelines to facilitate collaboration between midwives and TBAs in KZN were developed. These guidelines aim to foster community unity by involving various stakeholders, ultimately enhancing maternal and neonatal healthcare outcomes. These guidelines are expected to assist in bridging the gap between midwives and TBAs, fostering a collaborative environment that leverages the strengths of both groups. By improving mutual respect and understanding, enhancing communication, and involving the community, the guidelines aim to create a more cohesive and effective maternal and neonatal healthcare system in KZN.

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APPENDICES

Appendix 1: Ethical Clearance



24 March 2023

Ms N P Ndaba
280117 Hhashini Area
Elandskop
Pietermaritzburg
3201

Dear Ms Ndaba

Development of Guidelines to facilitate collaboration between midwives and traditional birth attendants in KwaZulu-Natal, South Africa

Ethical Clearance number IREC 307/22

The DUT-Institutional Research Ethics Committee acknowledges receipt of your gatekeeper permission letter.

Please note that FULL APPROVAL is granted to your research proposal. You may proceed with data collection.

Any adverse events [serious or minor] which occur in connection with this study and/or which may alter its ethical consideration must be reported to the DUT-IREC according to the DUT-IREC Standard Operating Procedures (SOP's).

Please note that any deviations from the approved proposal require the approval of the DUT-IREC as outlined in the DUT-IREC SOP's.

APPENDIX 2a: LETTER TO KZN PROVINCIAL OFFICE

Ms Nompumelelo Pearl Ndaba
Durban University of Technology
15 FJ Sithole Road
Imbali Township
Pietermaritzburg
3201

Dr E Lutge
Manager: Health Research and Knowledge Management Unit
Kwazulu-Natal Department of Health
330 Longmarket Street
Pietermaritzburg
3201

Dear Dr Lutge,

RE: REQUEST FOR APPROVAL TO CONDUCT RESEARCH AT THE KWAZULU-NATAL DEPARTMENT OF HEALTH

I am Ms. Nompumelelo Pearl Ndaba, a doctoral nursing student at the Durban University of Technology. I am writing to request approval to conduct a research study at facilities of the KwaZulu-Natal Department of Health situated at Estcourt District. The research I wish to conduct is titled: Development of Guidelines to facilitate collaboration between midwives and traditional birth attendants in KwaZulu-Natal, South Africa

I am conducting a qualitative study which will include the focus group discussions with midwives and pregnant women in Antenatal care, and women who have delivered in the Post Natal Wards.

I am humbly seeking your consent to conduct interviews at these identified institutions. The interviews will be scheduled with minimum disruption to service delivery and all Covid 19 protocols of the institution will be complied with.

I have provided you with a copy of my proposal which includes copies of the data collection tools, letter of Information, and consent form to be used in the research process, Gate Keeper support letters from the various institutions, as well as a copy of the approval letter which I received from the Institutional Research Ethics Committee (IREC).

If you require any further information, please do not hesitate to contact me on the following contacts: Cell Phone 073 842 8426, email address pearln@dut.ac.za

Thank you for your time and consideration in this matter.

Yours sincerely,

Nompumelelo Pearl Ndaba
Durban University of Technology

Appendix 2b: permission letter from Health Research and Knowledge Management Unit



health

Department:
Health
PROVINCE OF KWAZULU-NATAL

Physical Address: 330 Langalibalele Street, Pietermaritzburg
Postal Address: Private Bag X9051
Tel: 033 395 2805/ 3189/ 3123 Fax: 033 394 3782
Email:
www.kznhealth.gov.za

DIRECTORATE:

Health Research & Knowledge
Management

NHRD Ref: KZ_202303_003

Dear Ms NP Ndaba
(DUT)

Approval of research

1. The research proposal titled '**Development of Guidelines to facilitate collaboration between midwives and traditional birth attendants in KwaZulu-Natal, South Africa**' was reviewed by the KwaZulu-Natal Department of Health (KZN-DoH).

The proposal is hereby **approved** for research to be undertaken at Estcourt Hospital, Injisuthi, Madiba, Wembezi, Connor, Forderville, Cornfields and Hlathikhulu clinic.

2. You are requested to take note of the following:

- a. **Kindly liaise with the facility manager BEFORE your research begins.**

This is to ensure that conditions in the facility are conducive to the conduct of your research. These include, but are not limited to, an assurance that the numbers of patients attending the facility are sufficient to support your sample size requirements, and that the space and physical infrastructure of the facility can accommodate the research team and any additional equipment required for the research.

- b. *All research conducted in KwaZulu-Natal must comply with government regulations relating to Covid-19. These include but are not limited to: regulations concerning social distancing, the wearing of personal protective equipment, and limitations on meetings and social gatherings.*

- c. *Please ensure that you provide your letter of ethics re-certification to this unit, when the current approval expires.*

- d. *Provide an interim progress report and final report (electronic and hard copies) when your research is complete to **HEALTH RESEARCH AND KNOWLEDGE MANAGEMENT, 10-102, PRIVATE BAG X9051, PIETERMARITZBURG, 3200** and e-mail an electronic copy to hrkm@kznhealth.gov.za*

- e. *Please note that the Department of Health shall not be held liable for any injury that occurs as a result of this study.*

For any additional information please contact Mr X. Xaba on 033-395 2805.

Yours Sincerely

Dr E Lutge
Chairperson, Provincial Health Research Committee

Date: 06/03/2023

Fighting Disease, Fighting Poverty, Giving Hope

Appendix 3a: Request for Permission from uThukela District Office

Ms Nompumelelo Pearl Ndaba
Durban University of Technology
15 FJ Sithole Road
Imbali Township
Pietermaritzburg
3201

17 February 2023

The District Director
UThukela District Manager
32 Lyell Street,
Ladysmith
3370

Dear Mrs N. Ndlovu

RE: REQUEST FOR APPROVAL TO CONDUCT RESEARCH AT THE KWAZULU-NATAL DEPARTMENT OF HEALTH

I am Ms. Nompumelelo Pearl Ndaba, a Doctoral nursing student at the Durban University of Technology. I am writing to request approval to conduct a research study at facilities of the KwaZulu-Natal Department of Health situated at Estcourt and Weenen sub-District. The research I wish to conduct is titled: Development of Guidelines to facilitate collaboration between midwives and traditional birth attendants in KwaZulu-Natal, South Africa.

I am conducting a qualitative study which will include the focus group discussions with midwives and pregnant women in Antenatal care, and women who have delivered in the Post Natal Wards. I am humbly seeking your consent to conduct interviews at these identified Institutions. The interviews will be scheduled with minimum disruption to service delivery and all Covid 19 protocols of the institution will be complied with.

I have provided you with a copy of my proposal which includes copies of the data collection tools, letter of Information, and consent form to be used in the research process, Gate Keeper support letters from the various institutions, as well as a copy of the approval letter which I received from the Institutional Research Ethics Committee (IREC).

If you require any further information, please do not hesitate to contact me on the following contacts: Cell Phone 0768130923, email address pearln@dut.ac.za

Thank you for your time and consideration in this matter.

Yours sincerely,

Nompumelelo Pearl Ndaba
Durban University of Technology

Appendix 3b: Permission from uThukela District Office



KWAZULU-NATAL PROVINCE
HEALTH
REPUBLIC OF SOUTH AFRICA

DIRECTORATE:

Physical Address 32 Lyell Street Ladysmith
Postal Address : Private Bag 9958
Tell: 036 631 2202 Fax: 036 631 0530
Email: secretary.uthukela@kznhealth.gov.za www.kznhealth.gov.za

Uthukela District Office

Enquiries: Mrs. N.C Ndhlovu
Date: 20 February 2023

Ms Nompumelelo Pearl Ndaba
Durban University of Technology
15 FJ Sithole Road
Imbali Township
Pietermaritzburg
3201

RE: LETTER OF SUPPORT TO CONDUCT A STUDY AT UTHUKELA DISTRICT

I have pleasure in informing you that permission has been granted to you by the District Office to conduct research/Study on **'Development of Guidelines to facilities' collaboration between midwives and traditional birth attendants in KwaZulu Natal, South Africa.**

Please note the following:

1. Your request received on the 20 February 2023 refers.
2. Please ensure that you adhere to all the policies, procedures, protocols and guidelines of the Department of Health with regards to this research.
3. This research will only commence once this office has received confirmation from the Provincial Health Research Committee in the KZN Department of Health.
4. Please ensure this office is informed before you commence your research.
5. The District Office will not provide any resources for this research.
6. You will be expected to provide feedback on your findings to the District Office.

Thanking you.

MRS NC NDHLOVU
DISTRICT DIRECTOR
UTHUKELA HEALTH DISTRICT

Appendix 4a: Request letter to the CEO Estcourt Hospital & Clinics

Ms Nompumelelo Pearl Ndaba
Durban University of Technology
15 FJ Sithole Road
Imbali Township
Pietermaritzburg
3201
24 March 2023

TO: CHIEF EXECUTIVE OFFICER
Estcourt Hospital
Old Main Road
Estcourt,
Kwazulu Natal
South Africa
3310

Dear Mr Bekenya

RE: REQUEST FOR APPROVAL TO CONDUCT RESEARCH IN YOUR FACILITY

I am Ms. Nompumelelo Pearl Ndaba, a doctoral nursing student at the Durban University of Technology. I am writing to request approval to conduct a research study in the facilities under your leadership (Estcourt Hospital and Clinics) where I will be interviewing the midwives working in all maternity departments as well as women attending antenatal care and post natal care.

The research I wish to conduct is titled: Development of Guidelines to facilitate collaboration between midwives and traditional birth attendants in KwaZulu-Natal, South Africa.

I am conducting a qualitative study which will include the focus group discussions with midwives and pregnant women in Antenatal care, and women who have delivered in the Post Natal Wards. I am humbly seeking your consent to conduct interviews at these identified units. The interviews will be scheduled with minimum disruption to service delivery and all Covid 19 protocols of the institution will be complied with.

I have provided you with a copy of my proposal as well as a copies of approval letters which I received from various relevant departments including the Institutional Research Ethics Committee (IREC).

I would like to schedule a meeting with you and your team if possible where I will explain the purpose of my study and give to you the information letters and consent forms for the staff in your facilities. Thereafter, I will be coming to the facilities the following week to check if there is anyone who has signed consent forms, then start with the interviews.

If you require any further information, please do not hesitate to contact me on the following contacts: Cell Phone 073 842 8426/ 076 813 0923, email address pearlIn@dut.ac.za

Thank you for your time and consideration in this matter.

Yours sincerely,

Nompumelelo Pearl Ndaba
Durban University of Technology

Appendix 4b: Permission letter from the Ceo Estcourt Hospital



KWAZULU-NATAL PROVINCE
HEALTH
REPUBLIC OF SOUTH AFRICA

DIRECTORATE:

CEO'S OFFICE

Private Bag X7058, ESTCOURT, 3310
Physical address, NO. 1 Old main road , 3310 ESTCOURT, 3310
Tel: 036 342 7042 Fax: 036 342 7116

Enquiries: Mr. M.P. Bekenya

Ext: 036 342 7042

05 April 2023

Ms NP Ndaba

DUT

KZN, South Africa

Re: Development of guidelines to facilitate collaboration between midwives and traditional birth attendants in Kwazulu-Natal, South Africa

Dear Ms Ndaba

As the Chief Executive Officer of Estcourt Hospital, I am pleased to support your efforts to conduct a study for the Development of guidelines to facilitate collaboration between midwives and traditional birth attendants in kwazulu-natal, South Africa. The unprecedented challenge presented by these practitioners requires an equally extraordinary response.

Please note that no research will commence at Estcourt Hospital without the full approval of the University of KwaZulu-Natal Biomedical Research Ethics Committee (UKZN BREX) and the KwaZulu-Natal Department of Health's Directorate of Health Research and Knowledge Management.

Ensure that my office as well as the Deputy Nursing Manager is informed before you commence your research and please provide regular feedback on your findings.

Best regards,

Mr. M.P. Bekenya

CEO- Estcourt hospital

Appendix 5: SAMPLE LETTER TO HEALTH INSTITUTION MANAGERS

Durban University of Technology
15 FJ Sithole Road
Imbali Township
Pietermaritzburg
3201
Date:

To:.....
Health Institution Manager
Name and address of institution

Dear Sir/ Madam,

RE: REQUEST FOR APPROVAL TO CONDUCT RESEARCH IN YOUR FACILITY

I am Ms. Nompumelelo Pearl Ndaba, a doctoral nursing student at the Durban University of Technology. I am writing to request approval to conduct a research study in your facility where I will be interviewing the midwives working in all maternity departments. The research I wish to conduct is titled: Development of Guidelines to facilitate collaboration between midwives and traditional birth attendants in KwaZulu-Natal, South Africa.

I am conducting a qualitative study which will include the focus group discussions with midwives and pregnant women in Antenatal care, and women who have delivered in the Post Natal Wards. I am humbly seeking your consent to conduct interviews at these identified units. The interviews will be scheduled with minimum disruption to service delivery and all Covid 19 protocols of the institution will be complied with.

I have provided you with a copy of my proposal which includes copies of the data collection tools, letter of Information, and consent form to be used in the research process, Gate Keeper support letters from the various institutions, as well as a copy of the approval letter which I received from the Institutional Research Ethics Committee (IREC).

I would like to schedule a meeting with you where I will explain the purpose of my study and give to you the information letters and consent forms for the staff in your facility. Thereafter, I will be coming to the facility weekly to check if there is anyone who has signed consent forms, then start with the interviews.

If you require any further information, please do not hesitate to contact me on the following contacts: Cell Phone 073 842 8426, email address pearlN@dut.ac.za

Thank you for your time and consideration in this matter.

Yours sincerely,

Nompumelelo Pearl Ndaba
Durban University of Technology

APPENDIX 6a: LETTER TO THE RELEVANT COMMUNITY LEADERS (ENGLISH)

Ms Nompumelelo Pearl Ndaba
Durban University of Technology
15 FJ Sithole Road
Imbali Township
Pietermaritzburg
3201

To: Mr Ngwenya
Community Leader

Dear Mr Ngwenya

**RE: REQUEST FOR APPROVAL TO CONDUCT RESEARCH IN THE COMMUNITY
– ESTCOURT**

I am Ms. Nompumelelo Pearl Ndaba, a doctoral nursing student at the Durban University of Technology. I am writing to request approval to conduct a research study in the community around Estcourt and Weenen Rural area. The research I wish to conduct is titled: Development of Guidelines to facilitate collaboration between midwives and traditional birth attendants in KwaZulu-Natal, South Africa.

I am conducting a qualitative study which will include the face – to –face interviews with the traditional birth attendants (TBAs) from different communities who are taking care of women from pregnancy to delivery. I am humbly seeking your consent to conduct interviews with the TBAs under your leadership. The interviews will be scheduled according to their availability and will be done at their homes.

I have provided you with a copy of my proposal which includes copies of the data collection tools, letter of Information, and consent form to be used in the research process, Gate Keeper support letters from the various institutions, as well as a copy of the approval letter which I received from the Institutional Research Ethics Committee (IREC).

If you require any further information, please do not hesitate to contact me on the following contacts: Cell Phone 073 842 8426, email address pearlN@dut.ac.za

Thank you for your time and consideration in this matter.

Yours sincerely,

Nompumelelo Pearl Ndaba
Durban University of Technology

APPENDIX 6b: LETTER TO THE RELEVANT COMMUNITY LEADERS (ISIZULU)

Ms Nompumelelo Pearl Ndaba
Durban University of Technology
15 F J Sithole Road
Imbali Township
Pietermaritzburg
3201
Usuku:

Iyaku: Mnumzane uNgwenya
Umholi Womphakathi

Sawubona Mnumzane uNgwenya

ISICELO SEMVUME YOKWENZA UCWANINGO ENDAWENI YASEMTSHEZI NAMAPHETHELO

Ngiwu Ms. Nompumelelo Pearl Ndaba, ofundela ezobudokotela enyuvezi yezobuchwepheshe yaseThekwini (Durban University of Technology). Lesi isicelo semvume yokwenza ucwaningo ezigodini ezahlukahlukene endaweni yaseMtshezi namaphethelo lapho ngingathola khona ababelethisi basemakhaya. Isihloko salolucwaningo sithi: Development of Guidelines to facilitate collaboration between midwives and traditional birth attendants in KwaZulu-Natal, South Africa.

Lolucwaningo ngizobe ngibabuza imibuzo emakhaya abo ngamunye ngamunye ezigodini ezahlukahlukene kulabo babelethisi asebeke basebenza nabesifazane abakhulelwe, ababelethayo nasebebelethile. Ngicela imvume yokuxoxisana nabo bonke ababelethisi abangaphansi kwesifunda sakho. Lolucwaningo luzokwenzeka ngezinsuku nezikhathi abakhululeke ngazo emakhaya abo lapho bezokhululeka khona.

Ngikufakele lapha kulomqingo kunesiphakamiso sesicelo sokwenza lolucwaningo, imibuzo engizobe ngibabuza yona, izincwadi ezibachazela ngalolucwaningo, ifomu lemivume yokungenela ucwaningo, incwadi yemvume ephuma ehovisi lezempilo laseMtshezi Kanye nemvume evela ehovisi elikhulu locwaningo yasenyuvesi.

Uma udinga eminye imininingwane noma unemibuzo mayelana nalolucwaningo, ungabimanqikanqika ukungithinta kulenombolo 073 842 8426, noma ngomqhafazo ku pearl@dut.ac.za

Ngiyabonga kakhulu ngesikhathi sakho.

Yimi ozithobayo,

Nompumelelo Pearl Ndaba
Durban University of Technology

6c: Permission letter from the Ward Councillor - Inkosi Langalibalele Municipality



Inkosi Langalibalele

CCLR SE NGWENYA

INKOSI LANGALIBALELE LOCAL MUNICIPALITY-UMKHANDLU WENDAWO

P.O BOX 15, Estcourt, 3310 Physical Address: Victoria Street,
Tel. No.:036 342 7800.

To: Ms NP Ndaba (Researcher) Durban University of Technology 15 F J Sithole Road Imbali Township Pietermaritzburg 3201	From: Mr S Ngwenya (Ward Councillor) 3310 Victoria Street Estcourt 3310
--	---

14 June 2023

Dear Ms Ndaba

APPROVAL TO CONDUCT RESEARCH WITH TBAs AT INKOSI LANGALIBALELE MUNICIPALITY

I have received your request and the documents attached.

Your request to conduct a research study with the TBAs in Inkosi Langalibalele Municipality in Estcourt on the topic: Development of Guidelines to facilitate collaboration between midwives and traditional birth attendants in KwaZulu-Natal, South Africa has been granted.

Please note the following:

- Your safety in the community is your responsibility.
- Produce this letter to all TBA homes prior to collecting data.
- Our office will not fund you for your research.
- Please give feedback when you have completed your research.

Regards

Mr S. E. Ngwenya

Signature & Stamp



Appendix 7a: Preselection tool for women (English)
IDENTIFICATION INFORMATION

NB: To be filled in by the researcher during the information session

Facility code:

DEMOGRAPHIC INFORMATION

NB: To be completed by the all women at the onset of the information giving session

A: Please ENTER your response in the space provided

Information required	Response
Age in years	
Number of Pregnancies	
Number of Deliveries	
Number of Child Deaths below 1year	

B: Please indicate with a cross (X) against your appropriate response

Ethnicity	African	Coloured	Indian	White
Marital status	Single	Married	Widowed	Divorced
Highest Education Level	None	Primary School	Secondary	Tertiary/University
Employment	Schooling	Unemployed	Employed	Self Employed

Please indicate with 'Yes' or 'No' who provided care for you during the periods in the table below (If other please explain in the space provided below the table)

	TBA	Midwife	Both	Other	All Pregnancies	Some Pregnancies
Pregnancy						
Labour/						
Delivery						
Post delivery						

Other: -----

Appendix 7b: Preselection tool for women (isiZulu)- ITHULUZI LOKUHLUNGA NGESIZULU

IMINININGWANE YOKUHLUKANISA

NB: Igcwaliswa umcwaningi ngesithuba sokunikeza imininingwane

Ikhodi lesikhungo:

IMINININGWANE YOBUNTU

QAPHELA: Igcwaliswa ibobonke abesifazane ngesithuba sokunikezwa kwemininingwane

A: Uyacelwa ukuba ugwalise izmpendulo zakho esikhaleni esinikeziwe

Imininingwane edingekayo	Impendulo
Iminyaka yakho yobudala	
Inani lokukhulelwa	
Inani lokubeletha	
Inani Labantwana abaphilayo	
Inani labantwana ababelethwa sebeshonile	
Inani lezisu ezaphuphuma	

B: Uyacelwa ukuba ukhombise ngophawu lwesiphambano (X) maqondana ne mpendulo evumelana nawe

Ubuzwe	African	Coloured	Indian	White
Isimo somshado	Awushadile	Ushadile	Ungumfelokazi	Wahlukanisile
Izinga eliphezulu lemfundo	Alikho	Amabanga aphantsi	Amabanga aphakeme	Tertiary/Inyuvesi/ikolishi
Ukusebenza	Uyafunda	Awusebenzi	Uyasebenza	Uyazisebenza

C. Uyacelwa ukuba uphendule Yebo noma Qha ukuthi ubani owakunakekela ngalezizikhathi ezisetifuleni elingezansi

	Umbelethisi wasekhaya	Umbelethisi wezempilo	Bobaili	Okunye	Konke ukukhulelwa	Kokunye ukukhulelwa
Ukukhulelwa						
Ukusikwa						
Ukubeletha						
Emmuva kokubeletha						

Okunye:

Appendix 8a: Information letter and consent form for midwives (English)



LETTER OF INFORMATION MIDWIVES

Title of the Research Study: Development of Guidelines to facilitate collaboration between midwives and traditional birth attendants in KwaZulu-Natal, South Africa

Principal Investigator/s/researcher: Ms Nompumelelo Pearl Ndaba

Co-Investigator/s/supervisor/s: Professor T.S.P. Ngxongo and Dr D.G. Sokhela

Brief Introduction and Purpose of the Study: It has been noted that there is slow improvement in maternal healthcare in our country. The existing health workforce shortage, which is mainly caused by prevailing funding constraints, poses challenges to the workforce and service delivery globally and an increased demand for consulting both traditional birth attendants (TBAs) and skilled birth attendants (SBAs) by pregnant women from conception to puerperium for many different reasons in South Africa. (TBAs) are traditional, independent, non-formally trained and community-based providers of care during pregnancy, childbirth and the postnatal period and they are members of the community. Some TBAs are elderly women who are trusted by the community in assisting with delivery and other traditional activities related to pregnancy, birthing and care of women and young children during pregnancy and post-delivery. Some were midwives before and others are Sangomas etc. there is evidence that at times women present late at the clinics and by the time they present themselves its usually too late. We have seen many women in the communities preferring to be seen by TBAs rather than going to the local clinics or Gate clinic in the nearest hospitals and in most cases they only do so when there are complications. These women present themselves late at the healthcare facilities with complications and sometimes the complications are with the mother or the un-born baby. It has been noted that there is no collaboration between the midwives and TBAs. Therefore, this study aims to develop practice guidelines to facilitate collaboration between midwives and traditional birth attendants in KZN, South Africa as a strategy to facilitate achieving Sustainable Development Goals through partnerships.

Greeting: Humble greetings to you and thank you for willing to be part of this study, I really appreciate it. I will be explaining the purpose of this research to you and please feel free to ask questions for clarity.

Introduce yourself to the participant I am Nompumelelo P. Ndaba a Doctoral student in the Nursing Department at the Durban University of Technology.

Invitation to the potential participant I would like to invite you as the person who works closely with these women to kindly participate in this research that I am doing.

What is Research: Research is a systematic investigation into a study of materials and sources done to establish facts and reach new conclusions.

Outline of the Procedures: Information letters were given to the managers to share with you in the institution so that you can start reading about the study. I will then visit each healthcare facility on the day that is agreed upon with the manager for the information giving session with all the midwives. I will bring more information letters for distribution to the midwives who did not receive them from the managers. I will also distribute the consent forms on that day which you can sign if you are willing to participate on this study. I will also leave envelopes for each person to put the consent forms, seal and post in a box that will be left at a strategic point in your facility. The box will be available at the clinic for maximum four weeks and the researcher will return to each clinic weekly to check if any consent forms have been posted into the box. On the day of data collection, I will ask for a convenient time with all the midwives willing to participate then have a group discussion.

Risks or Discomforts to the Participant: There will be no risks to all the participants who participate in the study.

Explain to the participant the reasons he/she may be withdraw from the Study: Participation is voluntary, and you may choose to withdraw from the study at any point. There will be no consequences to you should you wish to withdraw from the study. You can withdraw from the study because of illness, or if you no longer feel comfortable to be part of the study any more etc. I may, under no circumstances, withdraw you from the study but should you wish to terminate as a participant please feel free to notify me at any time with no consequences.

Benefits: This study is focused on development of Guidelines to facilitate collaboration between midwives and traditional birth attendants in KwaZulu-Natal, South Africa. The study will form the basis for further research in this area. The result of the findings will have a positive influence on the Department of Health, community (including TBAs/ patients). The completion of the research could assist and benefit the researcher by obtaining her Doctoral Degree in Nursing.

Inclusion criteria

In this study, participants who meet the following inclusion criteria will be selected to participate are:

- **Healthcare facilities** that are providing comprehensive maternity healthcare services (ANC, Intrapartum and PNC)
- **Registered midwives** who have been involved in the provision of ANC, intrapartum and PNC health services for more than six months
- **Women** attending the selected healthcare institution who are pregnant or are in the post-partum period who have attended TBAs and during pregnancy, labour and/ or post delivery
- **TBAs** offering maternity care to the women of uThukela District

Exclusion criteria

The following will be excluded from the study:

- **Healthcare facilities** not providing at all or not providing comprehensive maternity healthcare services
- **Midwives** who have worked in the maternity department for a period less than 6 months and those not working in maternity units.
- **Women** attending the selected healthcare institution who are pregnant or in the postpartum period who have not utilised services of the TBAs during pregnancy, labour and/ or post-delivery and those who will be beyond the post-partum period post-delivery at the time of recruitment

- **Women who have not attended the TBAs** during pregnancy, labour and/ or post delivery.
- **TBAs** not attending to pregnant women in this district will also be excluded from this study

Remuneration: There will be no remuneration for the participants or the researcher during or on conclusion of the study.

Costs of the Study: You will not be expected to cover any costs of this study

Confidentiality: You will be given respect throughout the study. I will not call you by name during a group discussion and your facility name will also not be revealed but codes will be used instead. Data that will be collected will also be kept confidential. My supervisors and I are the only people who will have access to the data.

Results: I will disseminate the results by Publishing in accredited journals and presenting in conferences. You can also access the findings through publications.

Research-related Injury: I would like to assure you that there will be no research-related injuries or adverse reaction during data collection.

Storage of all electronic and hard copies including tape recordings: The signed consent forms will be stored in a locked cupboard where I will be the only one who has access to. I will store recorded data in a password locked computer and I will be the only one having access to it. These will be kept for five years before they are destroyed.

Persons to contact in the Event of Any Problems or Queries: Ms N.P. Ndaba at pearln@dut.ac.za (Contact No. 073 842 8426)), Supervisor Professor T.S.P. Ngxongo ([Contact No.031 373 2606](tel:0313732606)) Co-Supervisor: Dr D.S Sokhela (Contact No. 031 373 2292) The Institutional Research Ethics Administrator - 031 373 2375.

Complaints can be reported to the Acting Director: Research and Postgraduate Support on researchdirector@dut.ac.za



CONSENT

Full Title of the Study: Development of Guidelines to facilitate collaboration between midwives and traditional birth attendants in KwaZulu-Natal, South Africa

Names of Researcher/s: Ms Nompumelelo Pearl Ndaba

Statement of Agreement to Participate in the Research Study:

- I hereby confirm that I have been informed by the researcher, _____ (name of researcher), about the nature, conduct, benefits and risks of this study - Research Ethics Clearance Number: _____,
- I have also received, read and understood the above written information (Participant Letter of Information) regarding the study.
- I am aware that the results of the study, including personal details regarding my sex, age, date of birth, initials and diagnosis will be anonymously processed into a study report.
- In view of the requirements of research, I agree that the data collected during this study can be processed in a computerised system by the researcher.
- I may, at any stage, without prejudice, withdraw my consent and participation in the study.
- I have had sufficient opportunity to ask questions and (of my own free will) declare myself prepared to participate in the study.
- I understand that significant new findings developed during the course of this research which may relate to my participation will be made available to me.

_____	_____	_____	_____
Full Name of Participant Thumbprint	Date	Time	Signature / Right

I, _____
(name of researcher) herewith confirm that the above participant has been fully
Informed about the nature, conduct and risks of the above study

_____	_____	_____
Full Name of Researcher	Date	Signature
_____	_____	_____
Full Name of Witness (If applicable)	Date	Signature
_____	_____	_____
Full Name of Legal Guardian (If applicable)	Date	Signature

Appendix 8b: Information letter and consent form for women (English)



LETTER OF INFORMATIONWOMEN

Title of the Research Study: Development of Guidelines to facilitate collaboration between midwives and traditional birth attendants in KwaZulu-Natal, South Africa

Principal Investigator/s/researcher: Ms Nompumelelo Pearl Ndaba

Co-Investigator/s/supervisor/s: Professor T.S.P. Ngxongo
Dr D.S. Sokhela

Brief Introduction and Purpose of the Study: It has been noted that there is slow improvement in maternal healthcare in our country. The existing health workforce shortage, which is mainly caused by prevailing funding constraints, poses challenges to the workforce and service delivery globally and an increased demand for consulting both traditional birth attendants (TBAs) and skilled birth attendants (SBAs) by pregnant women from conception to puerperium for many different reasons in South Africa. (TBAs) are traditional, independent, non-formally trained and community-based providers of care during pregnancy, childbirth and the postnatal period and they are members of the community. Some TBAs are elderly women who are trusted by the community in assisting with delivery and other traditional activities related to pregnancy, birthing and care of women and young children during pregnancy and post-delivery. Some were midwives before and others are Sangomas etc. there is evidence that at times women present late at the clinics and by the time they present themselves its usually too late. We have seen many women in the communities preferring to be seen by TBAs rather than going to the local clinics or Gate clinic in the nearest hospitals and in most cases they only do so when there are complications. These women present themselves late at the healthcare facilities with complications and sometimes the complications are with the mother or the un-born baby. It has been noted that there is no collaboration between the midwives and TBAs. Therefore, this study aims to develop practice guidelines to facilitate collaboration between midwives and traditional birth attendants in KZN, South Africa as a strategy to facilitate achieving Sustainable Development Goals through partnerships.

Greeting: Humble greetings to you and thank you for willing to be part of this study, I really appreciate it. I will be explaining the purpose of this research to you and please feel free to ask questions for clarity.

Introduce yourself to the participant I am Nompumelelo P. Ndaba a Doctoral student in the Nursing Department at the Durban University of Technology.

Invitation to the potential participant I would like to invite you as one of the people who has been treated by both the traditional birth attendants and the skilled birth attendants to kindly participate in this research that I am doing.

What is Research: Research is a systematic investigation into a study of materials and sources done to establish facts and reach new conclusions.

Outline of the Procedures: These are the information letters that explains the nature and purpose of my study. I am here today for the information giving session with you. I will also answer all your questions and if you are willing to participate in this study, you will then sign the consent form. I have with me an envelope for you

to put the consent form, seal and post in a box that is provided. We can then start with interview where you are comfortable to sit.

Risks or Discomforts to the Participant: There will be no risks to the participants who participate in the study.

Explain to the participant the reasons he/she may be withdraw from the Study: Participation is voluntary, and you may choose to withdraw from the study at any point. There will be no consequences to you should you wish to withdraw from the study. You can withdraw from the study because of illness, or if you no longer feel comfortable to be part of the study any more etc. I may, under no circumstances, withdraw you from the study but should you wish to terminate as a participant please feel free to notify me at any time with no consequences.

Benefits: This study is focused on Development of Guidelines to facilitate collaboration between midwives and traditional birth attendants in KwaZulu-Natal, South Africa. The study will form the basis for further research in this area. The result of the findings will have a positive influence on the Department of Health, community (including TBAs/ patients). The completion of the research could assist and benefit the researcher by obtaining her Doctoral Degree in Nursing.

Inclusion criteria

In this study, participants who meet the following inclusion criteria will be selected to participate are:

- **Healthcare facilities** that are providing comprehensive maternity healthcare services (ANC, Intrapartum and PNC)
- **Registered midwives** who have been involved in the provision of ANC, intrapartum and PNC health services for more than six months
- **Women** attending the selected healthcare institution who are pregnant or are in the post-partum period who have attended TBAs and during pregnancy, labour and/ or post delivery
- **TBAs** offering maternity care to the women of uThukela District

Exclusion criteria

The following will be excluded from the study:

- **Healthcare facilities** not providing at all or not providing comprehensive maternity healthcare services
- **Midwives** who have worked in the maternity department for a period less than 6 months and those not working in maternity units.
- **Women** attending the selected healthcare institution who are pregnant or in the postpartum period who have not utilised services of the TBAs during pregnancy, labour and/ or post-delivery and those who will be beyond the post-partum period post-delivery at the time of recruitment
- **Women who have not attended the TBAs** during pregnancy, labour and/ or post delivery.
- **TBAs** not attending to pregnant women in this district will also be excluded from this study

Remuneration: There will be no remuneration for the participants or the researcher during or on conclusion of the study.

Costs of the Study: You will not be expected to cover any costs of this study

Confidentiality: You will be given respect throughout the study. I will not call you by name during a group discussion and your facility name will also not be revealed but codes will be used instead. Data that will be collected will also be kept confidential. My supervisors and I are the only people who will have access to the data.

Results: I will disseminate the results by Publishing in accredited journals and presenting in conferences. You can also access the findings through publications.

Research-related Injury: I would like to assure you that there will be no research-related injuries or adverse reaction during data collection.

Storage of all electronic and hard copies including tape recordings: The signed consent forms will be stored in a locked cupboard where I will be the only one who has access to. I will store recorded data in a password locked computer and I will be the only having access to it. These will be kept for five years before they are destroyed.

Persons to contact in the Event of Any Problems or Queries:

Ms N.P. Ndaba at pearln@dut.ac.za (Contact No. 073 842 8426)), Supervisor Professor T.S.P. Ngxongo ([Contact No. 031 3732609](#)) Co-Supervisor: Dr D.S Sokhela (Contact No. 031 373 2292), The Institutional Research Ethics Administrator - 031 373 2375.

Complaints can be reported to the Acting Director: Research and Postgraduate Support on researchdirector@dut.ac.za



CONSENT

Full Title of the Study: Development of Guidelines to facilitate collaboration between midwives and traditional birth attendants in KwaZulu-Natal, South Africa

Names of Researcher/s: Ms Nompumelelo Pearl Ndaba

Statement of Agreement to Participate in the Research Study:

I hereby confirm that I have been informed by the researcher, _____ (name of researcher), about the nature, conduct, benefits and risks of this study - Research Ethics Clearance Number: _____,

I have also received, read and understood the above written information (Participant Letter of Information) regarding the study.

I am aware that the results of the study, including personal details regarding my sex, age, date of birth, initials and diagnosis will be anonymously processed into a study report.

In view of the requirements of research, I agree that the data collected during this study can be processed in a computerised system by the researcher.

I may, at any stage, without prejudice, withdraw my consent and participation in the study.

I have had sufficient opportunity to ask questions and (of my own free will) declare myself prepared to participate in the study.

I understand that significant new findings developed during the course of this research which may relate to my participation will be made available to me.

Full Name of Participant Thumbprint	Date	Time	Signature /	Right

I, _____ (name of researcher) herewith confirm that the above participant has been fully informed about the nature, conduct and risks of the above study.

Full Name of Researcher	Date	Signature

Full Name of Witness (If applicable)	Date	Signature

Full Name of Legal Guardian (If applicable)	Date	Signature

Appendix 8c: Information letter and consent form for women (isiZulu)



INCWADI YOLWAZI YOMAMA

Isihloko socwango: Development of Guidelines to facilitate collaboration between midwives and traditional birth attendants in KwaZulu-Natal, South Africa

Umcwani omkhulu: Ms Nompumelelo Pearl Ndaba

Umluleki omkhulu/ umsi womluleki: Professor T.S.P. Ngxongo kanye no Dr D.S. Sokhela

Incazelo kafushane ngenhloso ngqangi yalolucwango: Kubonakele ukuthi likhula kancane izinga lokunakekeleka kwezempilo komama abakhulelwe. Umnyango wezempilo unenkinga yokushodelwa abahlengikazi kanti kunezinkinga kwezezimali okwenza kungasebenzeki kahle. Kubonakele ukuthi lezinkinga zize zibangele abanye abantu besifazane abafisa ukukhulelwa, abakhulelwe nababelethayo nasebebelethile bancamele ukuya kubabelethisi basemakhaya kunokuya emtholampilo ngenxa yezizathu ezahlukahlukene, loku kuyabonakala emhlabeni wonke jikelele. Ababelethisi basemakhaya bayazisebenza, abaqeqeshiwe nokubelethisa nokunakekela abakhulelwe kanti basebenzela emakhaya emiphakathini. Abanye balababelethisi kungaba omama abakhulile bendawo abathenjwayo ukuthi nasemphakathini ekunakekeleni ngakokone okuqondene nokukhulelwa nokubelethisa. Abanye babo babengabahlengikazi kanti abanye bayizangoma njalonjalo. Kunobufakazi ukuthi abantu besifazane abaningi abakhulelwe baya emtholampilo sekudlule eside isikhathi ngoba bencamela ukubonwa ababelethisi basemakhaya kunokuya emtholampilo kanti isikhathi esiningi baya emtholampilo ngoba izimpilo zabo noma ezabantwana sezisengozini. Sekubonakele ukuthi akukho ukusebenza ngokubambisana phakathi kwabahlengikazi Kanye nababelethisi basemakhaya. Ngakho-ke, inhloso yalolucwango ukuzama ukuthuthukisa umhlahlandlela wokusiza kube nokubambisana/ ukusebenzisana phakathi kwabahlengikazi Kanye nababelethisi basemakhaya esifundazweni sakwaZulu-Natal.

Isibingelelo: Ngibanibingelela ngokuzithoba futhi ngiyabonga ukuthi nizimisele ukuba ingxenye yalolucwango, ngiyabonga kakhulu. Ngizonichazela kabanzi ngenhlosongqangi yalolucwango, nikhululeke ukubuza imibuzo ukuze nicaciseleke.

Ukuzazisa kwabazongenela ucwango: Mina ngingu Nompumelelo P. Ndaba ngifundela ukuba udokotela wobuhlangikazi eNyuvesi yobuchwepheshe yaseThekwini.

Isimemo salabo okungenzeka bahlanganyele kucwango: Ngifisa ukukumema ukuba ube yingxenye yabantu abazongena kuloluhlelo njengoba usuke wahlolwa abahlengikazi kanye nababelethisi basemakhaya

Yini ucwango: Ucwango uhlelo oluhlelekile olwenzelwa ukuthola amaqiniso angampela bese ngifinyelela esiphethweni esisha.

Uhlaka lwenqubo lwalolucwango: Lezi izincwadi ezichaza kafushane ngohlobo lwalolucwango engilwenzayo. Njengoba ngilapha namhlanje ukuzonichazela ngalolucwango ngiphendule nemibuzo lapho ningaqondi khona. Kulabo abafisa ukungena kuloluhlelo, nizobe senisayina ifomu lesivumelwano ukuthi niyavuma ukuba yingxenye yocwango. Ngiphethe izimvilophu engizoninika zona ukuze uma senigcwalisile ifomu nilifake

phakathi niyivale bese nifaka ebhokisini engifike nalo. Emvakwalokho singabe sesiqala ngemibuzo yocwanningo khona lapha kulendlu esinikezwe yona ekhululekile.

Ubungozi nokungaphatheki kahle kwabazongenela ucwanningo: Abukho ubungozi obunganivelela njengoba nizongenela lolucwanningo.

Incazelo kwabazongenela ucwanningo ukuthi ikuphi okungenza bangabe besaqhubeka nocwanningo lungakapheli: Ukungenela lolucwanningo ukwenza ngokuzithandela futhi ungayeka noma ngabe inini futhi akukhompumela omubi ozokwehlela uma uyeka uzoqhubeka unakekeleke ngendlela kulomtholampilo. Ungayeka kulolucwanningo ngenxa yokugula, mawuzwa ungasakhululekile ukuba ingxenye yocwanningo, njalonzalo. Mina anginayo imvume yokukuyekisa ngaphandle uma kunesimo esiphooqayo kodwa uma uzizwa usufuna ukuyeka, ukhululeke ungazise noma ngabe inini.

Inzuzo: lolucwanningo lwenzelwa ukusiza kwakheke ubudlelwane nokusebenzisana phakathi kwabahlengikazi kanye nababelethisi basemakhaya ngokwenza umhlahlandlela ozosiza lobudlelwano. Lolucwanningo luzovulela nabanye abacwanningi ukuba baqhubeke bacwanninge kuwona lomkhakha. Imiphumela yalololucwanningo luzosiza nasemnyangweni wezempilo kanye nomphakathi (okubalwa labo abakhulelwe Kanye nababelethisi basemakhaya). Uma seluphelile lolucwanningo luzongisiza nami ngizuze iziqu zami zobudokotela wamanesi.

Abazokwazi ukungenela lolucwanningo:

Laba abalandelayo ibona abazokwazi ukungenela lolucwanningo:

- **Imitholampilo** enika usizo olugcwele kusukela kwabakhulelwe kuze kube bayabeletha
- **Ababelethisi** asebesebenze lapho kuxukuzwa khona, ababelethisayo kanye nabanakekela asebebelethile izinyanga eziyisithupha nangaphezulu
- **Omama** abakhulelwe, nasebebelethile asebeke babona ababelethisi basekhaya ngesikhathi bekhulelwe, noma ababelethiswe yibo.
- **Ababelethisi basekhaya** abanikeza usizo kulabo abakhulelwe baze babelethe kumaspala wasoThukela.

Abangeke bakwazi ukungenela lolucwanningo:

Laba abalandelayo ngeke bakwazi ukungenela lolucwanningo:

- **Imitholampilo** enganikezi usizo olugcwele kusukela kwabakhulelwe kuze kube bayabeletha
- **Ababelethisi** asebesebenze lapho kuxukuzwa khona, ababelethisayo kanye nabanakekela asebebelethile izinyanga ezingaphansi kweziyisithupha kanye nalabo abangasebenzi kulamagumbi okuxukuzwa, ukubelethisa kanye nasebebelethile
- **Abesimame** abahambela lemitholampilo kodwa abangakhulelwe, futhi nabangakaze babonane nababelethisi basekhaya ngesikhathi bekhulelwe noma bebeletha.
- **Abesimame** abangakaze babonwe ababelethisi basekhaya ngenkathi bekhulelwe noma bebeletha.
- **Ababelethisi basekhaya** abangasebenzi nabesifazane abakhulelwe noma ababelethayo kulomasipala abazokwazi ukungenela lolucwanningo.

Inkokhelo: Akekho ozokhokhelwa nozokhokhela omunye kulolucwanningo luze luphele.

Inani locwanningo: Awulindelekile ukuba ukhokhe kulolucwanningo.

Imfihlo: Uzonikwa inhlonipho kuze kube sekugcineni. Angeke ngikubize ngegama lakho ngesikhathi sixoxa kanye nomtholampilo wakho ngeke ubhalwe ngegama lawo, uzonikwa inhlonipho kuze kube sekugcineni. Akukho lapho uzobizwa khona ngegama lakho ngesikhathi sixoxa sihlange nabanye Kanye nomtholampilo wakho nawo ngeke ngiwubiza ngegama kunaloko ngizosebenzisa amakhodi. Ulwazi engizoluqoqa nalo ngizolubeka ngokuyimfihlo. Lonke lolu lwazi luzokwaziwa yimina kanye nabaluleki bami kuphela ukuthi lugcinwephi.

Imiphumela: Imiphumela ngizoyikhipha ngokubhala kumajenali amakhulu asemthethweni ngiphinde ngiyethule kwizingqungquthela ezinkulu. Nawe ungayithola lemiphumela kulezindawo engizibalile.

Ukulimala okuqondene nalolucwaningo: Ngicela ukukuqinisekisa ukuthi akukho ukulimala okuqondene nalolucwaningo okuzokwehlela ngesikhathi ngiqoqa ulwazi.

Silubekaphi ulwazi oluqoshiwekhompyutha, olubhaliwe phansi Kanye noluqoshiwe: amafomu esiⁱvumelwano asayiniwe azogcinwa ekhabetheeni elikhiywayo futhi imina ngedwa engizoba nokhiye wokuvula. Ulwazi olukwikhompyutha noluqoshiwe lona luzogcinwa kwikhompyutha ezoba nezinombolo zokuyikhiya nayo le izobe yaziwa yimina kuphela. Konke loku kuzogcinwa iminyaka emihlanu kuphela ngaphambi kokuba ngikulahle.

Laba abalandelayo abantu ongabathinta uma unemibuzo noma ufuna ukucaciseleka:

Ms N.P. Ndaba at pearln@dut.ac.za (Inombolo yocingo. 073 842 8426), Supervisor Professor T.S.P. Ngxongo ([Inombolo yocingo.031 3732609](tel:0313732609)), Co-Supervisor: Dr D.S Sokhela (Inombolo yocingo. 031 373 2292
Ihovisi locwaningo (Inombolo yocingo - 031 373 2375)

Izikhalo zona zingabikwa ehovisi likangqongqoshe obambile wezokucwaninga eNyuvesi:
researchdirector@dut.ac.za.



IFOMU LESIVUMELWANO

Isihloko esigcwele socwango: Development of Guidelines to facilitate collaboration between midwives and traditional birth attendants in KwaZulu-Natal, South Africa

Igama lomcwani: Ms Nompumelelo Pearl Ndaba

Isitatimende sesivumelwano ukungenela ucwango:

- Ngियाqinisekisa ukuthi mina ngazisiwe umcwani, _____ (igama lomcwani), mayelana nohlobo, indlela yokwenza, umhlomulo kanye nobungozi obungenzeka balolucwango – Inombolo eqinisekisa imvume yocwango:
 - ngiphinde ngathola, ngafunda futhi ngayiqonda incwadi engenhla engazisa ngalolucwango.
- ngiyaqonda ukuthi imiphumela yalolucwango, imininingwane yami emayelana nobulili bami, iminyaka, usuku lokuzalwa iziqalo zamagama ami kanye nezifo zami kuzofihlwa kungavezwa kulolucwango.
- Mayelana nezidingo zalolucwango, ngiyavuma ukuthi ulwazi oluqoshwe ngenkathi kwenziwa lolucwango umcwani angalufaka kuhlelo lekhompyutha.
 - ngivumelekile ukuhoxa noma yini ngaphandle kokubandlululwa, ngikhiphe nefomu lami lesivumelwano kulolucwango.
- Ngilitholile ithuba nesikhathi esanele sokubuza imibuzo (ngokungaphoqwa muntu) ngiyavuma futhi ngizimisele ukuba ingxenye yalolucwango.
 - Ngiyaqonda ukuthi kungaba khona okubalulekile okutholakayo lolucwango lusaqhubeka oluqondene nokungenela lolucwango, ngizokwaziswa ngakho.

Amagama akho aphelele

Usuku

Isikhathi

Sayina/ Faka isithupha

Mina, _____

(igama lomcwani) ngiyaqinisekisa ukuthi lo ozongenela ucwango wazisiwe ngokwanele ngohlobo locwango, indlela oluzokwenziwa ngayo kanye nobungozi obungavela.

Igama lomcwani.

Usuku

Sayina

Igama likafakazi (uma ekhona)

Usuku

Sayina

**Igama lomphathi
(uma kunesidingo)**

Usuku

Sayina



LETTER OF INFORMATION TBAs

Title of the Research Study: Development of Guidelines to facilitate collaboration between midwives and traditional birth attendants in KwaZulu-Natal, South Africa

Principal Investigator/s/researcher: Ms Nompumelelo Pearl Ndaba

Co-Investigator/s/supervisor/s: Professor T.S.P. Ngxongo and Dr D.G. Sokhela

Brief Introduction and Purpose of the Study: It has been noted that there is slow improvement in maternal healthcare in our country. The existing health workforce shortage, which is mainly caused by prevailing funding constraints, poses challenges to the workforce and service delivery globally and an increased demand for consulting both traditional birth attendants (TBAs) and skilled birth attendants (SBAs) by pregnant women from conception to puerperium for many different reasons in South Africa. (TBAs) are traditional, independent, non-formally trained and community-based providers of care during pregnancy, childbirth and the postnatal period and they are members of the community. Some TBAs are elderly women who are trusted by the community in assisting with delivery and other traditional activities related to pregnancy, birthing and care of women and young children during pregnancy and post-delivery. Some were midwives before and others are Sangomas etc. there is evidence that at times women present late at the clinics and by the time they present themselves its usually too late. We have seen many women in the communities preferring to be seen by TBAs rather than going to the local clinics or Gate clinic in the nearest hospitals and in most cases they only do so when there are complications. These women present themselves late at the healthcare facilities with complications and sometimes the complications are with the mother or the un-born baby. It has been noted that there is no collaboration between the midwives and TBAs. Therefore, this study aims to develop practice guidelines to facilitate collaboration between midwives and traditional birth attendants in KZN, South Africa as a strategy to facilitate achieving Sustainable Development Goals through partnerships.

Greeting: Humble greetings to you and thank you for willing to be part of this study, I really appreciate it. I will be explaining the purpose of this research to you and please feel free to ask questions for clarity.

Introduce yourself to the participant I am Nompumelelo P. Ndaba a Doctoral student in the Nursing Department at the Durban University of Technology.

Invitation to the potential participant I would like to invite you as the person who works closely with these women to kindly participate in this research that I am doing.

What is Research: Research is a systematic investigation into a study of materials and sources done to establish facts and reach new conclusions.

Outline of the Procedures: Information letters were given to the managers to share with you in the institution so that you can start reading about the study. I will then visit each healthcare facility on the day that is agreed upon with the manager for the information giving session with all the midwives. I will bring more information letters for distribution to the midwives who did not receive them from the managers. I will also distribute the consent forms on that day which you can sign if you are willing to participate on this study. I will also leave envelopes for each

person to put the consent forms, seal and post in a box that will be left at a strategic point in your facility. The box will be available at the clinic for maximum four weeks and the researcher will return to each clinic weekly to check if any consent forms have been posted into the box. On the day of data collection, I will ask for a convenient time with all the midwives willing to participate then have a group discussion.

Risks or Discomforts to the Participant: There will be no risks to all the participants who participate in the study.

Explain to the participant the reasons he/she may be withdraw from the Study: Participation is voluntary, and you may choose to withdraw from the study at any point. There will be no consequences to you should you wish to withdraw from the study. You can withdraw from the study because of illness, or if you no longer feel comfortable to be part of the study any more etc. I may, under no circumstances, withdraw you from the study but should you wish to terminate as a participant please feel free to notify me at any time with no consequences.

Benefits: This study is focused on development of Guidelines to facilitate collaboration between midwives and traditional birth attendants in KwaZulu-Natal, South Africa. The study will form the basis for further research in this area. The result of the findings will have a positive influence on the Department of Health, community (including TBAs/ patients). The completion of the research could assist and benefit the researcher by obtaining her Doctoral Degree in Nursing.

Inclusion criteria

In this study, participants who meet the following inclusion criteria will be selected to participate are:

- **Healthcare facilities** that are providing comprehensive maternity healthcare services (ANC, Intrapartum and PNC)
- **Registered midwives** who have been involved in the provision of ANC, intrapartum and PNC health services for more than six months
- **Women** attending the selected healthcare institution who are pregnant or are in the post-partum period who have attended TBAs and during pregnancy, labour and/ or post delivery
- **TBAs** offering maternity care to the women of uThukela District

Exclusion criteria

The following will be excluded from the study:

- **Healthcare facilities** not providing at all or not providing comprehensive maternity healthcare services
- **Midwives** who have worked in the maternity department for a period less than 6 months and those not working in maternity units.
- **Women** attending the selected healthcare institution who are pregnant or in the postpartum period who have not utilised services of the TBAs during pregnancy, labour and/ or post-delivery and those who will be beyond the post-partum period post-delivery at the time of recruitment
- **Women who have not attended the TBAs** during pregnancy, labour and/ or post delivery.
- **TBAs** not attending to pregnant women in this district will also be excluded from this study

Remuneration: There will be no remuneration for the participants or the researcher during or on conclusion of the study.

Costs of the Study: You will not be expected to cover any costs of this study

Confidentiality: You will be given respect throughout the study. I will not call you by name during a group discussion and your facility name will also not be revealed but codes will be used instead. Data that will be collected will also be kept confidential. My supervisors and I are the only people who will have access to the data.

Results: I will disseminate the results by Publishing in accredited journals and presenting in conferences. You can also access the findings through publications.

Research-related Injury: I would like to assure you that there will be no research-related injuries or adverse reaction during data collection.

Storage of all electronic and hard copies including tape recordings: The signed consent forms will be stored in a locked cupboard where I will be the only one who has access to. I will store recorded data in a password locked computer and I will be the only one having access to it. These will be kept for five years before they are destroyed.

Persons to contact in the Event of Any Problems or Queries:

Ms N.P. Ndaba at pearln@dut.ac.za (Contact No. 073 842 8426), Supervisor Professor.T.S.P. Ngxongo ([Contact No. 031 3732609](#)), Co-Supervisor: Dr D.S Sokhela (Contact No. 031 373 2292), The Institutional Research Ethics Administrator - 031 373 2375.

Complaints can be reported to the Acting Director: Research and Postgraduate Support on researchdirector@dut.ac.za



CONSENT

Full Title of the Study: Development of Guidelines to facilitate collaboration between midwives and traditional birth attendants in KwaZulu-Natal, South Africa

Names of Researcher/s: Ms Nompumelelo Pearl Ndaba

Statement of Agreement to Participate in the Research Study:

- I hereby confirm that I have been informed by the researcher, _____ (name of researcher), about the nature, conduct, benefits and risks of this study - Research Ethics Clearance Number: _____,
- I have also received, read and understood the above written information (Participant Letter of Information) regarding the study.
- I am aware that the results of the study, including personal details regarding my sex, age, date of birth, initials and diagnosis will be anonymously processed into a study report.
- In view of the requirements of research, I agree that the data collected during this study can be processed in a computerised system by the researcher.
 - I may, at any stage, without prejudice, withdraw my consent and participation in the study.
- I have had sufficient opportunity to ask questions and (of my own free will) declare myself prepared to participate in the study.
 - I understand that significant new findings developed during the course of this research which may relate to my participation will be made available to me.

_____	_____	_____	_____
Full Name of Participant Thumbprint	Date	Time	Signature / Right

I, _____
(name of researcher) herewith confirm that the above participant has been fully informed about the nature, conduct and risks of the above study.

_____	_____	_____
Full Name of Researcher	Date	Signature

_____	_____	_____
Full Name of Witness (If applicable)	Date	Signature

_____	_____	_____
Full Name of Legal Guardian (If applicable)	Date	Signature

Appendix 8e: Information letter and consent form for TBAs (Isizulu)



INCWADI YOLWAZI YABABELETHISI BASEMAKHAYA

Isihloko socwaningo: Development of Guidelines to facilitate collaboration between midwives and traditional birth attendants in KwaZulu-Natal, South Africa

Umcwaningi omkhulu: Ms Nompumelelo Pearl Ndaba

Umluleki omkhulu/ umsizi womluleki: Professor T.S.P. Ngxongo Kanye no Dr D.S. Sokhela

Incazelo kafushane ngenhloso ngqangi yalolucwaningo: Kobonakele ukuthi Iikhula kancane izinga lokunakekeleka kwezempilo komama abakhulelwe. Umnyango wezempilo unenkinga yokushodelwa abahlengikazi kanti kunezinkinga kwezizimali okwenza kungasebenzeki kahle. Kubonakele ukuthi lezinkinga zize zibangele abanye abantu besifazane abafisa ukukhulelwa, abakhulelwe nababelethayo nasebebelethile bancamele ukuya kubabelethisi basemakhaya kunokuya emtholampilo ngenxa yezizathu ezahlukahlukene, loku kuyabonakala emhlabeni wonke jikelele. Ababelethisi basemakhaya bayazisebenza, abaqeqeshiwe nokubelethisa nokunakekela abakhulelwe kanti basebenzela emakhaya emphakathini. Abanye balababelethisi kungaba omama abakhulile bendawo abathenjwayo ukuthi nasempakathini ekunakekeleni ngakokonke okuqondene nokukhulelwa nokubelethisa. Abanye babo babengabahlengikazi kanti abanye bayizangoma njalonjalo. Kunobufakazi ukuthi abantu besifazane abaningi abakhulelwe baya emtholampilo sekudlule eside isikhathi ngoba bencamela ukubonwa ababelethisi basemakhaya kunokuya emtholampilo kanti isikhathi esiningi baya emtholampilo ngoba izimpilo zabo noma ezabantwana sezisengozini. Sekubonakele ukuthi akukho ukusebenza ngokubambisana phakathi kwabahlengikazi kanye nababelethisi basemakhaya. Ngakho-ke, inhloso yalolucwaningo ukuzama ukuthuthukisa umhlahlandlela wokusiza kube nokubambisana/ ukusebenzisana phakathi kwabahlengikazi kanye nababelethisi basemakhaya esifundazweni sakwaZulu-Natal

Isibingelelo: Ngibanibingelela ngokuzithoba futhi ngiyabonga ukuthi nizimisele ukuba ingxenye yalolucwaningo, ngiya bonga kakhulu. Ngizonichazela kabanzi ngehlosongqangi yalolucwaningo, nikhululeke ukubuza imibuzo ukuze nicaciseleke.

Ukuzazisa kwabazongenela ucwaningo: Mina ngingu Nompumelelo P. Ndaba ngifundela ukuba udokotela wobuhlangikazi eNyuvesi yobuchwepheshe yaseThekwini.

Isimemo salabo okungenzeka bahlanganyele kucwaningo: Ngifisa ukukumema ukuba ube yingxenye yabantu abazongena kuloluhlelo njengoba uwumuntu osebenzisana nabo omama.

Yini ucwaningo: Ucwaningo uhlelo oluhlelekile olwenzelwa ukuthola amaqiniso angampela bese ngifinyelela esiphethweni esisha.

Uhlaka lwenqubo lwalolucwaningo: Lezi izincwadi ezichaza kafushane ngohlobo lwalolucwaningo engilwenzayo. Njengoba ngilapha namhlanje ukuzonichazela ngalolucwaningo ngiphendule nemibuzo lapho Ungaqondi khona. Uma ufisa ukungena kuloluhlelo, uzobe ususayina ifomu lesivumelwano ukuthi uyavuma ukuba yingxenye yocwaningo. Ngiphethe imvilophu engizokunika yona ukuze uma usugcwalisile ifomu ulilifake phakathi

uyivale bese ufaka ebhokisini engifike nalo. Emvakwalokho singabe sesiqala ngemibuzo yocwaningo lapho uzozizwa khululekile khona.

Ubungozi nokungaphatheki kahle kwabazongenela ucwaningo: Abukho ubungozi obungakuvelela njengoba uzongenela lolucwaningo.

Incazelo kwabazongenela ucwaningo ukuthi ikuphi okungenza bangabe besaqhubeka nocwaningo lungakapheli: Ukungenela lolucwaningo ukwenza ngokuzithandela futhi ungayeka noma ngabe inini futhi akukhompumela omubi ozokwehlela uma uyeka uzoqhubeka unakekeleke ngendlela kulomtholampilo. Ungayeka kulolucwaningo ngenxa yokugula, mawuzwa ungasakhululekile ukuba ingxenye yocwaningo, njalonzalo. Mina anginayo imvume yokukuyekisa ngaphandle uma kunesimo esiphooqayo kodwa uma uzizwa usufuna ukuyeka, ukhululeke ungazise noma ngabe inini.

lnzuzo: lolucwaningo lwenzelwa ukusiza kwakheke ubudlelwane nokusebenzisana phakathi kwabahlengikazi Kanye nababelethisi basemakhaya ngokwenza umhlahlandlela ozosiza lobudlelwano. Lolucwaningo luzovulela nabanye abacwaningi ukuba baqhubeke bacwaninge kuwona lomkhakha. Imiphumela yalololucwaningo luzosiza nasemnyangweni wezempilo kanye nomphakathi (okubalwa labo abakhulelwe Kanye nababelethisi basemakhaya). Uma seluphelile lolucwaningo luzongisiza nam! ngizuze iziqu zami zobudokotela wamanesi.

Abazokwazi ukungenela lolucwaningo:

Laba abalandelayo ibona abazokwazi ukungenela lolucwaningo:

- **Imitholampilo** enika usizo olugcwele kusukela kwabakhulelwe kuze kube bayabeletha
- **Ababelethisi** asebesebenze lapho kuxukuzwa khona, ababelethisayo kanye nabanakekela asebebelethile izinyanga eziyisithupha nangaphezulu
- **Omama** abakhulelwe, nasebebelethile asebeke babona ababelethisi basekhaya ngesikhathi bekhulelwe, noma ababelethiswe yibo.
- **Ababelethisi basekhaya** abanikeza usizo kulabo abakhulelwe baze babelethe kumaspala wasoThukela.

Abangeke bakwazi ukungenela lolucwaningo:

Laba abalandelayo ngeke bakwazi ukungenela lolucwaningo:

- **Imitholampilo** enganikezi usizo olugcwele kusukela kwabakhulelwe kuze kube bayabeletha
- **Ababelethisi** asebesebenze lapho kuxukuzwa khona, ababelethisayo kanye nabanakekela asebebelethile izinyanga ezingaphansi kweziyisithupha kanye nalabo abangasebenzi kulamagumbi okuxukuzwa, ukubelethisa kanye nasebebelethile
- **Abesimame** abahambela lemitholampilo kodwa abangakhulelwe, futhi nabangakaze babonane nababelethisi basekhaya ngesikhathi bekhulelwe noma bebeletha.
- **Abesimame** abangakaze babonwe ababelethisi basekhaya ngenkathi bekhulelwe noma bebeletha.
- **Ababelethisi basekhaya** abangasebenzi nabesifazane abakhulelwe noma ababelethayo kulomasipala abazukwazi ukungenela lolucwaningo.

Inkokhelo: Akekho ozokhokhelwa nozokhokhela omunye kulolucwaningo luze luphele.

Inani locwaningo: Awulindelekile ukuba ukhokhe kulolucwaningo

Imfihlo: Uzonikwa inhlonipho kuze kube sekugcineni. Angeke ngikubize ngegama lakho ngesikhathi sixoxa Kanye nomtholampilo wakho ngeke ubhalwe ngegama lawo. Uzonikwa inhlonipho kuze kube sekugcineni. Akukho lapho uzobizwa khona ngegama lakho ngesikhathi sixoxa sihlange nabanye Kanye nomtholampilo wakho nawo ngeke ngiwubize ngegama kunaloko ngizosebenzisa amakhodi. Ulwazi engizoluqoqa nalo ngizolubeka ngokuyimfihlo. Lonke lolu lwazi luzokwaziwa yimina kanye nabaluleki bami kuphela ukuthi lugcinwephi.

Imiphumela: Imiphumela ngizoyikhipha ngokubhala kumajenali amakhulu asemthethweni ngiphinde ngiyethule kwizingqungquthela ezinkulu. Nawe ungayithola lemiphumela kulezindawo engizibalile.

Ukulimala okuqondene nalolucwaningo: Ngicela ukukuqinisekisa ukuthi akukho ukulimala okuqondene nalolucwaningo okuzokwehlela ngesikhathi ngiqoqa ulwazi.

Silubekaphi ulwazi oluqoshiwe kwikhompyutha, olubhaliwe phansi Kanye noluqoshiwe: amafomu esivumelwano asayiniwe azogcinwa ekhabetheni elikhwayo futhi imina ngedwa engizoba nokhiye wokuvula. Ulwazi olukwikhompyutha noluqoshiwe lona luzokwikhompyutha ezoba nezinombolo zokuyikhiya nayo le izobe yaziwa yimina kuphela. Konke loku kuzogcinwa iminyaka emihlanu kuphela ngaphambi kokuba ngikulahle.

Lababalandelayo abantu ongabathinta uma unemibuzo noma ufuna ukucaciseleka:

Ms N.P. Ndaba at pearln@dut.ac.za (Inombolo yocingo. 073 842 8426), Supervisor Professor T.S.P. Ngxongo (Inombolo yocingo 031 3732609), Co-Supervisor: Dr D.S Sokhela (Inombolo yocingo. 031 373 2292)
Ihovisi locwaningo (Inombolo yocingo - 031 373 2375).

Izikhalo zona zingabikwa ehovisi likangqongqoshe obambile wezokucwaninga eNyuvesi:
researchdirector@dut.ac.za.

Appendix 9b: Interview guide for women (English)

IDENTIFICATION INFORMATION

NB: To be filled in by the researcher during the interview session

Facility code:

Participant code:

Date:

SECTION B: INTERVIEW QUESTIONS

GRAND TOUR STATEMENT

Please share with me your experiences regarding collaborations between midwives and TBAs

PROBING QUESTION 1

1. What collaborations do you know of that are available in this area between TBAs and midwives?
2. Would you appreciate if there were collaboration between the TBAs and midwives?
3. What would you like to see happen in the collaboration between midwives and TBAs?
4. How would these collaborations benefit you and other women in this area?

*Further probing will be done for each main question to clarify or get more information depending on responses to the each main question.***Appendix 9c: Interview guide for women (isiZulu)**

Appendix 9c: Interview guide for women (usiZuli)

IMININGWANE YOKUHLUKANISA

NB: Izogcwaliswa umcwaningi uma esebuza imibuzo

Ikhodi yendawo:

Ikhodi yomhlanganyeli:

Ususku:.....

IMIBUZO YOCWANINGO

UMBUZO OMKHULU WESINGENISO

Ngabe zikhona izinhlelo ozaziyo kulendawo zokusebenzisana ngokubambisana phakathi kwababelethisi bezempilo kanye nababelethisi bomdabu?

Imibuzo yokuphenya

1. Iziphi izindlela ozaziyo zokuhlanganela phakathi kwababelethisi bezempilo kanye nababelethisi bomdabu?
2. Ungakuthokozela ukubakhona kwezindlela zokuhlanganela phakathi kwababelethisi bezempilo kanye nababelethisi bomdabu?
3. Yini ongathanda ukuyibona yenzeka ekuhlangalenyeni kwababelethisi bezempilo kanye nababelethisi bomdabu?
4. Ngabe kungabasiza kanjani abesifazane ukubakhona kokuhlanganyela phakathi kwababelethisi bezempilo kanye nababelethisi bomdabu?

Imibuzo yokulandelela izobuzwa ukulandela imibuzo emikhulu ukucacisa noma ukuthola eminye iminingwane kuye ngezimpendulo kumbuzo nombuzo.

Appendix 9d: Interview guide for TBAS (English)

IDENTIFICATION INFORMATION

NB: To be filled in by the researcher during the interview session

Participant code: **Date:**

DEMOGRAPHIC INFORMATION

NB: To be completed by the interviewee at the onset of the interview session

Please indicate with a tick (✓) against the appropriate column for all the statements below

	<u>Years</u>
Age in years	
No of years as a Traditional Birth attendant	

Information	Responses			
	Gender	Male	Female	Other
Ethnicity	African	Coloured	Indian	White
Qualifications	Midwife	Nurse	Not a Nurse	

SECTION B: INTERVIEW QUESTIONS

Grandtour statement

Please share with me your experiences regarding collaborations between midwives and TBAs

Probing questions

1. What collaborations are available in this area between the TBAs and midwives?
2. What are your Perceptions regarding collaboration between TBAs and midwives?
3. How does the non-existence/existence of collaboration influence care for women?
4. What are other TBAs' views regarding collaboration with midwives?
5. In your opinion what is the midwives' position regarding collaboration with TBAs?
6. In your opinion how feasible is it to have collaboration between TBA and midwives?
7. In your opinion what factors could facilitate collaboration between TBAs and midwives?

Further probing will be done for each question to clarify or get more information depending on responses to the each main question.

Appendix 9e: Interview guide for TBAs (isiZulu)

IMININGWANE YOKUHLUKANISA

NB: Izogcwaliswa umcwaningi uma esebuzwa imibuzo

Ikhodi yendawo: Ikhodi yomhlanganyeli: Ususku:

IMININGWANE YOBUNTU

*NB: Izogcwaliswa ongenele ucwaningouma ngaphambi kokukuqalwa ukuxoxisana
Ngicela ukhombise ngaloluphawu (✓) eduze kwekholomu elinezitatimende ngezansi*

Iminingwane	Impendulo
Inani leminyaka yakho yobudala	
Inani leminyaka usebenza njengombelethisi wendabuko	

Iminingwane	Izipendulo			
Ubulili	Owesilisa	Owesifazane	Okunye	
Ubuzwe	Owomdabu	Ikaladi	Indiya	Omhlophe
Uqeqesho	Umbelethisi wezempilo	Umhlengikazi	Angisiye umhlengikazi	

ISIGABA B: IMIBUZO YOCWANINGO

Umusho omkhulu wesingeniso

Ngicela ungixoxele ngolwazi lwakho ngezinhlelo zokuhlanganyela ezikhona kulendawo phakathi kwababelethisi bezempilo nababelethisi bendabuko?

Imibuzo yokuphenya

1. Iziphi izindlela zokuhlanganela ezikhona kulendawo phakathi kwababelethisi bendabuko nalababelethisi?
2. Luthini uvo lakho ngokuhlanganela phakathi phakathi kwababelethisi bendabuko nalababelethisi?
3. Kuphazamisa kanjani ukunakekelwa kwabesifazane ukungabikhona kokuhlanganyela phakathi kwababelethisi bendabuko nalababelethisi?
4. Uthini umbono wababelethisi bendabuko ngokuhlanganela nababelethisi bezempilo?
5. Ngokubona kwakho, uthini umbono wababelethisi bezempilo ngokuhlanganyela nababelethisi bezendabuko?
6. Ngokubona kwakho, kulula kangakanani ukubakhona kokuhlanganela phakathi kwababelethisi bendabuko nababelethisi bezempilo?
7. Ngokubona kwakho ikuphi okugakhuthaza ukuhlanganyela phakathi kwababelethisi bendabuko nababelethisi bezempilo?

Eminye imibuzo yokuphenya izobuzwa ukulandela imibuzo emikhulu ukucacisa noma ukuthola eminye iminingwane kuye ngezimpendulo kumbuzo nombuzo.

Appendix 10a: Sample of transcription and analysis report for FGD with the midwives, Traditional birth attendants and women

Focus group discussion 3, Health facility No. 3 (H003), participants (M 15 – 18), Date: 06 May 2023

All interviews started with the interviewer greeting the participants, introducing herself and thanking them for agreeing to participate in the study. The interviewer also reminded them that she will maintain anonymity and allocate codes instead of their names including facilities and homes. Lastly, the participants were reminded that they can withdraw at any time.

Interview questions	Responses	Analysis	
		Themes	Subthemes
<p>Grand tour statement: Please share with me your experiences regarding collaborations between midwives and TBAs</p>	<p>M15: I have no experience regarding collaboration and I have never heard of it here at work.</p> <p>M17: I have none, I have never heard of any collaboration, but I think that can be a good idea when looking at how women are rushed to hospitals with complications during labour, delivery and post-delivery.</p> <p>M18. I don't know if you will call this experience where a woman came to us sent by a TBA because she suspected a big baby and felt she will not be able to deliver her and we appreciated that.</p> <p>Interviewer: that was nice, did you communicate with this TBA to get more information or appreciate her for referring this woman?</p> <p>M18. No I didn't we just spoke amongst each other and hoped all TBAs can do the same so we can maybe understand how they work.</p>	<p>Collaborations between Midwives and TBAs services</p>	<p>Non –existence of collaborations between Midwifery and TBA services.</p> <p>Teamwork between midwifery and TBA services.</p>
<p>Probing questions: What collaborations are available in this area between the TBAs and midwives?</p>	<p>M16. ----- there is no collaboration at all between us and the TBAs in this area. The one problem is that each party works in silos since we did not know that we can collaborate.</p> <p>M15. Midwifery and TBAs services are both important when it comes to women's</p>	<p>Midwifery and TBA services in the area.</p>	<p>Awareness of midwifery and TBA services existence in the area</p> <p>Utilization of midwifery and/or TBA services</p> <p>Factors influencing utilization of midwifery and TBA services</p>

	<p>health and women use us both which means we need to be open to this guideline so we can work together for their sake.</p> <p>M17. There is no collaboration here but we know that women are attending the TBAs secretly and they also come to us for safety and when they have problems. I guess we will be able to work well together if we come together and they discuss what they give to women that make them complicate.</p> <p>M18. As much as there are different reasons that push women to use either us or TBAs or both, we need to support them so we do not to lose them.</p> <p>Interviewer: What do you mean by that?</p> <p>M18. I mean we need to appreciate each other and what we do and not shout at women when they use TBAs because they know their pregnancy needs better.</p>	<p>Collaborations between Midwives and TBAs services</p>	<p>Non –existence of collaborations between Midwifery and TBA services. Factors influencing non-existence of collaborations between Midwifery and TBA services. Teamwork between midwifery and TBA services.</p>
<p>What are your Perceptions towards collaboration between midwives and TBAs?</p>	<p>M18. Collaboration sounds like a good idea since we are worried about women and babies health.</p> <p>Interviewer: What are you worried about?</p> <p>M18. Most of the time when women use both TBAs and us, they come to us when they have complications after taking concoctions given by the TBAs, so it would be better if we collaborate so that we know what they give women and advise.</p> <p>Interviewer: Ok I understand. What are the other colleagues saying about collaboration?</p> <p>M15. I support the idea, but I am not sure if it is a good idea,</p>	<p>Practices in the absence of collaboration</p>	<p>Acknowledgement of each other's Existence Attitudes and respect towards each other</p> <p>Influences of current practices to patient care outcomes Communications</p>

	<p>who will be responsible for the mistakes that will be done by the TBAs since we on the other hand are guided by SANC, who is guiding them?</p> <p>M17. I am with you on that one but, I think if they can also register in some organization, at least they can also be able to practice with us.</p> <p>M16. I support collaboration I think it is something we should have done long ago so we can understand how TBAs work and they also understand how we work. Also since there is no collaboration, we know women are using both the clinics and TBAs.</p>		
<p>In your opinion what factors could facilitate collaboration between TBAs and midwives?</p>	<p>M15. I think working hand in hand with the TBAs will help where we can talk about problems we are all facing and solutions.</p> <p>M17. Involving community leaders can assist since they meet with the communities a lot and they will make them aware of the collaboration so that it continues well. I think family members especially husbands and mother-in-laws since they are the closest support for women.</p> <p>M16. If we can start to communicate with them now, that will assist in sharing ideas especially what they add in their concoction that they give to women as <i>isihlambezo</i>.</p> <p>M18. I think working together with respect and ensuring that we understand each other's roles may also help since this collaboration will benefit mostly women.</p>	<p>Feasibility of collaborations</p>	<p>Benefits of collaboration Requirements for successful sustained collaborations</p>

Appendix 10b: Sample of transcription and analysis report for interviews with TBAs

Participant 5 (T5), Female 55 years, Study site (H5), Date: 03 June 2023

Interview questions	Responses	Analysis	
		Themes	Subthemes
<p>Grandtour statement: Please share with me your experiences regarding collaborations between midwives and TBAs</p>	<p>There is no experience with collaboration here. We just work on our own with no support which we need since we need things to work.</p>		
<p>Probing Questions What collaborations are available in this area between the TBAs and midwives?</p>	<p>There are no collaborations in this area my child I work on my own and the nurses are working on their own. We know each other, but we do not contact each other in any way which is important. As long as we both know that we have an important role to play in the pregnant women's health collaboration can happen.</p>	<p>Midwifery and TBA services in the area</p>	<p>Awareness of midwifery and TBA services existence in the area. Utilisation of midwifery and/or TBA services. Factors influencing utilisation of midwifery and TBA services.</p>
<p>What are your Perceptions regarding collaboration between TBAs and midwives?</p> <p>Do you think there is anything the nurses do that you can learn from them as well?</p>	<p>For me I think it is good because we will learn a lot from them and we will be able to teach them some of the things from our side so they know what we do.</p> <p>Oh yes remember they have training and we are sure they know what they are doing, they just don't want to accept that women also benefit from us.</p>	<p>Collaborations between Midwives and TBAs services</p>	<p>Non –existence of collaborations between Midwifery and TBA services. Factors influencing non-existence of collaborations between Midwifery and TBA services. Teamwork between midwifery and TBA services.</p>
<p>How does the non-existence/existence of collaboration influence care for women?</p>	<p>-----non-existence of collaboration influence care of women in many ways, like women hiding that they attend TBAs since they shout at them.</p>	<p>Practices in the absence of collaboration</p>	<p>Acknowledgement of each other's Existence. Attitudes and respect towards each other.</p>

	<p>If there was collaboration it would have been easy for us to communicate with the nurses if we are not sure of something.</p> <p>The other problem is that nurses have a negative attitude towards us sometimes, they think we do not know what we are doing or they do not believe to what we are doing which makes it difficult to communicate with them even if you want to ask something sometimes.</p>		
<p>What are other TBAs' views regarding collaboration with midwives?</p>	<p>I am not sure because we have never discussed it, but I am sure they will appreciate and support it. I am sure with proper communication we will know each other and be able to work well together with respect especially if the focus is on one thing. I also know they will like collaboration for us to be able to refer women easily.</p>	<p>Collaborations between Midwives and TBAs services</p>	<p>Non –existence of collaborations between Midwifery and TBA services</p> <p>Factors influencing non-existence of collaborations between Midwifery and TBA services</p> <p>Teamwork between midwifery and TBA services</p>
<p>In your opinion what is the midwives' position regarding collaboration with TBAs?</p>	<p>Hey, I do not know but I don't think they would want to work with us because they say bad things to the women about us.</p> <p>I hope they can come close so we can teach each other one or two things, and I am sure we can learn a lot from them.</p>	<p>Collaborations between Midwives and TBAs services</p>	<p>Non –existence of collaborations between Midwifery and TBA services</p> <p>Teamwork between midwifery and TBA services</p>
<p>In your opinion how feasible is it to have collaboration between TBA and midwives?</p>	<p>It will work well if the nurses agrees because I am sure the other TBAs will support this for the sake of the women.</p> <p>I think if we also involve community leaders so that they know about this</p>	<p>Feasibility of collaborations</p>	<p>Benefits of collaboration. Requirements for successful and sustained collaborations.</p>

	collaboration and because it will benefit everyone in our area.		
In your opinion what factors could facilitate collaboration between TBAs and midwives?	<p>I think good communication will help for us to get to know each other.</p> <p>Learning that both parties has an important role to play in a woman's life during pregnancy up to post delivery.</p> <p>Respect for each other and ensure that we put women first at all times.</p> <p>Most of all would be working together to benefit women.</p>	Practices in the absence of collaboration	<p>Acknowledgement of each other's Existence.</p> <p>Attitudes and respect towards each other.</p> <p>Influences of current practices to patient care outcomes.</p> <p>Communications.</p>

Appendix 10c: Sample of transcription and analysis report interviews with women

Participant 7 (W7), 35 years, Health facility No. 2 (H2), Date: 26 June 2024

Interview questions	Responses	Analysis	
		Themes	Subthemes
<p>GRAND TOUR STATEMENT Please share with me your experiences regarding collaborations between midwives and TBAs</p>	<p>Yol do not think there are collaborations here. No one between the midwives and the TBAs know what the other is doing. Each one does their own thing. Collaboration will be a good thing because we use both for now and hope that we attend TBAs because of the nurses attitude when they learn that we use TBAs In short I have not experienced collaboration in this area.</p>	Practices in the absence of collaboration	<p>Acknowledgement of each other's Existence. Attitudes and respect towards each other. Influences of current practices to patient care outcomes. Communications.</p>
<p>PROBING QUESTIONS What collaborations do you know of that are available in this area between of TBAs and midwives?</p>	<p>As I said, there are no collaborations in this area my sister because the moment the nurses realize that you have seen a TBA, they start shouting at us. Ok, unless if you are talking about when the TBAs encourage us to also go to the clinic for antenatal care even if we go to them. That's all I know because nurses do not approve us using TBAs, instead they shout at us and call them names.</p>	Collaborations between Midwives and TBAs services	<p>Non –existence of collaborations between Midwifery and TBA services. Factors influencing non-existence of collaborations between Midwifery and TBA services. Teamwork between midwifery and TBA services.</p>
<p>Would you appreciate if there were collaboration between the TBAs and midwives?</p>	<p>I would appreciate it a lot my sister. Interviewer: why and what would you appreciate? I would appreciate it because we need them both. The nurses need to learn that it is not everything that needs them but there are other things that can only be done by TBAs like protecting the baby during pregnancy.</p>	Collaborations between Midwives and TBAs services	<p>Non –existence of collaborations between Midwifery and TBA services Factors influencing non-existence of collaborations between Midwifery and TBA services Teamwork between midwifery and TBA services</p>

	<p>Also this collaboration will assist in teaching the TBAs some of the important things they do not know and the nurses can also learn to identify problems that can only be referred to TBAs.</p> <p>We will also use TBAs freely without hiding it from the nurses.</p>		
<p>What would you like to see happen in the collaboration between midwives and TBAs?</p>	<p>I would like to see both nurses and TBAs working well together where they will respect each other not fight. I would like to see them communicate about us and refer us to each other.</p> <p>They must allow us to use both for different problems and trust that we know what we are doing.</p> <p>Nurses must also supply TBAs with things like gloves, aprons and other important things because they do not have and they are not working remembering that this benefits us all.</p>	<p>Midwifery and TBA services in the area.</p> <p>Practices in the absence of collaboration</p>	<p>Awareness of midwifery and TBA services existence in the area</p> <p>Utilization of midwifery and/or TBA services</p> <p>Factors influencing utilization of midwifery and TBA services</p> <p>Acknowledgement of each other's Existence</p> <p>Attitudes and respect towards each other</p> <p>Influences of current practices to patient care outcomes</p> <p>Communications</p>
<p>How would these collaborations benefit you and other women in this area?</p>	<p>This collaboration will benefit us by allowing us to use both nurses and TBAs without hiding anything. TBAs will be able to get help and knowledge from the nurses especially of things they don't have and knowledge.</p> <p>We will benefit by giving birth even at home by the TBAs freely then go to the clinics for check-ups, I am sure even the clinics will be relieved because it is always full.</p>	<p>Feasibility of collaborations</p>	<p>Benefits of collaboration.</p> <p>Requirements for successful and sustained collaborations.</p>

Appendix 11: Statement of confidentiality



DURBAN UNIVERSITY OF TECHNOLOGY
INYUVESI YASETHEKWINI YEZOBUCHWEPHESHE

STATEMENT OF CONFIDENTIALITY

NB: This statement is to be signed by all participants before engaging in the review of the guidelines. This statement aims to ensure that all information discussed, reviewed, and shared during the review process remains confidential.

Confidentiality Agreement

I,(FULL NAME AND SURNAME)..... acknowledge that as a reviewer for the ["Guidelines to Facilitate Collaboration between Midwives and Traditional Birth Attendants"], I will have access to sensitive and proprietary information. I understand that maintaining the confidentiality of this information is critical to the integrity of the research and the protection of intellectual property.

I agree to the following terms:

Confidential Information: All documents and discussions, and any other information shared during the review process shall be considered confidential.

YES NO

Non-Disclosure: I will not disclose, discuss, or share any confidential information with individuals outside of the review process without prior written consent from the researcher.

YES NO

of Information: I will use the confidential information solely to review and provide feedback on the guidelines. I will not use the information for any other purpose.

YES NO

Security Measures: I will take all reasonable measures to protect the confidentiality of the information. This includes not leaving documents unattended, not sharing access to electronic files, and returning all printed materials to the researcher after the review.

YES NO

Duration of Obligation: The confidentiality obligations will continue indefinitely, or until the confidential information becomes publicly available through no fault of my own.

YES NO

Return of Materials: Upon completion of the review process, or on request by the researcher, I will return all materials containing confidential information.

YES NO

Breach of Agreement: I understand that any breach of this confidentiality agreement may result in legal action and other remedies as deemed appropriate by the researcher and their institution.

YES NO

By signing below, I acknowledge that I have read, understood, and agree to the terms of this Statement of Confidentiality. I commit to maintaining the confidentiality of all information shared during the guideline review process.

Signature:
Reviewer's Name Date:

Witness: Signature:.....
Name and Surname Date:

Thank you for your cooperation and commitment to maintaining the confidentiality of this important review process.

Acknowledged by:

Signature:
Name and Surname: Nompumelelo P. Ndaba (Researcher) Date

APPENDIX 12: GUIDELINE CHECKLIST



CHECKLIST FOR GUIDELINES TO FACILITATE COLLABORATION BETWEEN MIDWIVES AND TBAS IN KWAZULU-NATAL SOUTH AFRICA

Dear Participant

After reading the proposed/ preliminary guidelines, please indicate on this checklist whether the guidelines conform to the following criteria by answering the following questions. You are free to attach extra notes if the space provided is not sufficient.

CRITERIA		
Clarity: Are the guidelines clearly formulated?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Remarks/Recommendations:		
Comprehensiveness: Are the guidelines complete? Do they cover all the themes identified in the attached document?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Remarks/Recommendations:		
Credibility: Do the guidelines address what is indicated by the themes?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Remarks/Recommendations		
Applicability: Are the guidelines appropriate for application (implementation)?	<input type="checkbox"/> YES	<input type="checkbox"/> NO

APPENDIX 13: PRELIMINARY GUIDELINES

PRELIMINARY GUIDELINES DEVELOPED FOR FACILITATION OF COLLABORATION BETWEEN MIDWIVES AND TRADITIONAL BIRTH ATTENDANTS

The following guidelines were developed as presented in Table 1 below. Each set is described in the section below the table.

Table 1 Overview of developed guidelines

Guideline	Targeted stakeholders	Focus area	Page
Guidelines to facilitate collaboration between midwives and TBAs			
A	Midwives, TBAs and community	Guideline to facilitate communication, openness, and transparency	1
B	Midwives and TBAs	B. Guideline to facilitate shared vision and sense of responsibility	
C	Midwives, TBAs, community	C. Guideline to foster a sharing and caring environment for collaboration	
D	Midwives and TBAs	D. Guidelines to promote teamwork and cooperation between midwives and TBAs	
E	Midwives and TBAs	E. Guideline to facilitate paradigm shift and values clarification between midwives and TBA	

8.2.2.1 Guidelines to facilitate collaboration between midwives and TBAs

There is a need to ensure smooth collaboration between midwives and TBAs in this province to ensure the best community relationships and reduce MMR. Mutale *et al.* (2020) in their study also highlighted the need to formalise links between traditional healers and their counterparts by providing allopathic health services which will assist in recognising healers in the healthcare system through good communication, relationship building, and identification of areas for collaboration between the two parties.

Developing guidelines to facilitate collaboration between midwives and TBAs in this province, stems from the need to improve maternal and neonatal health outcomes it came up in this study that TBAs hold significant influence and trust within the communities, and women trust them more than the healthcare facilities for different reasons which have been discussed making them vital players in maternal care. However, their practices need to be supported since they seem to pose risks to mothers and infants leading to high MMR since they are not trained. Midwives on the other hand, are trained in modern obstetric practices and they are trusted to offer

higher-quality care. By establishing these guidelines, there is a possibility to create a structured framework where midwives can mentor and support TBAs ensuring that traditional practices are supplemented with safe and up-to-date medical knowledge thus improving the overall standard of care.

The recommendation for developing such guidelines includes promoting mutual respect and understanding between midwives and TBAs, ensuring clear communication channels, and providing joint training programmes. This collaborative approach allows for the integration of culturally accepted practices with scientifically validated medical procedures, fostering trust and cooperation. The guidelines and roles and responsibilities, establish protocols for referral and emergency situations, and emphasise the importance of continuous education. By doing so, the health system can leverage the strengths of both midwives and TBAs, ensuring that mothers and babies receive the best possible care throughout pregnancy, childbirth, and the postnatal period. Developing these guidelines involves fostering an environment of mutual respect and partnership which can be achieved by designing comprehensive training programmes that bring midwives and TBAs together to learn and share skills and knowledge. These programmes should focus on bridging the gap which exist between traditional practices and the modern medical standards, highlighting the importance of evidence-based care while respecting cultural traditions. Including the establishment of clear communication and referral protocols in these guidelines to ensure seamless coordination, particularly in emergencies is important. The roles and responsibilities of both midwives and TBAs must be explicitly defined to avoid confusion and ensure responsibility and accountability. By implementing these guidelines, the health system can maximise the strengths of both midwives and TBAs, ultimately improving maternal and newborn health outcomes through a cohesive and integrated approach to care

A. Guideline to facilitate communication, openness, and transparency amongst midwives and TBAs

Rationale for implementation of this guideline

Women in this province, especially those living in the rural communities utilising both healthcare facilities and TBAs require quality care from both midwives and TBAs for different problems. This is not easy when there is no proper communication between the two parties. Both midwives and TBAs need to ensure communication, openness and transparency for them to be able to collaborate well and sustain the collaboration. The findings of the study revealed that there is lack of communication between midwives and TBAs leading to them working in silos.

Transparency builds trust and credibility, as stakeholders, perceive the organization as reliable and honest like the healthcare facilities. This trust is crucial for maintaining strong, positive relationships, especially between the caregivers, in this case, the

midwives and TBAs. In crises, clear and open communication is vital for effective management and minimising reputational damage, which will be helpful between midwives and TBAs since they come from different backgrounds. A culture of transparency will encourage improvement and innovation by maintaining open feedback channels, ensuring the collaboration is sustainable. Overall, these guidelines will create a foundation that will be more effective and ethical.

Recommendation for implementation of this guideline

The following are the recommendations for the implementation of this guideline should it be taken into consideration:

- Establishment of clear communication channels and mechanisms for information sharing between midwives and TBAs by ensuring that there are regular meetings between the two parties including community meetings attendance where challenges, successes, and ongoing cases are discussed.
- Ensuring effective teamwork and coordination of care to ensure seamless continuity of care and see that challenges are overcome easily
- Developing and agreeing on communication tools such as phones for urgent information and referral, and documents for detailed client information on referral, while ensuring privacy and confidentiality.
- Ensuring and building mutual respect and understanding between the midwives and TBAs.
- Having joint training programmes where midwives and TBAs can shadow each other where they observe each other's practices for better understanding and recognising each other's roles.
- Involvement of both midwives and TBAs in the decision-making of a client who utilises both practitioners.
- There should be training on conflict resolutions since the two parties are not used to working together and mediators should be selected from both parties.
- Development of indicators to measure the effectiveness of communication, collaboration and mental health outcomes and maternal health outcomes
- Regular evaluation of the collaboration process and adjustment whenever necessary for improvement.

B. Guidelines to facilitate shared vision and sense of responsibility

Midwives participants expressed fear of collaborating with TBAs since they did not know what will happen if they make a mistake with women they are caring for since with them they have a regulatory body which is the South African Nursing Council (SANC) guiding their practice. What made the midwives more worried was that the TBAs are not trained for anything but they believe in what they are doing which made them to decide to give it a try and share their vision, skills and assistance. This guideline will enhance collaboration and improve maternal and newborn health

outcomes ensuring that midwives and TBAs bring unique skills and knowledge to maternal care. With midwives having formal training in obstetrics and gynecology, and TBAs offering traditional wisdom and experience that resonates with local cultural practices collaboration will work well. By fostering sharing and collaboration, these guidelines can help integrate the strengths of both approaches, leading to more comprehensive and culturally sensitive care. This guideline will also promote ensure that patients receive consistent care across different providers which is particularly important in areas where access to healthcare facilities is limited. Shared care models will address both physical and emotional needs of women since midwives provide clinical care, TBAs offer emotional support and guidance based on cultural practices, leading to a more holistic approach to maternal care. Therefore, when midwives and TBAs work together, it demonstrates commitment to respecting and valuing local traditions while providing high-quality care and this can build trust within communities, encouraging more individuals to seek professional help when needed.

Recommendations for implementation of this guideline

- Outline the roles and responsibilities of midwives and TBAs participating in the collaboration framework by specifying how each role complements the other.
- Engage all stakeholders (midwives, TBAs, community leaders, and health authorities) in the development and implementation of the collaboration process to ensure that the guidelines are practical and culturally appropriate.
- Organise regular meetings with involved stakeholders to discuss progress, address challenges, and gather feedback on the implementation of the guidelines.
- Organise training sessions that include both midwives and TBAs which will focus on areas such as communication skills, cultural competence, and clinical updates. These training sessions may ensure the specific needs and practices of both groups.
- Encourage effective communication channels between midwives and TBAs which will include regular meetings, shared digital platforms, or communication protocols to ensure timeous and accurate information exchange.
- Promote mutual respect and recognition of each other's expertise and acknowledge the value of traditional practices and integrate them with modern medical approaches.
- Ensure development of systems to monitor, implement and evaluate the guidelines, including tracking adherence, effectiveness and identifying areas for improvement of collaboration.
- Evaluate the impact of the collaboration by using data to ensure that the guidelines are achieving their intended goals and adjust strategies as necessary.

- Offer support services to midwives and TBAs such as administrative assistance for the implementation of the guidelines effectively.

C. Guidelines to foster sharing and caring amongst midwives and TBAs

Rationale for implementation of this guideline

These guidelines are developed to enhance teamwork and cooperation between midwives and TBAs to improve maternal and child health outcomes. By fostering a collaborative environment, both midwives and TBAs can share their unique skills and knowledge to provide better care for the women. Therefore, implementing these guidelines to promote teamwork and cooperation between midwives and TBAs is crucial for improving maternal and infant health outcomes. These guidelines will assist in fostering collaboration by combining the clinical expertise of midwives with the cultural knowledge of the TBAs thus satisfying women who are utilising both. This will ensure that pregnant women receive comprehensive care that respects their cultural context while adhering to medical best practices. Cooperation can lead to better monitoring of pregnancies, timely referrals to medical facilities, and shared knowledge, ultimately reducing MMR in this province. Moreover, promoting teamwork between these groups helps bridge gaps in healthcare access in underserved areas, creating a more integrated and effective healthcare system that benefits the entire community.

Recommendations for implementation of this guideline

- Develop a joint mission statement that reflects the shared goals of improving maternal and child health where clear achievable objectives for both midwives and TBAs will be set.
- Set long-term goals such as reducing maternal and neonatal mortality rates including improving communication and sharing best practices.
- Acknowledge and respect the unique skills and experiences of both midwives and TBAs to encourage teamwork amongst them.
- Monitor training on cultural sensitivity and traditional practices to ensure learning and mutual respect between the two groups.
- Utilise the suggested communication tools to facilitate ongoing dialogues such as consultation, clarity, referral and feedback.
- Develop emergency protocols that both midwives and TBAs are trained to follow to prevent delays and complications.
- Conduct regular simulation workshops with TBAs to practice collaborative emergency response.

D. Guideline to facilitate a sharing and caring environment for collaboration

Rationale for implementation of this guideline

The study findings found that having platforms where midwives and TBAs can meet and share their views, knowledge and skills will assist in collaboration. Implementing this guideline is essential since it will assist in enhancing communication, resolving conflicts, and increasing productivity amongst the midwives and TBAs during collaboration. It will promote inclusivity and diversity, ensuring that all team members feel valued and heard. Consistent practices foster accountability and support a stable, supportive culture, boosting morale and job satisfaction. This guideline will also serve to stimulate innovation and creativity by creating a safe space for new ideas and streamline the onboarding process the midwives and TBAs. Overall, clear guidelines enable teams to adapt to changes more effectively, leading to a more cohesive, efficient, and innovative collaboration.

Recommendation for implementation of this guideline

- Plan review meetings to discuss progress and develop action plans based on feedback and evaluation results to continuously improve the collaborative environment.
- Hold continuous education and professional development workshops with feedback sessions on maternal and child health and cultural competency.
- Facilitate and encourage the sharing of best practices and successful strategies between midwives and TBAs.
- Establish clear procedures for addressing and resolving conflicts should they arise.
- Ensure that both midwives and TBAs have equal opportunities to contribute to discussions and decision-making processes.
- Promote an understanding and respect for cultural differences and traditional practices.
- Implement programmes to recognise and celebrate the contributions and successes of both midwives and TBAs during the collaboration.
- Provide constructive feedback in a supportive and respectful manner, focusing on strengths and areas for improvement.
- Develop tools such as messaging apps, emails, and online platforms to maintain continuous communication and strengthen the referral system.
- Create a non-judgemental space where all team members feel comfortable expressing their thoughts and concerns.
- Clearly define and communicate the roles and responsibilities of both midwives and TBAs to avoid misunderstandings.

D. Guideline to facilitate teamwork and cooperation between midwives and TBAs

Rationale for implementation of this guideline

This guideline aims to improve maternal and neonatal health outcomes and enhance teamwork and cooperation between midwives and TBAs. Effective collaboration between the two groups is essential for improving maternal and child health outcomes and it will ensure that both groups can effectively share knowledge, skills, and resources, enhancing the quality of care provided and it will bridge the gap between modern practices and traditional practices ensuring comprehensive care. There are usually positive outcomes when there is teamwork and cooperation between groups especially if both groups have common goals, it becomes easy for them to work as a team to ensure reduced MMR and improve maternal and neonatal health outcomes. Moreover, this guideline will establish clear roles and responsibilities and reduce misunderstandings, it will also assist in promoting a collaborative approach to address common challenges arising along the way leading to safer and more effective maternal health services.

Recommendation for implementation of this guideline

- Conduct trainings which will involve both midwives and TBAs for knowledge sharing and mutual respect.
- Training of TBAs which will include simulation to ensure their skills are upgraded in line with the modern obstetric practices and identify tasks that can be safely managed by TBAs. TBAs can be paired with midwives for mentorship as part of training
- Clearly defining roles and responsibilities of midwives and TBAs to ensure that there is no overlapping of work and highlight work requiring the expertise of midwives.
- Organise and hold meetings where midwives and TBAs will discuss different cases, share their experiences and resolve any conflicts.
- Establish reliable communication channels to ensure continuous communication e.g. (emergencies, for clarification, for referral and feedback).
- Ensure respect between midwives and TBAs build trust and respect for traditional knowledge and cultural practices of TBAs and vice versa.
- Provide TBAs with resources such as PPEs, cord scissors, sterilising solutions, and referral forms to ensure that they are effective in what they are doing.
- Involve the community and the leader in ensuring collaboration is sustained by conducting awareness campaigns to educate them about the need and benefits of integrating TBAs into the healthcare system.
- Improve and implement policies and protocols that will support the integration of TBAs into the formal healthcare system.

- Establish mechanisms for referral and feedback from both midwives and TBAs to improve and sustain collaboration.
- Evaluate and assess the effectiveness of teamwork and cooperation initiatives between midwives and TBAs.

E. Guideline to facilitate paradigm shift and values clarification between midwives and TBA

Rationale for implementation of this guideline

This guideline is essential for aligning the approaches of the midwives and TBAs, and improving maternal and child health outcomes by encourage both groups to understand and appreciate each other's roles, perspectives, and expertise, fostering mutual respect and cooperation. By clarifying values, midwives and TBAs can find common ground in their shared goal and vision of providing the best possible care for mothers and infants. This paradigm shift can really lead to more effective collaboration, where both practices are integrated and as a result, this alignment reduces conflicts, enhances trust within the community, and ensures a more holistic approach to maternal and neonatal healthcare, ultimately leading to better health outcomes and increased satisfaction among patients. Therefore, implementing this guideline requires a multifaceted approach that focuses on education, good communication, and collaborative practices.

Recommendations for implementation of this guideline

- Develop and conduct workshops that include both midwives and TBAs, focusing on shared goals, best practices, and mutual respect which will incorporate cultural competency training to help midwives understand the cultural significance of TBAs and vice versa, fostering mutual respect.
- Establish regular meetings where midwives and TBAs can discuss cases, share experiences, and resolve conflicts, which will also improve teamwork.
- Implement structured feedback mechanisms that allow both groups to voice their concerns and suggestions in a constructive manner.
- Involve both midwives and TBAs when developing care protocols that respect traditional practices while ensuring patient safety.
- Develop standardised procedures that integrate traditional and modern medical practices, ensuring a cohesive approach to maternal and child healthcare.
- Conduct community education campaigns, which will assist in highlighting the importance of both midwives and TBAs, promoting respect and cooperation between them.
- Engage community leaders to introduce the guidelines and for them to support and endorse the guidelines, ensuring community buy-in and adherence.

- Use of feedback from evaluations to continuously refine and improve the guidelines and their implementation.
- Ensure that healthcare institutions adopt policies that support and enforce the guidelines, providing the necessary resources and infrastructure.

Appendix 14: Translated IsiZulu Guideline

IZIQONDISO ZOKUKHUTHAZA INSEBENZISWANO PHAKATHI KWABABELITHISI NABABELITHISI BASEKHAYA KWAZULU-NATAL, ENINGIZIMU AFRIKAABABELETHISI ABAQEQESHIWE

8.1 ISINGENISO

Isahluko 8 sethula iziqondiso eziphakanyisiwe ngokunjalo nezincomo zokuthi zingasetshenziswa kanjani. . Iziqondiso lezi zibhekisise okutholiwe nalokho okube yizincomo ezigabeni zokuqala zalolu cwaningo okufinyelele kuzo ukufeza izinhloso zokuqala ezinhlanu zalolu cwaningo . Iziqondiso zenziwe kulandelwa izinyathelo eziyi-12 ezichazwa nguVermuelen nabanye (2019) njengoba zethuliwe esahlukweni esedlule. Kuhlonzwe amaqoqwana ayisithupha njengamqoka ekukhuthazeni insebenziswano phakathi kwababelethisi abaqeqeshiwe nababelethisi basekhaya futhi zikhethwe kususelwa emaphuzwini ayisihlanu anomthelela kunsebenziswano eyimpumelelo ngokokuchaza kukaRollins (2015). Iziqondiso ezethulwe kulesi sahluko ngezokugcina ezibukeziwe, zaqinisekiswa futhi zaphasiswa ngongoti abafanelekile njengoba bethuliwe esahlukweni esedlule. Ziyatholakala ngezilimi ezimbili eziqavile ezisetshenziswa endaweni obekwenziwa kuyo ucwaningo (isiNgisi nesiZulu). OlwesiNgisi kwethulwe ngalo kulesi sahluko bese olwesiZulu lutholakale kwesikubiza ngokuthi Isenezelo 15.

8.2 UKWETHULWA KWEZIQONDISO

I. Isihloko seziqondiso

Guidelines to facilitate collaboration between Iziqondiso zokukhuthaza insebenziswano phakathi kwababelethisi abaqeqeshiwe nababelethisi basekhaya.

II. Umbhali

Lezi ziqondiso zethulwe nguNkosazana uNompumelelo Pearl Ndaba njengengxenywe yocwaningo lwakhe ekufezeni izidingo zeZiqu zobuDokotela oPhikweni lweSayensi yezeMpilo eDurban University of Technology, eThekwini, eNingizimu Afrika.

III. Injongo yalezi ziqondiso

Injongo yalezi ziqondiso ngukukhuthaza insebenziswano phakathi kwababelethisi abaqeqeshiwe nababelethisi basekhaya ngenhloso yokubambisana ekwelekeleleni nasekunakekeleni omama nezinsana zabo ngesikhathi esandulela ukubeletha, isikhathi sokusikwa nasemva kokubeletha ngenhloso jikelele yokunciphisa ukufa komama nezingane endaweni.

IV. Izinhloso zeziqondiso

Izinhloso zalezi ziqondiso yilezi:

- Ukukhuthaza insebenziswano phakathi kwababelethisi abaqeqeshiwe nababelethisi basekhaya.
- Ukulungisa izimo ezingase ziphazamise insebenziswano eyimpumelelo.
- Ukukhuthaza umfelandawonye nokusebenza njengethimu uma kuhlizekwa abesifazane nezingane ngezinsizakalo.
- Ukuqinisekisa ukuthi insebenziswano phakathi kwababelethisi abaqeqeshiwe nababelethisi basekhaya iqhubeka njalo.

V. Abajongiwe

Kwabajongwe ngalezi ziqondiso kubalwa laba abalandelayo:

- Izikhungo zonakekelo lwezempilo zaKwaZulu-Natali ezihlinzeka ngezinsizakalo zonakekelo lwezempilo kwabesifazane abangomama nezingane.
- Abasebenzi bonakekelo lwezempilo, ikakhulukazi ababelethisi abaqeqeshiwe, abasezikhungweni ezahlukahlukene zonakekelo lwezempilo.
- Imiphakathi nababelethisi basekhaya kuSifunda uThukela nezindawo ezisakhele.
- Noma yiziphi ezinye izizinda okukhona kuzo ababelethisi basekhaya.

VI. Ububanzi nokusebensizeka kweziqondiso

Lezi ziqondiso zihlose ukunikeza izincomo zokukhuthaza nokulondoloza insebenziswano phakathi kwababelethisi basekhaya nababelethisi basekhaya njengezinhlaka ezimbili ezinikeza unakekelo kumama, umntwana nosana kule ndawo okucwaningwa ngayo. ababelethisi abaqeqeshiwe Isidingo salezi ziqondiso sibangwe ubufakazi bokuzibonela njengoba bubikwe ababelethisi abaqeqeshiwe kanye nomcwaningi bokuthi iningi labesifazane abakhulelwe, ikakhulukazi bemiphakathi yasemakhaya, kuba ngukuthi kabalutholi unakekelo lwezempilo besakhulelwe, kabezi kusenesikhathi ukuzobeletha futhi abayi ukuyothola izinsizakalo zonakekelo emva kokubeletha kodwa baya emtholampilo sekwephuzile, kakade sebenezinkinga ezihlobene nokukhulelwa, ukubeletha noma ubudlenzane. . Imvamisa, laba besifazane kubikwe ukuthi bebenakekelwa ngababelethisi basekhaya emiphakathini yaboababelethisi abaqeqeshiwe Iziqondiso eziphothuliwe ziyosetshenziswa abasebenzi bezokubelethisa (ikakhulukazi ababelethisi abaqeqeshiwe), ababelethisi basekhaya, abesifazane nemindeni yabo njengabantu abangase bathinteke noma babe nomthelela kunsebenziswano phakathi kwababelethisi abaqeqeshiwe nababelethisi basekhaya.

VII. Uhlaka olungokomthetho

Okulandelayo kungeminye yemithetho emqoka futhi okufanele ilandelwe ekusebenziseni iziqondiso eziphakanyisiwe::

- UMnyango Wezempilo eNingizimu Afrika (2005). Umthetho Wezobuhlengikazi, 2005 (Umthetho 33 ka- 2005).
- UMnyango Wezempilo Kazwelonke eNingizimu Afrika(2020) Iqhingankomba Lemfundo Nokusebenza Kwezobuhlengikazi Nezokubelethisa (2020/21-2025/26).
- UMnyango Wezempilo Kazwelonke eNingizimu Afrika(2016) Iziqondiso Zonakekelo Lwezokubeletha eNingizimu Afrika.

VIII. Izingamulelo

KZN: KwaZulu-Natal

iMMR:	Maternal Mortality Rate
MNCWH:	Maternal, Neonatal, Child and Women's Health
PPEs:	Personal Protective Equipment
WIL:	Work Integrated Learning
SA:	South Africa
SANC:	South African Nursing Council
SDG:	Sustainable Development Goal
TBA:	Traditional Birth Attendant
WHO:	World Health Organization

IX. Uhlu lwamatemu

- Unakekelo olwandulela ukubeletha:: Ngokweziqondiso zonakekelo olwandulela ukubeletha eNingizimu Afrika (2016), unakekelo olwandulela ukubeletha luklanyelwe ukuqinisekisa ukukhulelwa okuyimpumelelo ngangokunekwenzeka kwabesifazane nabantwana babo.
- Insebenziswano Isimo lapho abantu ababili noma ngaphezulu, izinhlaka noma izinhlangano kuhlangukano ndawonye ukuzwenza umsebenzi noma ukufinyelela umgomo othile.
- Umsebenzi wezempilo womphakathi: Ilungu lomphakathi elikhethwe amalungu omphakathi laqeqeshelwa ukunikeza izinsizakalo eziyisisekelo zonakekelo lwezempilo nezokubeletha emizini yomphakathi ebangeni lokuvikela, ukukhuthaza nokuvuselela
- Ukuzibandakanya komphakathi: Inqubo ebandakanya amalungu omphakathi ekuxazululeni izinkinga noma ekuthatheni izinqumo esebenzisa izinsiza zawo noma imibono ukuhlonza izinkinga zawo.
- Umbungu: Ingane engakazalwa, kusukela esigabeni sokuqala (ukuphela kweviki lesishiyagalolunye sihlalile isisu, sekwakheke izitho ezivelele) kuze kubelethwe
- Isikhungo sonakekelo lwezempilo: Indawo ehlinzeka ngonakekelo lwezempilo kokubili olomphakathi noluzimele. Lokhu kungaba yizibhedlela, imitholampilo, izikhungo ezelapha zingalalisi nezikhungo zonakekelo lwezempilo olukhethekile olunjengezikhungo zokubelethisa nezikhungo zonakekelo lwezengqondo.

- Uphiko lonakekelo lwezempilo: Isakhiwo sonakekelo esikhungweni sezempilo
- Ukufa komama: lokhu ngukufa kowesifazane ngenkathi ekhulelwe noma sekusele izinsuku ezingama-42 ukuba abelethe, kungakhathaliseki ubude nohlobo lokukhulelwa, nganoma yiyiphi imbangela ehlobene noma ebhebhethekiswe ukukhulelwa noma ukusingathwa kwakho kodwa kungenzekanga ngengozi noma ngenhloso. . Ukufa kwababelethayo kwesikhungo kubhekisela ekufeni kwababelethayo esikhungweni sezempilo.
- Umbelethisi: NgokweSouth African Nursing Council (SANC), umbelethisi ngumuntu obhalisiwe futhi ogunyazwe yi-SANC njengongoti ozimele onikwe imvume yokusebenza njengombelethisi ngokomthetho weNingizimu Afrika.
- Insandakuzalwa: Noma yimuphi osanda kuzalwa onezimpawu zokuphila kungakhathaliseki ubude besikhathi sokukhulelwa (SANC).
- Umbelethisi wasekhaya: Umuntu olekelela umama ngenkathi ebeletha futhi oqale ukuthola ikhono lakhe ngokuzibelethisela noma ngokuqeqeshwa ngabanye ababelethisi basekhaya..
- Ibangalokusebenza: NgokukaSANC lena yimingcele ebekelwe umhlengikazi noma umbelethisi wasekhaya kuye ngokwezigaba

X. Isendlalelo esivela kumbhali

Insebenziswano phakathi kwababelethisi abaqeqeshiwe nababelethisi basekhaya nalokho abalekelela ngakho kunamathuba amqoka okwenza kube lula ukuthola unakekelo olusizingeni ngesikhathi sokubeletha nokwenza ngcono impilo komama nasezinganeni.a. Lo mbono wesekwa ngoBehruzi nabanye (2017) abathi ukuze kuhlangezwe nezifiso zabesifazane nohlobo lokunakekelwa ngumbelethisi abalukhethayo, ngokunjalo nokufeza izidingo zabasifazane nemindeni yabo, kudingeka ukuba abahlinzeki bonakekelo lokubeletha basebenze ngobambiswano olusezingeni eliphakeme kakhulu., . Inhlangothi Yomhlaba YababelethisiAbabelethisi abaqeqeshiwe (ICM) (2023) iyaweseka umbono wensebenziswano ngokugcizelela ukuthi nanxa ababelethisi abaqeqeshiwe belekelelana nabesifazane, imindeni nemiphakathi ukuze ukukhulelwa nokubeletha kube yimpumelelo, ukuthuthukiswa kwezempilo ezinhle nokuvikela izifo kwezokubeletha nonakekelo losana akunakufezwa ngumkhakha owodwa ongabasebenzi bezempilo, umphakathi noma

iqenjana eliqamba inqubomgomo. a. Ngakho, bagcizelela ukuthi insebenziswano yemikhakha enhlobonhlobo ineqhaza elikhulu ekuhlinzekeni ngonakekelo olusezingeni eliphakeme lwezocansi, ezokuthola abantwana, ezokubeletha nezezinsana.. Nanxa ngokomgomo i-ICM ibhekisela kubasebenzi bezempilo, ababelethisi basekhaya abanakushiywa ngaphandle kwazise nabo banesandla ekusingathweni kwabesifazane ngenkathi bekhulelwe, besikwa noma bengabadlenzane. Lokhu kufakazelwa ngokutholwe kulolu cwaningo, kufakazelwe futhi ngabalobi abaningana okubalwa kubo uKassie nabanye (2022) noMusie nabanye (2022) abagcizelelayo ukuthi ababelethisi basekhaya emazweni angakathuthuki kuyaphi anjengo-India, Bangladesh neNingizimu Afrika, ukubala nje abambalwa, asebenza njengabahlinzeki bezinsizakalo kwabesifazane nezinsana ezincane ngesikhathi sokusikwa, ukubeletha nesobudlenzane ikakhulukazi ezindaweni zasemakhaya. Inhlangotho i- ICM yeseka ukufunwa konakekelo oluqhubekayo kusukela ekukhulelweni, ekubeletheni nasebendlezaneni nobambiswano nanoma yibaphi ababambiqhaza abadingekayo ukuqinisekisa ukuthi unakekelo lusizingeni, aluphuzi futhi lutholakala eduze. NgokweICM, uchungechunge lwensebenziswano luxhumanisa abasebenzi bezempilo yomphakathi nonakekelo lwezempilo oluzinze emphakathini.abazinze emphakathini. Baqhubeka bachaze ukuthi abesifazane abaningi, abantu bobulili obuxhantile,nezinsana, bayaqhubeka befa noma bebanamahlalakhona kungenasidingo ngoba bengaphuthumanga ukufuna unakekelo lombelethisi oqeqeshiwe, kokunye ngoba bengakwazi ukufinyelela izinsizakalo zezempilo ezingcono uma kuba nezingxaki ekubeletheni(ICM 2023). Ngakho, ababelethisi abaqeqeshiwe kufanele bakhe amaxhama okubambisana nabanye abasebenzi bezempilo, abaqambi bemithethomgomo nezinhloko zamazwe ngamazwe ukuqinisekisa unakekelo lwezempilo lokuthola abantwana, lobelethayo nolosana olutholakala ngesikhathi, olufinyelelekayo emhlabeni jikelele

Lezi ziqondiso zihlose ukunikeza iziphakamiso zokukhuthaza insebenziswano enganqamuki phakathi kwababelethisi basekhaya nababelethisi abaqeqeshiwe endaweni ecwaningwayo kokubili okubangabahlinzeki bonakekelo lobelethayo nosana.a. Ucwainingo lolu lusekelwe yimibhalo yocwaningo oluveza ukuthi nanxa laba behlinzeka ngezinsizakalo kodwa basebenza ngokuzimela okungenakuxhumana

noma okungenakusebenzisana phakathi kwabo. Ngenxa yalokho, kungase kuvele izinkinga ekukhulelweni ezithinta omama nezinsana zabo ebezingase, ngokwemibhalo yocwaningo, zincishiswe noma zinqotshwe yinsebenziswano phakathi kwalezi zihlaka. . Inhloso jikelele yalezi ziqondiso ngukuthuthukisa impumelelo kwezempilo yobelethayo nosana lwakhe ngokwazana, ukuxhumana okuhle nokucobelelana ulwazi ngenkambiso engungqaphambili. UMorley noCashell (2017) bayafakaza ukuthi unakekelo oluvelele lwezempilo luchuma ngensebenziswano. Ngokwalaba babhali, amalungu ethimu exube amakhono kokwenziwayo aponsa esivivaneni ngolwazi lwemikhakha ehluahlukene futhi anenkuthalo namaqhinga amasha futhi anekhono lokusingatha izimo eziyingcuphe uma kuqhathaniswa nethimu nje esebenza ngendlela evamile. Njengoba bakha amaxhama ensebenziswano, bayakwazi ukuvula amathuba emibono ebanzi nalokho okudinga ukusukunyelwa ngokushesha ngangokunokwenzeka ukugwema amaphutha ayizindleko, ukuqala kabusha nokungaqondani ekuxhumaneni.. UMorley noCashell (2017) bagcizelela ukuthi kubaluleke kakhulu lokho lapho imibono nendlela yokubuka izinto kumalungu ethimu kungefani, njengoba kwenzekile kubabelethisi abaqeqeshiwe nababelethisi basekhaya kulolu cwaningo.a

Lezi ziqondiso zibheka nhlangothi zonke ngenhloso yonakekelo lwezempilo oluyimpumelelo kobelethayo nosana lwakhe, ukuqinisekisa unakekelo oluphephile noludidiyela inqubokwenza yesintu nentuthuko yamanje kwezokwelapha. . Uma sekunalezi ziqondiso nomphumela ozolandela wobambiswano phakathi kwababelethisi abaqeqeshiwe nababelethisi basekhaya, kucatshangwa ukuthi ukufa kwababelethayo nokwezinsana kungancishiswa a. Lokhu kungakhulisa inqwaba yamasu okungenelela okuhlose ukunciphisa ukufa kwababelethayo nokwezinsana okunjengokuhlonzwa kusenesikhathi kwezinkinga nokudluliselwa kumbelethisi okuzonciphisa izinkinga ezibangwa ukulibala ekufuneni, ukufinyelela nokuthola unakekelo njengoba kucaciswe ohlakeni lwezilibaziso ezintathuababelethisi abaqeqeshiwe(Thaddeus noMaine 1994). Ngaphezu kwalokho, kutholakale ukuthi ukungenelela kokukhulisa insebenziswano nomfelandawonye phakathi kwababelethisi abaqeqeshiwe nababelethisi basekhaya kwakha ubudlelwano obuhle

bukhuthaze nokudidiyelwa kwababelethisi basekhaya ekuqeqeshweni kwababelethisie-Indonesia (Mwoma, Kituku noGitome 2021).

Ukuqagula izingasibonelo nokucobelelana ngenqubokwenza enhle kungakhuthaza ukuhlinzekwa koqeqesho, ikakhulukazi kubabelethisi basekhaya eminxeni emqoka nebucayi yonakekelo lwezempilo kobelethayo nakusana okunjengokusheshe kuhlonzwe okungahambi kahle nokusingatha izimo eziphuthumayo lapho bengekho abahlinzeki ngezinsizakalo abanolwazi noma ngenkathi besalindiwe. . U-Adatara nabanye (2019) ecashunwe nguMusie nabanye (2022) bagcizelela ubumqoka bokuba ezezempilo zibuqhakambise ubumqoka bababelethisi basekhaya nokubaluleka kokubahlomisa ngamakhono akamuva kwazise yibona abaseduze kakhulu kwabesifazane ngesikhathi bekhulelwe kuze kube bayabeletha. Lokhu kuqhakanjiswa kungaba nomthelela omuhle emizameni yaleli zwe yokunqanda ukufa ngaphambi kokubeletha, emuva kokubeletha nokuphila nezifo ezibeka impilo ebungcupheni. .

Kunobufakazi obungokocwaningo bokuthi enye inqubo yababelethisi basekhaya nezihlambezo ezinikwa omama nezingane kungase kungabi okuphephile ngoba akuphasisiwe ngokuhlolwa okungokwesayensi. (Aziato no-Omenyo nabanye 2018; Scina 2017; Boltman-Binkowski 2016). Ngakho, kwethenjwa ukuthi uma ababelethisi basekhaya nababelethisi abaqeqeshiwe bebambisana, lokhu kungavula amathuba okuba nabo bayazi kancane inqubokwenza yabanye, abanobuchule kukho nalokho ababuthaka kukho.ababelethisi abaqeqeshiwe. Lokhu kunganika ulwazi ngenqubokwenza noma ukusilela okunomthelela omubi ekukhulelweni okuyimpumelelo nempilo yeziguli kudale amathuba okudingida lokhu nokuhlonza amasu okunqoba lezi zithiyo Kungadala futhi amathuba emfundo nokuqeqeshwa ukuqinisekisa inqubokwenza ephephile ezolandelwa ngababelethisi abaqeqeshiwe nababelethisi basekhaya.. U-Ohaja, Murphy-Lawless, noDunlea (2020) bayafakaza ukuthi inbenziswano phakathi kwababelethisi basekhaya nababelethisi abaqeqeshiwe yisu eliwusizo lokudidiyela ababelethisi basekhaya babe yingxenyeye yohlelo lonakekelo lwezempilo oluhlelekile. . Uqeqesho, ukucathulisa nobambiswano phakathi kwababelethisi basekhayanababelethisi abaqeqeshiwe kuthuthukisa

amakhono abo, ngaleyo ndlela kukhulise inani lababelethisi basekhaya bese kusizakalwa kalula ngamakhono abo.. Lokhu kumqoka ngokuqavile ngoba ngokungefani nababelethisi abaqeqeshiwe abakutholile ukuqeqeshwa okuhlelekile base bekwazi ukuhlinzeka ngonakekelo lwezimpilo olufundelwe, iningi lababelethisi basekhaya abakutholanga ukuqeqeshwa okuhlelekile. U-Adatara, Strumpherand Ricks (2018) bayakufakazela lokhu futhi bancoma ukuba ababelethisi basekhaya bakhe amaxhama obambiswano emiphakathini yasemakhaya ukuqinisekisa uqeqesho lwamakhono akamuva lunikwa bonke ababelithisayo.

Kuyethenjwa futhi ukuthi insebenziswano phakathi kwababelethisi abaqeqeshiwe nababelethisi basekhaya kuzokhuthaza udluliselo phakathi kwala maqembu omabili. Udluliselo luzosiza ukuqinisekisa ukuthi ababelethisi basekhaya bayakwazi ukudlulisela isiguli esikhungweni sonakekelo lwezempilo futhi nababelethisi abaqeqeshiwe bayakwazi ukudlulisela isiguli emuva kumbelethisi wasekhaya kusenesikhathi. Lokhu kuzonciphisa izilibaziso kuqinisekise nokuqhubeka konakekelo okubalwa kukho ukwazi insukaphi yeziguli nokulandelela ukululama kwazo.. IRwanda Maternal Newborn and Child Strategic Plan 2018-2024 yagqamisa ukuthi iningi lokufa kwababelethayo nokwezinsana kuleli zwe kwakuhlobene nokulibaziseka ekudlulisweni, ukusingathwa kabi kwesimo nokuphuza ukubona okungahambi kahle esigulini (Rwanda Ministry of Health 2018). Insebenziswano nababelethisi abaqeqeshiwe kanye noqeqesho kuzokwelekelela ekuqinisekiseni ukuthi ababelethisi basekhaya abagagameli lapho benakekela iziguli futhi iziguli ezidinga unakekelo olungaphezu kwezinga lolwazi lwabo zidluliselwa ngokushesha ezikhungweni zonakekelo lwezempilo ukuze ziyothola unakekelo oluthe thuthu (Adatara, Strumpher and Ricks 2018).

Kuyacaca kulokhu okutholwe kulolu cwaningo kanye nemibhalo yocwaningo olwandulele lolu ukuthi ukuqamba iziqondiso zensebenziswano phakathi kwababelethisi abaqeqeshiwe nababelethisi basekhaya kumqoka ekwenzeni ngcono impumelelo yempilo yobelethayo nosana , ukuqinisekisa unakekelo oluqaphela amasiko noluphephile nokusebenzisa ngenzuzo izinsizakalo zonakekelo lwezempilo Iziqondiso ezinjalo zizosiza ekunciphiseni igebe phakathi kweenqubokwenza yesintu

nezonakekelo lwezempilo lwesimanje, ukuqinisekisa ukuthi bonke abesifazane bathola unakekelo olusezingeni eliphakeme uma bebeletha.

XI. Iqoqa lindlelakwenza iziqondiso

Lezi ziqondiso ziqanjweukukhuthaza insebenziswano phakathi kwababelethisi abaqeqeshiwe nababelethisi basekhaya nobekungenye yezinhloso zalolu cwaningo kuthathelwe kokutholwe ngucwaningo nezincwadi zalolu cwaningo obelwenziwana kuSifunda uThukela, KwaZulu-Natali eNingizimu Afrika kugxilwe kubabelethisi abaqeqeshiwe, ababelithisi basekhaya nabesifazane ezindaweni zokubelethisa ezahlukahlukene. Ucwawano luhlaziye amasu abesetshenziswa endaweni mayelana nobambiswano phakathi kwababelethisi basekhaya nonakekelo lwezokubelethisa eSifundeni uThukela kodwa kwatholakala ukuthi ibingekho insebenziswano. Nokho indlela okubukwa ngayo ababelethisi basekhaya nababelethisi abaqeqeshiwe nemibono yabesifazane mayelana nensebenziswano yababelethisi basekhaya nababelethisi abaqeqeshiwe ibimihle kakhulu, neningi emaqenjani amathathu eyishayela ihlombe insebenziswano. Amaphuzu athonya insebenziswano phakathi kwababelethisi abaqeqeshiwe nababelethisi basekhaya kucatshangiwe ngawo wonke ngenkathi kuhlangukiswa lezi ziqondiso. Iziqondiso eziphothiliweziqinisekise ongoti bezokubelethisa, abesifazane nababelethisi basekhaya ukuthi zihambelana nezimo nokulungela abazozisebenzisa.

XIII. UHLU LWEZIQONDISO

UHLU	ISIQONDISO
A	Isiqondiso sokukhuthaza ukuxhumana, ukuvulelekana nokungafihlelani
B	Isiqondiso sokukhuthaza impokophelo efanayo nomoya wokwazisa umsebenzi
C	Isiqondiso sokukhuthaza umoya wokwabelana nokunakekelana kunsebenziswano
D	Isiqondiso sokukhuthaza ukusebenza njengethimu nokubambisana phakathi kwababelethisi abaqeqeshiwe nababelethisi basekhaya

E	Isiqondisa sokukhuthaza ukubuka ngeso elehlukile nokucaciswa kobugugu phakathi kwababelethisi abaqeqeshiwe nababelethisi basekhaya.
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**ISIQONDISO A:
ISIQONDISO SOKUKHUTHAZA UKUXHUMANA, UKUVULELEKELANA
NOKUNGAFIHLELANI PHAKATHI KWABABELETHISI ABAQEQESHIWE**

Isizathu sokusebenzisa lesi siqondiso

Abesifazane kulesi sifundazwe, ikakhuluakzi labo abahlala emiphakathini yasemakhaya esebenzisa kokubili izikhungo zonakekelo lwezempilo nababelithisi basekhaya badinga unakekelo olusezingeni elihle kukho kokubiliababelethisi abaqeqeshiwe nababelethisi basekhaya ngenxa yezinkinga ezahlukahlukene. Lokhu akulula uma kungekho ukuxhumana okufanele phakathi kwezinhlangothi zombili.. Kokubili ababelethisi abaqeqeshiwe nababelethisi basekhaya kudingeka baqinisekise ukuthi kunokuxhumana, ukuvulelekelana nokungafihlelani ukuze bakwazi ukubambisana kahle ngokuqhubeka njalo. Ukungafihlelani kwakha ukwethembana nokukholakala, kwazise ababambiqhaza babheka izinhlaka ezinjengezikhungo zonakekelo lwezempilo njengezethembekile neziqotho Lokhu kwethenjwa kumqoka ekulondolozeni ubudlelwane obuhle, ikakhulukazi kubanakekeli, futhi kulokhu, ababelethisi abaqeqeshiwe nababelethisi basekhaya. Uma kunezinkinga, ukuxhumana okucacile nokuvulekile kumqoka ebuphathini obuyimpumelelo nokunciphisa ukonakala kwedumela okuzoba wusizo phakathi kwababelethisi abaqeqeshiwe nababelethisi basekhaya njengoba bevela ezizindeni ezingafani. Isiko lokungafihlelani lizokhuthaza ukwenza kangcono nokuqhamuka namasu amasha ngokuqinisa imigudu evulekile yokubikelana, kuqinisekiswa ukuthi lolo bambiswano lungoluqhubekayo. Kukho konke, lezi ziqondiso zizokwakha isisekelo esizoba yimpumelelo futhi esizoba nenkambisonhle.

Izincomo zokusetshenziswa kwalesi siqondiso

- Ukuphenjwa kwemigudu ecacile yokuxhumana namasu okwabelana ngolwazi phakathi kwababelethisi abaqeqeshiwe nababelethisi basekhaya ngokuqinisekisa ukuthi kuvame imihlangano phakathi kwalezi zinhlangothi,

okubalwa kukho nemihlangano yomphakathi okungadingidwa kuyo izinselelo, impumelelo nezinkinga ezisaqhubeka.

- Ukuqinisekisa ukusebenza njengethimu okuyimpumelelo nokudiidiyelwa konakekelo ukuqinisekisa ukuqhubeka konakekelo okungenazihibe kanye nokuqinisekisa ukuthi izinselelo zinqotshwa kalula.
- Ukuqamba nokuvumelana ngamathuluzi okuxhumana anjengamafoni uma kunolwazi oluphuthumayonodluliso, namadokhumenti eminingwane ephelile yokudluliswayo, kube kuqikelelwa ubungasese nokungadalulinokuba nesifuba.
- Ukuqinisekisa nokwakha ukuhloniphana nokuqondana phakathi kwababelethisi abaqeqeshiwe nababelethisi basekhaya.
- Ukuba nezinhlelo zokuqeqeshwa ndawonyelapho ababelethisi abaqeqeshiwe nababelethisi basekhaya bengasebenza ngokulandelelana beqaphela inqubokusebenza yomunye ukuze baqonde kangcono babone nendima yomunye nomunye.
- Ukubandakanya kokubili ababelethisi abaqeqeshiwe nababelethisi basekhaya ekuthatheni izinqumo kwesiguli esisebenzisa bobabili abasebenzi.
- Kufanele kube noqeqesho lokuxazulula udweshu njengoba lezi zinhlangothi zombili zingakujwayele ukusebenza ndawonye futhi abalamuli kufanele bakhethwe kuzo zombili izinhlangothi.

ISIQONDISO B:

ISIQONDISO SOKUKHUTHAZA IMPOKOPHELO EFANAYO NOKWAZISA UMSEBENZI

Isizathu sokusebenzisa lesi siqondiso

Lesi siqondiso sizokhuthaza insebenziswano senzengcono nempilo kamama nosana eyimpumelelo ukuqinisekisa ukuthi ababelethisi abaqeqeshiwe nababelethisi basekhaya baletha amakhono abo akhethekile nolwazi lwabo lokunakekela ababelethayo. Njengoba ababelethisi abaqeqeshiwe bethole uqeqesho oluhlelekile kwezabantwana nezokubelethisa, nababelethisi basekhaya beza nenhlakanipho yesintu namava okuthakwe nenqubokwenza yamasiko asendaweni, insebenziswano

enjalo kulula ukuba ibe yimpumelelo. Ngokukhuthaza ukwabelana nensebenziswano, lezi ziqondiso zingalekelela ukudidiyela okuhle kwazozimbili izindlelakubuka, kuholele onakekelweni oluphelele nolucabangela amasiko endawo. Lesi siqondiso futhi sizoqinisekisa ukuthi iziguli zithola unakekelo olungaguqukuguki kubo bonke abahlinzeki abahlukahlukene lapho khona ukufinyelela unakekelo lwezempilo kulinganiselwe. Amasu onakekelo okwabelwana ngawo azobhekelela izidingo zabesifazane ezingokwenyama nezingokomzwelo kwaziseababelethisi abaqeqeshiwe banikeza unakekelo, ababelethisi basekhaya basekela ngokomzwelo namacebiso athathelwe kundlelakwenza engokwesiko, umphumela kube iqhingakwenza eliphelele lokunikeza unakekelo kobelethayo. Uma ababelethisi abaqeqeshiwe nababelethisi basekhaya besebenza ngokuhlanganyela, lokhu kukhombisa ukuzibophezela ekuhlonipheni nasekwaziseni amasiko endawo ngenkathi kunikezwa unakekelo olusezingeni eliphakeme futhi lokho kungenza umphakathi ubethembe, kukhuthazeke ukwanda kwabantu abanganqikazi ukuza uma bedinga usizo.

Izincomo zokusebenzisa lezi ziqondiso

- Chaza indima nomthwalo wababelethisi abaqeqeshiwe nababelethisi basekhaya ababambe iqhaza kunsebenziswano enkankanywayo ucacise nokuthi indima ngayinye inikezelana kanjani nenywe.
- Xoxisana nabo bonke ababambiqhaza (uMnyango wezeMpilo, ababelethisi abaqeqeshiwe, ababelethisi basekhaya, abaholi bomphakathi nabasemagunyeni kwezempilo) ekukhandweni nasekusetshenzisweni kohlelo lwensebenziswano ukuqinisekisa ukuthi lezi ziqondiso ziyasebenziseka futhi zihambelana namasiko.
- Hlela njalo imihlangano nabambiqhaza ababandanekayo ukudingida osekwenziwe, ukudingida izinselelo nokuqoqa lokho okuyizenanelo ngokusetshenziswa kweziqondiso.
- Hlela izithangami zoqeqesho ezibandakanya kokubili ababelethisi abaqeqeshiwe nababelethisi basekhaya ezizogxila emaphuzwini anjengamakhono okuxhumana, ukusebenza nezizindamasiko ezehlukahlukene nemibiko ngentuthuko yabasacathuliswa. Lezi zithangami

zoqeqesho zingaqinisekisa ukuthi kuyahlangatshezwana nezidingo ngqo kanye nendlela kwenza yezinhlangothi zombili..

- Khuthaza ukuhloniphana nokungashayi indiva amakhono abanye futhi uqhakambise ubumqoka bezindlelakwenza zesintu bese uzididiyela namasu ezokwelapha esimanje.
- Qinisekisa ukukhandwa kohlelo lokulandelela, ukusebenzisa nokuhlola iziqondiso, ngokunjalo nokubona ukuthi kuyananyathelwa yini kuzo, ukuphumelela kwazo nokuhlonza amaphuzu okungenziwa kangcono luwo insebenziswano.
- Hlola umthelela wensebenziswano ngokusebenzisa imininingo ukuqinisekisa ukuthi iziqondiso ziyakufeza okuhlosiwe bese ulungisa uma kunesidingo.
- Nika ukweseka kubabelethisi abaqeqeshiwe nababelethisi basekhaya njengolekelelo ezinhlelweni zokusebenzisa iziqondiso ngempumelelo.

ISIQONDISO C:

ISIQONDISO SOKUKHUTHAZA UMOYA WOKWABELANA NOKUNAKEKELA KUNSEBENZISWANO

Isizathu sokusebenzisa lesi siqondiso

Ukusebenzisa lesi siqondiso kumqoka ngoba kuzolekelela ekwenzeni ngcono ukuxhumana, ukuxazulula izingxabano nokwenyusa izinga lokusebenza kwababelethisi abaqeqeshiwe nababelethisi basekhaya ngenkathi kusetshenziswa. Kuzokhuthaza ukumbandakanya bonke nokuvumela ukwehlukahlukana, ukuqinisekisa ukuthi amalungu ethimu azizwa emqoka futhi enikwa indlebe. Indlelakwenza engaguquguquki iqinisa uukulandisa futhi ilethe usiko oluzinzile lokwesekwa ukuqinisa ukuzethembanokugculiswa ngumsebenzi Lesi siqondiso futhi sizokhuthaza ukuqamba amasu amasha ngokuvumela ukubeka imibono ngokungesabi nokuphuthumisa ukwethulwa nokujwayezwa umsebenzi ababelethisi abaqeqeshiwe nababelethisi basekhaya. Sekukonke, iziqondiso ezicacile zenza

amathimu akwazi ukuzivumelanisa nezinguquko ngempumelelo, okuholela kunsebenziswano engenazihibe, eyimpumelelo neqhamuka nezinto ezintsha.

Izincomo zokusebenzisa lesi siqondiso

- Hlela imihlangano yokubukeza yokudingida osekwenziwe nokuqhamuka namasu okuzokwenziwa kususela kokubikiwe nasemiphumeleni yokuhlola umsebenzi ukuze kuqhubeke kwenziwa ngcono isimo sensebenziswano.
- Ukubamba izikhuthazakusebenza zokuzithuthukisa zemfundo nezomsebenzi ezihambisana nezithangami zokucobelelana ngonakekelo lwababelethayo nezingane ngokunjalo nokusebenza nabezinsana nabezizinda ezehlukahlukene.
- Ukukhuthaza ukwabelana ngendlelakwenza engcono namaqhinga ayimpumelelo okusetshenziswa ababelethisi abaqeqeshiwe nababelethisi basekhaya.
- Ukusungula inqubo ecacile yokubhekana nezingxabana nokuzixazulula uma zivela.
- Ukuqinisekisa ukuthi kokubili ababelethisi abaqeqeshiwe nababelethisi basekhaya banamathuba alinganayo okubamba iqhaza nasekuthatheni izinqumo.
- Khuthaza ukuqonda nokuhlonipha ukuhlukahlukana kwamasiko nendlelakwenza yesintu.
- Sebenzisa izinhlelo zokuqhakambisa nokushayela ihlombe iqhaza nempumelelo yakho kokubili ababelethisi abaqeqeshiwe nababelethisi basekhaya ngesikhathi sensebenziswano.
- Nikeza ukwenanelangendlela enokweseka nenhlonipho, ugxila kokuhle nasemaphuzwini okusadinga ukwenza ngcono kuwo.
- Yenza amathuluzi ezobuchwepheshe okuthumela imiyalezo, ama-imeyili nezinkundla zokuxhumana nokusimamisa ukuxhumana okunganqamuki nokuqinisa uhlelo lodluliso.
- Yakha umoya wokungahlulelani lapho onke amalungu ethimu ezizwa ekhululekile ukusho akucabangayo nokuwakhathazayo.

- Chaza ngokucacile futhi wazise bonke ngendima nomthwalo wakho kokubili ababelethisi abaqeqeshiwe nababelethisi basekhaya ukugwema ukudideka nokungaqondani.

ISIQONDISO D:

IZIQONDISO ZOKUKHUTHAZA UKUSEBENZA NJENGETHIMU NENSEBENZISWANO PHAKATHIABABELETHISI ABAQEQESHIWE NABABELETHISI BASEKHAYA

Isizathu sokusebenzisa lesi siqondiso

Lesi siqondiso sihlose ukuthuthukisa unakekelo lwababelethayo nabadlenzane oluyimpumelelo nokwenza ngcono ukusebenza njengethimu nensebenziswano phakathiababelethisi abaqeqeshiwe nababelethisi basekhaya. Insebenziswano eyimpumelelo phakathi kwalezi zinhlangothi zombili imqokafuthi izoqinisekisa ukuthi zombili izinhlangothi zingabelana ngokuzuzisayo ulwazi, amakhononezinsiza, ukwenza ngcono izinga lonakekelo olunikezwayo futhi izovala igebe phakathi kwezindlelakwenza zesimanje nalezo zesintu ukuqinisekisa unakekelo oluphelele. Imvamisa kunemiphumela emihle uma kusetshenzwa njengethimu nensebenziswano ikakhulukazi uma zombili izinhlangano ziphokophelele okufanayo, kubalula ukuba zisebenze njengethimu ukuqinisekisa ukuncipha kwezinga lokufa kwababelethayo nokwenza ngcono unakekelo lwababelethayo nemidlenzane oluyimpumelelo. Ngaphezu kwalokho, lesi siqondiso sizosungula izindima ezicacile nomthwalo wabasebenzi sinciphise nokudideka, futhi sizolekelela ekukhuthazeni ukubuka ngeso lokubambisana ukubhekana nezinsalelo eziqhamuka ngenkathi kuqhutshekwa, okuzoholela ekuhlinzekeni ngezinsizakalo eziphephile neziphumelela kangcono zezempilo ekubeletheni.

Izincomo zokusetshenziswa kwalesi siqondiso

- Yenzisa uqeqesho oluzobandakanya kokubiliababelethisi abaqeqeshiwe nababelethisi basekhaya ukuze kwabelwane ngolwazi nokuhloniphana.
- Uqeqesho lwababelethisi basekhaya luzabandakanya ukulingisela ukuqinisekisa ukuthi amakhono abo ayathuthukiswa ngokuhambelana

nenqubokwenza yesimanje yezokubelethisa nokuhlonza nemisebenzi engasingathwa ngempumelelo ngababelethisi basekhaya.. Ababelethisi basekhaya bangaba ngophathina bababelethisi abaqeqeshiwe ukuze bacathuliswe njengengxenywe yoqeqesho lwabo.

- Ukuchaza nokucacise indima nomthwalo wababelethisi abaqeqeshiwe nababelethisi basekhaya ukuqinisekisa ukuthi akukho ukugamanelana komsebenzi nokuqhakambisa umsebenzi odinga ubuchwepheshebabelethisi abaqeqeshiwe.
- Hlela futhi ubambe imihlangano laphoababelethisi abaqeqeshiwe nababelethisi basekhaya bezodingida izimo ezahlukene baxoxe ngababhekane nakho futhi baxazulule noma yiziphi izingxabano.
- Sungula imugudu yokuxhumana ethembekile ukuqinisekisa ukuxhumana okunganqamuki(isib. uma kunesimo esiphuthumayo, ukucacisa, kodluliso nokwenanela).
- Qinisekisa ukuhloniphana phakathi kwababelethisi abaqeqeshiwe nababelethisi basekhaya bese uphamba ukuthemba nokuhlonipha ulwazi lwesintu nendlelakwenza engokwesiko yababelethisi basekhaya, nabo benze okufanayo kwabaqeqeshiwe.
- Hlinzeka ababelethisi basekhaya ngezinsiza ezinjengempahla yokuzivikela, izikele, izibulalamagciwane, namafomu odluliso ukuqinisekisa ukuthi basebenza ngempumelelo kwabakwenzayo.
- Bandakanya umphakathi nabholi ukuqinisekisa ukuthi insebenziswano ayinaziphazamiso ngokwenza imikhankaso yokuqwashisa ukubafundisa ngesidingo nezinzuzo zokudidiyela ababelethisi basekhaya ezinhlelweni zonokekelo lwezempilo.
- Yenza ngcono bese uyayisebenzisa inqubomgomo nemithetho edinga ukulandelwa okuzokweseka ukudidiyelwa kwababelethisi basekhaya ezinhlelweni ezihlelekile zonakekelo lwezempilo.
- Sungula izindlelazodluliso nokwenanela kukho kokubili ababelethisi abaqeqeshiwe nababelethisi basekhaya ukuthuthukisa nokuqinisekisa insebenziswano.

- Hlola impumelelo yokusebenza njengethimo nemizamo yensebenziswano phakathi kwababelethisi abaqeqeshiwe nababelethisi basekhaya.

ISIQONDISO E:

ISIQONDISO SOKUKHUTHAZA UKUBUKA NGESO ELEHLUKILE NOBUGUGU KWABABELETHISI ABAQEQESHIWE NABABELETHISI BASEKHAYA

Isizathu sokusetshenziswa kwalesi siqondiso

Lesi siqondiso sibalulekile ukudlelanisa indlelakubuka yababelethisi abaqeqeshiwe nababelethisi basekhaya ngokukhuthaza ukuba izinhlangothi zombili ziqonde futhi zazise indima yomunye nomunye, imibono nobungoti, nokukhuthaza ukuhloniphana nokubambisana. Ngokucacisa ubuguguababelethisi abaqeqeshiwe nababelethisi basekhaya bangabona ngaso linye ngabakuphokophelele okungukunika omama nezinsana unakekelo olungcono ngangokunokwenzeka. Lokhu kubuka ngeso elehlukile kungaholela ngempela ensebenziswaneni eyimpumelelo kangcono, lapho zombili izindlelakwenza zididiyelwa futhi njengomphumela, lokhu kudlelanisa kunciphisa izingxabano kwandise ukuthembana emphakathini kuqinisekise nendlelakubuka ebhekelela konke kunakekelo lwezempilo ngesikhathi sokubeletha nesobudlenzane, ekugcineni kuholele emiphumeleni engcono nokukhula kokugculiseka ezigulini. Ngakho, ukusebenzisa lesi siqondiso kudinga indlela ebuka nhlangothi zonke egxila ekufundiseni, ukuxhumano okuhle nenqubokwenza enokubambisana.

Izincomo zokusetshenziswa kwalesi siqondiso

- Yenza futhi ubambe izikhuthazakwenza ezibandakanya kokubili ababelethisi abaqeqeshiwe nababelethisi basekhaya, kugxilwe emigomeni efanayo, inqubokwenza enhle nokuhloniphana okuzodidiyela noqeqesho lokusebenzisana nezizindamasiko ezahlukahlukene ukusiza ababelethisi abaqeqeshiwe baqonde ubumqoka obungokwesiko kwababelethisi basekhaya, nabo ngokunjalo baqonde okwababelethisi abaqeqeshiwe, ukukhuthaza ukuhloniphana.

- Sungula imihlangano yazikhathi zonke lapho ababelethisi abaqeqeshiwe nababelethisi basekhaya bezoxoxa khona ngezimo, babelane ngamava, baxazulule nezingxabano okuzokwenza ngcono ukusebenza njengethimu.
- Sebenzisa amasu okwenanela ahlelekile okuvumela izinhlangothi zombili ukuba zibeke ilaka lazo ngokuzikhathazayo nokungaba yizixazululo ngendlela eyakhayo.
- Bandakanya kokubili ababelethisi abaqeqeshiwe nababelethisi basekhaya lapho wenza inqubokulandelwa yonakekelo ehlonipha inqubokwenza yesintu ube uqinsekisa ukuphepha kwesiguli.
- Qamba izinyathelo ezididiyela inqubokwenza yezokwelapha yesintu neyesimanje, uqinisekisa amasu angenazihibe onakekelo lwezempilo yomama nomntwana.
- Qhuba imikhankaso yokufundisa umphakathi ezolekela ekuqhakambiseni ubumqoka bakho kokubili ababelethisi abaqeqeshiwe nababelethisi basekhaya, ukukhuthaza ukuhloniphana nensebenziswano phakathi kwabo.
- Xoxisana nabaholi bomphakathi wethule iziqondiso ukuze bazeseke futhi bazigunyaze ukuqinisekisa ukwamukelwa kwazo ngumphakathi nokunamathela kuzo.
- Sebenzisa okuphawule ekuhloleni obekwenziwa ukuze ulokhu ucolisisa futhi uzithuthukisa iziqondiso nokusetshenziswa kwazo.
- Qinisekisa ukuthi izikhungo zonakekelo lwezempilo ziyayemukela futhi ziyayisebenzisa inqubomgomo eyeseka nephoqelela iziqondiso, ukuhlinzeka ngezinsiza nengqalasizinda okudingekayo.

8.3 AMAZWI OKUPHETHA

Insebenziswano engenazihibe phakathi kwababelethisi abaqeqeshiwe nababelethisi basekhaya ingaqinisekisa ubudlelwane bomphakathi obuhle kakhulu iphembe namaxhama ensebenziswano ekuphokopheleni ukunciphisa ukufa komama bebeletha UMutale nabanye (2020) baqhakambisa isidingo sohleleko lwamaxhama phakathi kwabelaphi besintu nabalingani babo ngokuhlinzeka ngezinsizakalo zezempilo eziyindidiyela ezizolekelela ekuqashelweni kwabelaphi ezinhlelweni zonakekelo lwezempilo kusetshenziswa ukuxhumana okuhle, ukwakhiwa

kobudlelwane nokuhlonzwa kwamikhakha yensebenziswano phakathi kwezinhlangothi zombili. Ukuqamba lezi ziqondiso ukuphamba insebenziswano phakathi kwababelethisi abaqeqeshiwe nababelethisi basekhaya kulesi sifundazwe kubukwa njengomnyakazo omuhle nanjengeqhaza eliqavile kuzinsizakalo zonakekelo lwababelethayo nezingane kuleli zwe. Lezi zinsizakalo, uma zisetshenziswa zingakhuthaza ukusebenzisana nokwazana kahle phakathi kwababelethisi abaqeqeshiwe nababelethisi basekhaya, ukuqinisekisa imigudu yokuxhumana ecacile nokuhlinzeka ukuhlanganyela ezinhlelweni zokuqeqesha Indlela yensebenziswano ingavumela futhi ukudidiyelwa kwenqubokwenza engokwesiko eyamukelekile, eqinisekiswe ngokwemigudu yesayensi ukukhuthaza ukwethembeka nokubambisana. Ukwabelana ngendima nemithwalo, ukusungula inqubokulandelwa ehlekile yokudlulisa iziguli uma kunezimo eziphuthumayo nokuvula amathuba emfundo eqhubekayo kungagwema ukushiyana kwamakhono akho kokubili fababelethisi abaqeqeshiwe nababelethisi basekhaya, ukuqinisekisa ukuthi omama nezingane bathola unakekelo oluvelele ngangokunokwenzeka kukho konke ukukhulelwa, ukubeletha nangesikhathi sobudlenzane. Ukuqamba lezi ziqondiso kubandakanya ukukhuthaza umoya wokuhloniphana futhi kuyiqhaza elingeke lizuzise iSifunda uThukela kuphela kodwa nezinye izifundazwe, ngokunjalo neNingizimu Afrika, kwedlulele nakwamanye amazwe njengoba nezinye izindawo emhlabeni jikelele nazo zinababelethisi basekhaya kanye nababelethisi abaqeqeshiwe abasebenza endaweni efanayo ngaphandle kokuxhumana nensebenziswano.

8.4 IQOQA LESAHLUKO

Lolu cwaningo luqambe iziqondiso ezizokwelekelela kunsebenziswano phakathi kwababelethisi abaqeqeshiwe nababelethisi basekhaya KwaZulu-Natali. Ukuqamba iziqondiso zensebenziswano kucabangisisile ngenzuzo nokulinganiselwa kwakho kokubili ezokubelethisa nezinsizakalo zababelethisi basekhaya. Umgomo bekungukuqamba uhlelo lapho lezi zinsizakalo zinikezelana, ekugcineni zizuzisa impilo nenhlalakahle yabesifazane abakhulelwe endaweni yasemakhaya obekucwaningwa ngayo. Kulindelwe ukuba iziqondiso, uma zisetshenziswa, zizobhekana namaphuzu anjengoqeqesho, ukuxhumana, amasu okudlulisela iziguli, nokudidiyelwa kwenqubokwenza yesintu ihlangabezane nemigomo yesimanje

yonakekelo lwezempilo. Lezi ziqondiso zizozuzisa umphakathi ozobandakanya umphakathi nemindeni nabo abazoqinisekisa ukweseka ngokukhuthaza abesifazane ukuba nabo basebenzise uhlelo lonakekelo lwezempilo. Ababelethisi abaqeqeshiwe bazofunda izindlela ezintsha zokusingatha abesifazane, bakwazi nokuhlonza abesifazane abadinga unakekelo lwababelethisi basekhaya babadlulisele kubona, futhi ababelethisi basekhaya nabo bazozuza ngokuthola ulwazi lwezokwelapha nezinsiza bakwazi ukuxhumana nezikhungo zonakekelo lwezempilo noma nini uma kunesidingo. Abesifazane bayingxenye ebaluleke kakhulu kulolu cwaningo futhi bazozuza ngokuthola unakekelo olusizingeni kukhona kokubili ababelethisi abaqeqeshiwe nababelethisi basekhaya ngaphandle kovalo lokuthethiswa uma besebenzisa ababelethisi basekhaya.

Appendix 15: Introduction to Research Ethics Certificate



Zertifikat Certificat

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Appendix 16: Editing certificate

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DUT doctoral thesis: **GUIDELINES TO FACILITATE COLLABORATION
BETWEEN MIDWIVES AND TRADITIONAL BIRTH ATTENDANTS IN
KWAZULU-NATAL**

I confirm that I have edited this thesis and the references for clarity and language. I returned the document to the author with track changes so correct implementation of the changes and clarifications requested in the text and references is the responsibility of the author. I am a freelance editor specialising in proofreading and editing academic documents. My original tertiary degree which I obtained at the University of Cape Town was a B.A. with English as a major and I went on to complete an H.D.E. (P.G.) Sec. with English as my teaching subject. I was a part-time lecturer in the Department of Homoeopathy at the Durban University of Technology for 13 years and supervised many master's degree dissertations during that period.

Dr Richard Steele

7 December 2025

per email

Appendix 17: Turnitin Report

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GUIDELINES TO FACILITATE COLLABORATION BETWEEN
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