INDIGENOUS STORIES OF PREGNANT WOMEN IN BOTSHABELO ON ENSURING POSITIVE PREGNANCY OUTCOMES

by

DITSIETSI PALESA VALERIA KORTMAN

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SUPERVISOR: MRS M.R. MPELI
CO-SUPERVISOR: MRS M. MOTLOLOMETSI

DECLARATION

I, Ditsietsi Palesa Valeria Kortman hereby declare that the dissertation submitted for the Magister Socientiae (MSoc Sci) in Nursing degree to the University of the Free State and entitled:

Indigenous Stories of Pregnant Women in Botshabelo on Ensuring Positive Pregnancy Outcomes is my original work and has not been previously submitted for another academic qualification at any university/faculty, and that all the sources that I have used have been indicated and acknowledged by means of complete references.

Signature: …… **Date:** 31 January 2020

(DPV Kortman)

DEDICATION

This research study is dedicated to:

- Myself: The naive woman who was trapped deep within me. Trapped in her thoughts and belief that she was not capable and intelligent enough to complete this research project. With this work, I affirm the woman within me that: “Not even the sky is the limit”.
- My husband: Moalusi Moalusi II. I am grateful to his undying love and support. This journey was hard, but he made it easy by sharing its travails with me.
- My mother: Tlaleng Adonsi. I would never survive the rigorous demands and loneliness of this study without her prayers which anchored me throughout.
- My siblings: I thank them for always being their sister’s keeper. I thrive because they always have my back.

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I sincerely express my most heartfelt gratitude to:

- Almighty God: For the opportunity and endurance to begin and to bring to completion what I have started. Without His Grace, this project would still be nothing but an unfulfilled dream.
- The study participants: Without their contribution, there would be no study for me to begin with. I sincerely thank them for opening up to a stranger and trusting me with their personal stories.
- My supervisor, Mrs M. Mpeli: I do not have enough words to thank her for the expert support and remarkable patience, as well as her uncompromising encouragement. She has been a fountain of knowledge and wisdom which always succoured me without any disappointment. I thank her endlessly for everything.
- My co-supervisor, Mrs Motlolometsi: I thank her for the guidance and vastness of knowledge and experience she imparted.
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- The University of the Free State postgraduate fees bursary. I am utterly thankful for the funding opportunity to pursue my postgraduate studies.
- The University of the Free State School of Nursing's Research Committee: Thank you the funding, your assistance helped with editing fees.
- The Free State Department of Health: I am indebted to the trust shown by granting me permission to conduct the research.
- Dr TJ Mkhonto: I extend my thankfulness for his professional language editing of this dissertation.

LANGUAGE EDITING DECLARATION

PROOF OF ACADEMIC EDITING

This letter serves as proof of comprehensive academic editing, language control, text redaction, research methodology compatibility, and technical compliance for **Mrs Palesa DV Kortman (Student Number: 2009014263)** in respect of her manuscript submitted to me for her Master of Social Science in Nursing (MSoc Sci Nursing) degree registered with the Faculty of Health Sciences at the University of the Free State, with the title:

Indigenous Stories of Pregnant Women in Botshabelo on Ensuring Positive Pregnancy Outcomes

In my capacity as an independent academic editor, I attest that all possible means have been expended to ensure that the final draft of **Mrs PDV Kortman's** document reflects acceptable language control standards expected of postgraduate research studies.

I have also provided editorial support in respect of her academic supervisor's suggested corrections and recommendations in compliance with acceptable practices in research methodology.

I have further undertaken to keep all aspects of **Mrs PDV Kortman's** study confidential, and as her own individual initiative in compliance with conventional ethical principles in research.

Sincerely.

TJ Mkhonto
BA Ed: North-West University, Mahikeng (1985)
M Ed (School Administration): University of Massachusetts-at-Boston, USA, Harbor Campus (1987)
PhD (Higher Education Curriculum Reform, Design & Management): University of Johannesburg, Aucklandpark Campus (2008)

All enquiries:
Email: mkhonto9039@gmail.com
Cell: 062 921 9826 **OR** 076 035 2929

Signed: _____ **Date:** 27 January 2020

Dr TJ Mkhonto dd/mm/yyyy

Independent Academic Editor

ACRONYMS USED IN THE STUDY

AIDS	Acquired Immune Deficiency Syndrome
ANC	Ante-Natal Care
BDH	Botshabelo District Hospital
CEO	Chief Executive Officer
DoH	Department of Health
FSDoH	Free State Department of Health
FSP	Free State Province
GSDG	Global Sustainable Development Goal
HIV	Human Immune Virus
HSREC	Health Sciences Research Ethics Committee
IUGR	Intra-Uterine Growth Restriction
LMICs	Low to Middle Income Countries
NDoH	National Department of Health
NaPeMMCO	National Perinatal Morbidity and Mortality Commitee
SA NDoH	South African National Department of Health
STIs	Sexually Transmitted Infections
WHO	World Health Organisation

CLARIFICATION OF CONCEPTS

CLARIFICATION OF CONCEPTS

The key concepts identified in this study reflect the dominant literature-based themes and perspectives, conceptual/ theoretical orientations of the study, as well as the relevance or significance of the study's empirical preferences as adopted by the researcher (Mertens, 2015:2). Furthermore, the rationale for the clarification of the below-cited concepts premises on the need to present both their connotative and denotative or contextual application in the study. The sequence of the concepts does not suggest their order of prioritisation in the study. The following concepts are used and discussed in this study:

Ensuring

Developing a particular mechanism or contribution to a particular situation to enhance or influence its outcomes (Merriam-Webster Dictionary, 2018). For the purpose of this study, 'ensuring' refers to the precautionary indigenous measures undertaken to influence a safe pregnancy and a healthy baby as the desired end-result of the pregnancy.

Positive

A state characterised by a presence rather than the absence of a distinguishing feature (Oxford Advanced Learner's Dictionary, 2010:1140). In this study, 'positive' refers to an alive baby as the end-result of pregnancy.

Pregnancy outcome

The final result or end-result of conception, characterised by a live birth, (full-term or pre-term birth) stillbirth or abortion, of which abortions and stillbirths are common adverse pregnancy outcomes that do not result in live births (Asiki, Baisley, Marions, Seeley, Kamali & Smedman, 2015:280; Blackwell's Nursing Dictionary, 2005:476). For the purposes of this study, 'pregnancy outcome' refers to the pregnant women's indigenous practices in ensuring a healthy mother and an alive baby upon delivery.

Indigenous

Tradition-based practices and cultures according to which particular groups of people or communal societies preserve their cultural integrity by resisting assimilation into policies of the nation-state (Corntassel, 2003:78). For the purposes of this study, 'indigenous'

refers to socio-cultural practices that resist collaboration with conventional or dominant healthcare guidelines in the prevention of adverse pregnancy outcomes.

Stories

Narratives that are a representation or embodiment of events and understanding of individual or group experiences within a certain context (Andrews, Squire & Tamboukou, 2008:23). In this study, 'stories' refer to indigenously framed narratives by pregnant women relating to the role of socio-cultural influences in ensuring maternal and foetal wellbeing.

Pregnancy

The state of having an embryo developing in the woman's uterus from conception until birth (Blackwell's Nursing Dictionary, 2005:476). In this study, 'pregnancy' refers to an alive foetus in-utero at any gestational age.

Women

Female human adults (Oxford Advanced Learner's Dictionary, 2010:1710). For the purpose of this study,' women' refers to pregnant females attending antenatal care at local clinics, from 18 years of age.

ABSTRACT

Negative pregnancy outcomes such as stillbirths are an undesirable occurrence in Botshabelo, Free State Province. The fear of such outcomes often propels pregnant women to seek multiple interventions to ensure positive pregnancy outcomes instead. In many African cultures, pregnancy is considered a sensitive life event. Necessarily, traditional methods ought to be in place for the protection of the pregnant woman and her unborn baby. It is against this background that the purpose of the study was to explore and describe the indigenous stories of pregnant Botshabelo women in ensuring positive pregnancy outcomes.

The study opted for a qualitative research design approach in its exploration and description of the indigenous stories of pregnant Botshabelo women in their endeavour to ensure positive pregnancy outcomes. In-depth individual interviews were conducted with 12 (twelve) purposively sampled pregnant Botshabelo women for the collection of the study's empirical data, which was subsequently analysed thematically for the purpose of constructing intelligible categories of meanings in relation to both the investigated problem and the study's main purpose.

The main findings of the study revealed that indigenous beliefs and practices were a vital element during pregnancy among the Botshabelo women. These culturally-steeped beliefs and practices were viewed as fundamentally instrumental and central to the support systems required for sustenance before, during, and after pregnancy.

The key recommendations included the implementation of an integrated health system that prioritised collaboration of indigenous and non-indigenous health systems.

Key words: indigenous stories, positive pregnancy outcomes, ensuring, negative pregnancy outcomes, effective health systems

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CHAPTER 1
OVERVIEW OF THE STUDY

1.1. INTRODUCTION/ CONTEXT OF THE STUDY

This chapter presents an overview of the entire study in respect of its constitutive research variables that have been presented and discussed in more detail in the ensuing chapters (Savin-Baden & Major, 2013:14). Following the introduction, the chapter further entails critical research variables or units of analysis such as the research problem, aim or purpose of the study and its attendant research question, clarification of concepts, the research design and methods (methodology), data collection and analysis, the sampling domain, ethical issues, scope of the study, chapter layout, and the conclusion of this chapter.

Relevant documentation of indigenous stories of women regarding the prevention of negative pregnancy outcomes is absolutely critical, since it is likely to enable effective and sustainable preventative strategies for the healthcare system. Hamid, Malik and Richard (2014:331) confirm that such documentation is the bedrock of policies aimed at informing and influencing positive pregnancy outcomes in the context of cultural attitudes, beliefs and practices of the local communities. Socio-cultural structures, as well as societal and cultural values and practices have an impact on the behaviours and stories of individuals regarding the prevention of negative pregnancy outcomes (Hamid et al., 2014:331). However, dissimilarity in viewpoints between society and healthcare providers is likely to create communication disengagement. For instance, it is well known that the strategy of preconception care is likely to promote positive pregnancy outcomes, but such a service is still not asserting a specific target in reducing negative pregnancy outcomes, as 40% of the pregnancies are unplanned, and the essential biomedical, behavioural and social health interventions prior to pregnancy are compromised (WHO, 2013:2).

There is sufficient evidence to support the efficacy of implementing preconception care that targets the biomedical, behavioural, social and environmental factors prior to pregnancy (Dean, Lassi, Imam & Bhutta, 2014:1). Good quality antenatal care (ANC) is another strategy of care, marked by early booking and ongoing monitoring of the pregnant

woman's health status and foetal well-being (Joshi, Torvaldsen, Hodgson & Hayen, 2014:2). According to Al-Ateeq and Al-Rusaiess (2015: 239), comprehensive antenatal care is a platform for imparting beliefs and addressing attitudes for the best pregnancy outcomes. Contrarily, there is a claim that these established interventions may be limited in altering the maternal behaviours and preventing several conditions associated with adverse pregnancy outcomes (Esposito, Ambrosio, Napolitano & Di Giuseppe, 2015:2). The latter authors further espouse that women could possibly be receiving little information during gynaecological examinations. It is also not well established whether or not the gynaecological information communicated to the pregnant mothers and their families was consistent with their socio-cultural circumstances and belief system. Given the potential benefits of preconception care and comprehensive antenatal care, it would be expected that there would be a noticeable reduction of negative pregnancy outcomes consequently.

The global rate of 2.6 million stillbirths annually is reflective of the magnitude of negative pregnancy outcomes, with 90% of these occurring in low-to-middle income countries (LMICs) (World Health Organisation/ WHO, 2014:12). In South Africa, there are currently about 20 000 stillbirths annually, implying a rate of 55 stillbirths on a daily basis (Michalow, Chola, McGee, Tugendhaft, Pattinson, Kerber & Hofman, 2015:1). The ramifications of such figures are that more improvements are still needed for South Africa to meet the set stillbirth targets of fewer than 12 stillbirths per 1000 live births by 2030 (WHO, 2014:21). Although there is evidence of achievement of a slight 2% annual rate reduction worldwide, such reduction is not satisfactory, as one death is just one too many (Frøen, Lawn, Heazell, Flenady, de Bernis, Kinney, Blencowe & Leisher, 2016:4).

The statistical information above indicates that the crisis of negative pregnancy outcomes still persists, which provides an opportunity to revisit the current preventative practices and explore other measures to target preconception, antenatal and intrapartum care for the women and their families. Based on the high rates of preventable negative pregnancy outcomes, the question arises whether or not such information (preventable negative pregnancy outcomes) is communicated to the women. If so, whether such information was comprehended, given that the women filtered such information based on their socio-cultural orientation and experiences (Svensson, Barclay & Cooke, 2008:336-37).

1.1.1**.** Factors Associated With Negative Pregnancy Outcomes

The causes of negative pregnancy outcomes are numerous, and these are attributable to maternal, foetal and socio-economic factors. Maternal factors relate to the medical conditions that the mother may have prior to, or during the pregnancy; such as the Human Immune Virus (HIV), Rubella, hypertensive disorders and diabetes (Aminu, Unkels, Mdegela, Adaji & van der Broek, 2014:146). Maternal factors and related complications of pregnancy are ranked the highest amongst all other factors associated with negative pregnancy outcomes (National Perinatal Morbidity and Mortality Committee/ NaPeMMCO, 2011:22). The foetal factors that could lead to negative pregnancy outcomes include congenital abnormalities, placental abruption, placenta previa and intra-uterine growth restriction (IUGR) due to amniotic and uterine problems (Aminu et al., 2014:146).

A large number of the negative pregnancy outcomes (97.6 %) was attributed to the maternal conditions originating in the antenatal period, while a very small percentage (2.4%) was due to malformation of the foetus (NaPeMMCO, 2011:22). Socio-economic factors such as poverty and lack of education also contribute to high stillbirth rates in developing countries (Aminu et al., 2014:146). Hamid et al. (2014:331) state that socio-cultural factors may be a major barrier in preventing negative pregnancy outcomes. In such contexts, a pregnant woman may not have the financial means to consume sufficient nutrients during pregnancy, or may be prevented from doing so by culturally induced considerations. Such a state of affairs may result in maternal malnutrition, eventually causing intrauterine growth restrictions. It is evident from the multiple literature-based perspectives that the documentation of indigenous stories of pregnant women could enhance the conceptualisation and combat problems linked to the negative pregnancy outcomes syndrome engendered by socio-economic and cultural factors (Aminu et al., 2014:146).

1.1.2. Evidence-based Strategies for Prevention of Negative Pregnancy Outcomes

Preconception care is vital in improving pregnancy outcomes to eventually ensure positive end- results. Preconception care interventions are aimed at empowering a child-bearing woman to decide when to conceive, in order to ensure that she is in the best state of health possible. Such interventions serve as a mechanism to reduce health risks that may affect the foetus due to maternal ill-health (Dean et al., 2014:1). The essence of

preconception care is to ensure the pregnant woman's healthiest state prior to the pregnancy; thus, minimising complications (Witt & Huntington, 2016:1).

The importance of comprehensive antenatal care and its attendant early booking, is that it ensures a healthy maternal status, as well as good growth and development of the foetus (Mason, Chandra-Mouli, Baltag, Christiansen, Lassi & Bhutta, 2014:2). This can be achieved by health education, routine supplement nutrition, and early detection of complications (Hofmeyr & Mentrop, 2015:902); as well as the disuse of traditional medicines, which may be harmful to the wellbeing of the foetus (Eni-Olurunda, Akinbode & Akinbode 2015:316).

1.2. PROBLEM STATEMENT

The research problem is essentially the articulation of a problematic or difficult situation that the researcher intends to resolve by undertaking the study (De Vos, Strydom, Fouche & Delport, 2011:117). In the case of this study, the research problem is principally located within the unabated occurrence of negative pregnancy outcomes (e.g. stillbirths) as a factor of both socio-economic and cultural factors in Botshabelo, Free State Province (FSP).

The reduction of the rate of negative pregnancy outcomes is commendable as a global sustainable development goal (GSDG) and a target expected to be achieved by 2030. However, the worldwide 2% improvements in stillbirth mortality rates has not had positive effects in Botshabelo, where stillbirth rates remain high at 16.4% for 2018-2019 (Free State Department of Health/ FSDoH, 2019:61). The current preconception and antenatal care practices may be limited in their scope to alter a history of pregnant women characterised by disturbing high figures of negative pregnancy outcomes. In this regard, maternal care guidelines should focus on communicating risk factors to pregnant mothers during preconception care and antenatal period. Such risks include genetic disorders due to family history, poorly controlled medical conditions and use of alcohol and recreational drugs by the mother (National Department of Health/ NDoH, 2015:33-35). Although such focus is indispensable, it may preclude other sources of information and socio-cultural aspects that were likely to either support/ complement or negate the conventional healthcare information system and practices.

It is the contention of this study that imparting information that is incongruent with local beliefs may not be a panacea or guarantee comprehension of such information. Therefore, the study focuses on the importance of endorsing pregnant women's indigenous (culturally-steeped) stories relating to childbirth as an essential component in optimising foetal wellness and ensuring positive pregnancy outcomes. The results of the study should provide a clear understanding of the reasons for the slow statistical decline of stillbirth despite the prevalence of acknowledged preventive measures.

1.3. RESEARCH PURPOSE

The aim or purpose of the study is the fundamental measure of the primary intention of the particular study; that is, what it intends to achieve in broad terms (Henning, Van Rensburg & Smit, 2004:56). In this regard, the study's aim or goal is: *To explore and describe the indigenous stories of pregnant women in Botshabelo relating to positive pregnancy outcomes*. Based on the findings, recommendations are made to enrich existing preventive care strategies to eliminate negative pregnancy outcomes.

1.4. RESEARCH QUESTION

Research questions are basically the interrogative representation of the research purpose, and guide the researcher throughout the study within the framework of the problem to be resolved (Marshall & Rossman, 2016:28). In this study, the pertinent research question is: *What are the indigenous stories of pregnant women in Botshabelo regarding positive pregnancy outcomes?*

1.5. RESEARCH DESIGNS

Research design is defined as a blueprint or management plan outlining the decisions, processes and strategies adopted for the execution or implementation of the research, from which other researchers are able to choose the applicable strategy to their needs (De Vos et al., 2011:73). Most importantly, the research design logically encompasses the research philosophy or paradigm and assumptions, the research approach and the research methods or techniques (Polit & Beck, 2012:194).

1.5.1 Research Paradigm/ Philosophy

The research philosophy or paradigm is reflective of a particular conceptual perspective and assumptions that underpin the scientific parameters, inclination or orientation of a research study in respect of its methodological approaches and interpretation of nature, science and reality (Mertens, 2015:2; Polit & Beck, 2012:195). A researcher brings certain paradigms to an inquiry, based on a set of basic beliefs or worldview to guide her/his research-related activities (Creswell, 2013:18). A paradigm is defined as a set of perceptual views that direct the research and characterises how such an inquiry may be understood and addressed (Botma, Greeff, Mulaudzi & Wright, 2010: 40).

The present study is concerned with ascertaining and assessing the indigenous stories of pregnant Botshabelo women in their attempts to ensure positive pregnancy outcomes in the context of their socio-economic and cultural environments. There are various ways in which pregnant women prepare for childbirth (Abbyad & Robertson, 2011:52). The researcher sought to explore the methods of childbirth preparation in ensuring positive pregnancy outcomes. The outcomes of such an assessment are likely to be different from one pregnant woman to the other, based on their backgrounds (Ragolane, 2017:25). The socio-demographic, cultural and economic factors, as well as sources of information during pregnancy, brought about multiple truths that needed to be explored, described and analysed. As such, the study adopted the constructivist philosophical paradigm, also referred to variously as naturalist/ ecological/ ethnographic, or phenomenological/ interpretivist. Despite the nomenclature, these paradigmatic orientations are characterised by assumptions, which are ontological, epistemological, methodological and axiological in their nature (Creswell, 2013:20). The constructivist perspective was adopted for its allowance of the researcher to explore the richness and complexity of the research participants' views regarding the phenomenon of interest (Creswell, 2013:24).

The constructivist perspective or tradition is premised on the construction, interpretation and understanding of nature (reality) or a phenomenon from the viewpoint of the individuals or research participants as influenced by their naturalistic environment (ecology) as they have direct experiences, knowledge and perceptions of the self-same environment or phenomenon the researcher is investigating (Rubin & Rubin, 2012:33). Edmonds and Kennedy (2012:47) intimate that, as opposed to the positivist paradigm

and its objectively oriented interpretation of phenomena, the constructivist orientation to socially constructed forms of reality and phenomena were most likely to be subjective since the participants with whom the researcher interacts in the course of (qualitative) collection were the 'insiders' whose knowledge, experiences and perceptions were regarded as ontologically and epistemologically dependable and reliable versions of the particular reality or state of affairs being investigated. In such situations, the researcher's role is primarily to broaden understanding of the investigated phenomenon by deconstructing or dissembling and reconstructing (re-assembling) the variability and multiplicity of the 'insiders' versions or perspectives of the 'truth' (Edmonds & Kennedy, 2012:47).

Accordingly, the constructivist paradigm begins on the premise that the human world is different from the natural world, and as such, humans construct their reality (Creswell, 2013:24). In constructivism, the reality is socially constructed through the interaction of people over human history, and it reflects the subjective experiences of human beings and the interpretation thereof (Willis, 2007:54). In this study, the constructivist paradigm was opted for, given that the researcher's principal intention was to capture the essence of the lived social experiences of the participants for the purpose of exploring and describing their meaning and accurate portrayal attached to it (Streubert & Carpenter, 2011:78). Indigenous stories of pregnant women are likely to form inherent or intrinsic experiences as their way of life. The researcher aimed at capturing these experiences as articulated by the participants.

In the current study, pregnant women were provided with the opportunity to detail their own realities through the subjective meaning of their own experiences which varied from one participant to the other, based on their religious, political and socio-cultural practices. The researcher then documented the complexity of the constructed views of each individual. In understanding their constructed worldviews, the researcher held the following philosophical assumptions: ontology, epistemology, methodology and axiology (Creswell, 2007:20; De Vos et al.,2011: 309). Ontological assumptions are based on the researcher's untested beliefs on the nature of reality and its characteristics; how the reality should be viewed and studied. Within the framework of constructivism, the researcher embraces the idea that there are multiple views of reality (Creswell, 2013: 20, 21). In this study, both the researcher's and the pregnant women's subjective views of reality informed their common/uncommon experiences concerning negative pregnancy

outcomes.

Epistemological assumption are concerned with what counts as knowledge, and justification of such claims (Creswell, 2013: 20, 21). Epistemology particularises the format of the beliefs rather than its content (Botma et al., 2010:40). In this study, the pregnant women's indigenous stories were articulated through their capacity to construct their own subjective experiences, as well as the events encoded in community practices where they interact with others. In this regard, the researcher's main purpose was to document and interpret the narrated data as the articulated account of the participants and not as her own version and understanding of the nature of negative pregnancy outcomes. The participants who directly or personally experienced negative pregnancy outcomes constructed their own experience-based perspective, not necessarily based on scientific facts, but their lived experiences.

Methodology refers to strategies on how the researcher can acquire the data provided by the participant (Botma et al, 2010:41). Data were collected from pregnant women in antenatal care clinics in Botshabelo, through in-depth individual interviews. The aim was to attempt to comprehend their belief systems prior to and during pregnancy necessary for ensuring positive pregnancy outcomes.

According to Creswell (2007:20), the qualitative researcher does bring values to the research project. In choosing to do this study, the researcher's values were noted and they warranted attention during the process of the study. Furthermore, during the interviews, the values of pregnant women outlined their preferred practices. Thus, this study is value-laden. Indigenous stories are value-laden, just as the researcher came into the study with her values. These assumptions will be elaborated in chapter 2.

1.6. RESEARCH APPROACH

Bogdan and Biklen (2007:24) allude that a research approach is mainly defined on the basis of the particular philosophical paradigm and assumptions adopted by the researcher. For example, a quantitative study would largely be grounded on the positivist tradition in its data collection and analytic processes. On the other hand, a predominantly qualitative study would largely be influenced by the constructivist/ ethnographic or naturalistic/ ecological perspectives.

In this study, the qualitative research approach was adopted, largely due to the study's imperative to obtain its (oral) primary information from the very participants who experienced the phenomenon of negative pregnancy outcomes in their own familiar naturalistic or ecological environment (Thomas & Magilvy, 2011:152). The qualitative research approach was vital for this study, in which individual interviews were conducted in order to enable participants to 'voice' their experiences and feelings regarding the phenomenon at hand as described by Creswell (2007:48). Amongst other factors, the qualitative research approach was resorted to, due to its advantage of incorporating both the explorative and descriptive aspects in reference to the behaviour, feelings and attitudes of the selected participants; which is difficult to determine in a positivist quantitative study. The 'difficulty' is posed by requirement for objectivity, which does not premise on the emotional domain for is data collection, especially on a previously unknown phenomenon (Creswell, 2013:24). Based on the purpose of the study, explorative, descriptive and phenomenological designs were deemed appropriate.

1.7. RESEARCH TECHNIQUES/ METHODS

While the research design specifically focus on the philosophical foundations and processes or strategies adopted in the study, the research techniques or methods particularly refer to the specific type and nature of research tools or instruments utilised for acquiring data of interest (De Vos et al., 2011:360). The research methods are also adopted in relation to both the research problem and main purpose of the study (Rossman & Rallis, 2012:12).

The research methods adopted in this study encompass both the theoretical/ conceptual and empirical aspects of the negative outcomes of pregnancy within a socio-economic and cultural context (Walliman, 2015:69). The study's theoretical/ conceptual domain provided mainly secondary (non-empirical) data, which was instrumental in the conceptualisation and exploration of literature-based background knowledge on negative pregnancy outcomes. On the other hand, the primary and secondary information and data was obtained through the involvement of participants during the study's fieldwork, which also enhanced the explorative.

The systematic search, identification and synthesis of relevant sources of information was facilitated by means of reviewing relevant literature relating to pregnancy and its outcomes, particularly in socio-economically and culturally dominant contexts. In this regard, a methodically conducted review of literature and individual interviews provided the data collection architecture of the study.

1.7.1. Literature Review and Strategy

Searching, consulting and systematically reviewing relevant sources entailed multiple sources such as academic books, published and unpublished dissertations, research papers from reputable conference proceedings, policy documents and reports scientific journals, as well as databases and search engines for on-line (electronic) materials on the subject of pregnancy. This literature review strategy enabled the researcher's identification of gaps in the form of insufficient evidence-based studies to inform on the magnitude and scale of negative pregnancy outcomes as a product of cultural and socio-economic factors (Polit & Beck, 2012:195).

1.7.2. In-depth Interviews

Interviews are essentially a conversation or dialogue between the researcher and the participants or interviewees intended to provide a primary/ empirical perspective of the study (Rubin & Rubin, 2012:34). Since the study is within the framework of care, the exploratory interviews empowered pregnant women, because the questions elicited a dialogue between pregnant women and the researcher. Such a dialogue was envisaged to bring change in clinical practice, with regard to the participation of pregnant women in their care. Acosta, Oelke and Lima (2017:1) attest that deliberate health dialogues can bring about change in health practices and policies due to collaboration of knowledge and experiences.

1.8. DATA COLLECTION

Data was collected from pregnant women in antenatal care clinics in Botshabelo by means of unstructured in-depth individual interviews. The aim was to comprehend the participants' belief systems prior to, and during pregnancy necessary for ensuring positive pregnancy outcomes. An in-depth individual interview is the type of interview in terms of

which direct interaction occurs with an individual expected to possess and express the knowledge the research seeks to capture (Botma et al., 2010:205).

1.9. SAMPLING DOMAIN

The sampling domain encompasses participant-focused dynamics in terms of *who* they are, *where* they are physically located, and *how* they will participate (Ehrlich & Joubert, 2014: 350). In this regard, the main elements of the sampling domain are represented by the research setting, study population, sample size, sampling strategy and the sampling criteria. According to Botma et.al. (2010:124), sampling is the method of selecting study participants to represent the accessible population.

The study was conducted in Botshabelo, Free State Province, with twelve purposively selected pregnant women. For the purpose of this study, a total of 7 (seven) clinics (six local and one high-risk clinic) were selected for participation through simple random sampling, whose advantage is that all the clinics stood an equal chance of being or not being chosen (Polit & Beck, 2012:281). Therefore, no bias could occur. Once the clinics were randomised, the purposive sampling method was still utilised to sample participants. Purposive sampling means that participants were chosen for the study based on specific characteristics that should be included in the sample (Henning et al., 2004:71). The foremost determinant for selection was that of pregnant women at any gestational age were considered as potential participants The advantage of purposive sampling is that only the participants with the typical traits the researcher needs were sampled (Botma et al., 2010:126).

The disadvantage of purposive sampling is that it is time-consuming and there is the possibility of not securing all participants at the specified time (Marshall & Rossman, 2016:116). Only participants who were of benefit to the study were selected (Polit & Beck, 2012: 281). For instance, the inclusion criteria involved women who could read either Sesotho or English, for the purpose of reading and understanding the information leaflet and signing the consent forms. They had to reside in Botshabelo and converse in either Sesotho or English. Although Botshabelo is an area with a variety of tribes, the Basotho tribe is the most dominant, and Sesotho is the main language spoken.

1.10. ENSURING TRUSTWORTHINESS

In research, trustworthiness is a quality assurance mechanism by which the accuracy and validity of a measuring instrument and its consequent results are demonstrated (Polit & Beck, 2012:62). The extent of trustworthiness further establishes the extent of the study's scientific rigour, through which audiences and the research or scientific community are persuaded that the research findings are believable (Thomas & Magilvy, 2011:152). In qualitative studies, concepts such as reliability and validity are inapplicable (Saldana & Omasta, 2018:271). Rather, the most applicable measures are: credibility, transferability, dependability and confirmability (Marshall & Rossman, 2016:46).

1.10.1. Credibility

Credibility refers to the participants' beliefs that the researcher conducted the study effectively, and generated correct findings (Saldana & Omasta, 2018:272). In this study, credibility was influenced by the complexity of the phenomenon of negative pregnancy outcomes, which necessitated the use of multiple data collection means to converge on the truth. Consequently, prolonged stakeholder engagement augmented the in-depth individual interviews to enhance credibility as a factor of trustworthiness. Prolonged time was spent in the research field conducting extended discussions with the research participants. To ensure credible results, the study's audiotapes were listened to by the researcher and the supervisor as they understand the Sesotho language. An experienced co-coder assisted with data analysis. The data and results were shared with the participants for confirmation that their views were not misrepresented (Marshall & Rossman, 2016:46).

1.10.2. Transferability

Transferability refers to the extent to which the research results can be applied and easily used by other researchers in other research settings similar to the conditions that prevailed in this Botshabelo-based study (Botma et al., 2010:292). For the purpose of this study, transferability was ensured by means of a detailed audit trail of the study. In this regard, the researcher kept a thoroughly documented profile of the study from inception to execution, as well as the decisions taken throughout the entire research process (Marshall & Rossman, 2016:264). Such a provision ensures that future researchers are

able to review all theoretical and methodological aspects of the study for its scientific value.

1.10.3. Dependability

Dependability refers to the process of determining the stability, consistency and quality of data over time (Botma et al., 2010:292). This was achieved by ensuring that the data collected remained uncontaminated and preserved as it was during the interviews. The researcher compared the field notes to the audio-recorded interviews. The supervisor also checked that the transcripts were the same as the audiotapes discussions.

1.10.4. Confirmability

Confirmability refers to the extent of neutrality reflected in the findings of the study. There should be neutrality of findings between two or more people regarding the accuracy and relevance of the findings (Polit & Beck, 2012:154). In this study, the researcher was transparent in her engagement with the participants. In addition, the researcher always confirmed the participants' responses in order to avoid 'red-herring'; that is, analysing what was not stated (Babbie & Mouton, 2010: 16). An independent co-coder was used for the analysis of the collected data.

1.11. ETHICAL ISSUES

Ethical aspects are crucial for successful research to be achieved (Silverman, 2017:55). In Social Sciences research, ethical issues should be upheld, as data ought not to be obtained at the expense of human beings (De Vos et al., 2011:113). It is against this background that ethical issues of research principally focus on the researcher's compliance with administrative requirements prior to the study's commencement, as well as the fair treatment of the participants when the study actually begins (Polit & Beck, 2012:160).

1.11.1. Approval and Permission

Before the study commenced, ethical clearance was obtained from the Health Sciences Research Ethics Committee of the University of the Free State. Further permission to commence with the study was obtained from the Free State Department of Health.

Primary Health Care managers and the Chief Executive Officer (CEO) of Botshabelo District Hospital were informed of the study.

1.11.2. Informed Consent

The study and its purpose was fully disclosed by means of information leaflets. Informed consent was subsequently obtained prior to conducting the interviews. Participants signed consent forms, which were available in Sesotho and English. According to Saldana and Omasta (2018:192), the researcher is obligated to explain to the participants the nature, aims and objectives of the study, as well as the role of the participants. No immediate benefits were offered. However, the researcher informed the participants that the collected data could possibly be used in conferences and publications for awareness and to bring about change in the disciplinary field. Prospective participants were handed information leaflets to take home in order to read through and have adequate time to think about it, in order to make an informed decisions. When the prospective participants received an information leaflet, the research would request their contact numbers in order to follow them up in two days for their participation confirmation. Signed informed consent was subsequently obtained from pregnant women prior to the interviews. For those who voluntarily agreed to take part in the study, arrangements were made between the researcher and each participant to decide whether the individual interview would be conducted in a clinical setting or at the participant's natural setting (home).

The advantages of the participants' natural settings was that they were interviewed where everything was influenced or happened in terms of their lived experiences, and ensured maximum comfort, as each of the participants was likely to be more comfortable in their natural habitat (Ehrlich & Joubert, 2014:350). Once participants were recruited, the researcher found a quiet room or area in the clinic or home to conduct the interviews. Informed consent forms were already signed by the participants prior to the interview.

1.11.3. Voluntary Participation

Participation should be voluntarily at all times without any consequences for refusal to participate in the study (De Vos et al., 2011:116). Participants partook as autonomous adults who could also withdraw at any stage of the research should they feel uncomfortable to continue. There were neither any incentive for participation or any reprisal for any refusal or withdrawal from the study (Almalki, 2016:288).

1.11.4. Privacy, Confidentiality and Anonymity

The principles of privacy, confidentiality and anonymity imply the maintenance and protection of participants' identities and human rights from any public scrutiny arising from their participation (Kendall & Halliday, 2014:307). Confidentiality was upheld at all costs in this study. Participants were assigned numbers and no names were used to identify them. In addition, no particulars of the participants were shared with any unauthorised persons. The findings of the study were discussed and shared only with the relevant stakeholders. Data is password-protected, and only the researcher and her supervisor are privy to the raw data, which will be safely kept for 5 (five) years.

1.11.5. Risk and Beneficence

Possible risk and harm are possible in research, and the researcher is both professionally and ethically bound to 'do good' and not expose participants to any form of potential harm, physically, emotionally and psychologically (Kendall & Halliday, 2014:307). There were minimal risks anticipated. Nonetheless, the researcher notified the participants that they would be referred to Botshabelo District Hospital for psychologic consultation and evaluation in the event of any unforeseen risk occurring.

1.11.5.1. Protection of vulnerable populations

Pregnant women form part of the vulnerable population in society (Kim, Connolly & Tamim, 2014:1), and sensitivity to the vulnerable population is vital in research (Creswell, 2007:44). For this reason in particular, the researcher ensured that the participants were not exploited in any way. Their health status compelled that the researcher should reschedule the interview to a more convenient time in the event she sensed or perceived any physical discomfort to the participants (e.g. tiredness). Where possible, participants' partners and parents were also included as part of the interviews for support and comfort, provided that the participant consented. Furthermore, the participants were provided with details of the psychology department at Botshabelo Hospital for reference in case of psychological issues even after the study had been conducted.

Participants were not exploited merely by virtue of their age, religion or economic class. In this regard, all the pregnant women meeting the inclusion criteria stood an equal chance of being selected and treated fairly (Botma et al., 2010:13).

1.12. SCOPE OF THE STUDY

The scope of the study entails both the theoretical and methodological parameters or boundaries (delimitations) of the study, which does not imply any weaknesses on any aspect of the study in its totality (Babbie & Mouton, 2010:16). The study was conducted in Botshabelo only, with pregnant women living in Botshabelo and attending antenatal care at local clinics and or the high-risk clinic at the District Hospital. No other participant categories were involved.

1.13. LAYOUT OF CHAPTERS

The study consists of the following chapters:

Chapter 1: Consists of the introduction, problem statement, and orientation of the study.

Chapter 2: Outlines the research methodology (design and method) used in this study.

Chapter 3: Addresses data presentation and literature control.

Chapter 4: Presents the discussion of the findings, the conclusions reached, the recommendations made, and the limitations of the study.

1.14. CONCLUSION

In this chapter, the introduction, problem statement, concept clarification and study aim, the research methodology, ethical issues and chapter layout constituted the critical research variables of the whole study. The next chapter presents a more detailed account of the research design and methods adopted and applied in the study.

CHAPTER 2
RESEARCH METHODOLOGY

2.1. INTRODUCTION

In the preceding chapter, the overview of the study was outlined in relation to the indigenous stories of pregnant Botshabelo women when ensuring positive pregnancy outcomes. This chapter describes the research methodology that was adhered to in order to answer the research question. Firstly, the context of the research is outlined. Then an overview of the paradigm found suitable for the study, as well as the philosophical assumptions will be given. Furthermore, the chapter elaborates on the research design and techniques, along with the processes of data collection and analysis that were followed.

2.2. RESEARCH DESIGN

Research designs are defined as the strategies that the researcher intends to follow in conducting the study (Creswell, 2013:49). The research design is the overall plan the research undertakes, and starts from the point of data collection to the analysis of data, in order to achieve the intended goal of the study. As noted in Section 1.6 of the preceding chapter (Chapter 1), the research design pivotally locates the self-same study within a philosophical premise in order to guide the research processes and type of instrumentation (research methods) employed to resolve the problem and advance the achievement of the study's purpose. The purpose of this research is to explore and describe pregnant women's indigenous stories in ensuring positive pregnancy outcomes. A qualitative research approach was followed, supported by explorative, descriptive and phenomenological research designs were followed in this study.

2.2.1. Constructivist Paradigm/ Orientation of the Study

The most fundamental focus of the study is on establishing the indigenous beliefs, attitudes and practices which pregnant women adopt in their promotion of positive pregnancy outcomes in the context of their cultural backgrounds. In terms of this study, the pregnant women's practices are assumed to be embedded in their stories. It is in this

regard that the study embraced and pursued the constructivist paradigm in its research processes and data collection and analysis approaches.

As noted in sub-section 1.6.1 of the previous chapter, the ethnographic orientation of the study was viewed as relevant, since the constructed (and reconstructed) social realities, experiences and environment of the participants were a critical force or factor in the generation of the most needed data and evidence (Gray, Grove & Sutherland, 2017:47). Creswell (2014:24) confirms that in constructivism, each individual develops subjective meanings of their own varied and multiple experiences, which compels the researcher to search for the plausible truth from their complexity of views. The complexity of views and multiplicity of participants' experiences is induced by the constructivist perspective that reality is not fixed. Hence, each individual can construct his/her own multiple contextually directed realities (Polit & Beck, 2012:12). The multiple constructions of reality were useful in helping the researcher to acquire greater insight into the particular phenomenon under investigation (i.e. understanding of pregnancy outcomes in a socio-cultural milieu).

Each participant's construction of their own subjective experiences influenced and guided the researcher's ontological, epistemological, methodological and axiological assumptions from the viewpoints of the participants themselves. Ontology refers to the nature/ structure of reality and its understanding (De Vos et al., 2011:309). In the constructivist tradition, the researcher's ontological approach is aimed at embracing multiple realities through the diverse 'lenses' of the research participants themselves (Gray et al., 2017:47). In this study, each participant (pregnant woman) articulated her own experience from her own subjective view, based solely on their beliefs, attitudes and socio-cultural practices that were different from each other. Based on each pregnant woman's complex story, the researcher embraced and documented the complexity of the views with the intention of making holistic sense from them all in real-time as they were articulated during the interviews (Creswell, 2007:20).

The epistemological assumptions are based on the construction and function of knowledge, rather than reality; that is, understanding and explaining *how* we know *what* we know (Saunders, Lewis & Thornhill, 2009:118). Such assumptions are expressed in terms of *what* counts as knowledge and *how* these claims are justified as knowledge (Creswell 2014:21). In conducting the interviews at the participants' natural (historical and cultural) habitats (homes), the researcher minimised/ reduced "the objective

separateness" (the space that enables the researcher to understand what the participants are saying) between herself and the pregnant women (Creswell, 2014:21). The dissolution of 'distance' allocated the status of co-constructer of knowledge with the participants (Botma et al., 2010:40).

The researcher tried to get as close as possible to the situation being studied, in order to assemble the views of each participant as they were constructed. Correspondingly, the participants could also be viewed as co-researchers in this regard. Accordingly, the researcher paid more attention to the (oral and reciprocal) real-time format of the pregnant women's beliefs rather than the content of the stories as a true reflection of their day-to-day lives and interactions within their communities, as their indigenous practices are embedded and form part of the pregnant women's lifestyle in the society (Malema, 2014:131). It is noteworthy that the participants narrated their stories based on actual past and current experiences, rather than on scientific or clinical facts.

Methodological assumptions premise on the various methods or strategies employed to obtain the indigenous stories of pregnant Botshabelo mothers in ensuring positive pregnancy outcomes (Botma et.al., 2010:41). In this regard, the researcher utilised unstructured in-depth interviews and field notes as a mechanism to complement or triangulate the data collection regime of the study (Saunders et al., 2009:118). The purpose of these interviews was to gather sufficient data on the indigenous practices and beliefs of pregnant women in Botshabelo, prior to and during their pregnancies in order to promote positive pregnancy outcomes.

On the other hand, the axiological assumptions premise on the role of the values of both the researcher and the participants in the research equation (Creswell, 2013:20). The latter author asserts that qualitative researchers bring their preconceived values and biases. Thus, it is essential to make them known to the participants in advance. Notwithstanding the researcher's values that were noted and warranted attention during the research process, it is critical to mention that the indigenous stories themselves are value-laden (Mogawane, Mothiba & Malema, 2015:4). During the interviews, the pregnant women outlined their preferred practices, thereby revealing and accentuating their values. Since indigenous beliefs, attitude and practices are as value-laden as the researcher's interpretation of the findings, the researcher is responsible for openly discussing (with the participants) openly that values were prone to shape the stories and their interpretation

(Creswell, 2013:20). Consequently, the researcher outlined her values in the study to the participants, since she was imbued with the desire to better understand the meanings and implications of the indigenous stories from the perspective of those who directly experienced the phenomenon of socio-culturally induced negative pregnancy outcomes.

2.2.2. The Qualitative Research Approach

Qualitative research, which is consistent with constructivist/ phenomenological research, refers to the holistic and in-depth investigation of a phenomenon with the aim of gaining insights by discovering meaning (Creswell, 2007:48). In addition, qualitative inquiry is considered as a meaning-making process in which the researcher captures in-depth, individualised and contextual experiences and perspectives of people regarding the phenomenon of interest, and provide an interpretative logical extension of the meaning-making (Patton, 2015:3). Indigenous stories of pregnant women were likely to yield experiences with multiple truths on how their way of life ensures positive pregnancy outcomes. Such stories and experiences are unpredictable. Therefore, they have to be discovered, described and understood qualitatively (Streubert & Carpenter (2011: 20).

Mertens (2015:3) illuminate that qualitative designs are used when researchers desire to provide an in-depth description and exploration of a specific subject with the direct involvement of those affected. Researchers use qualitative designs for its range of advantages, including:

- It sheds light on individual issues and experiences as they happen/happened (Botma et al., 2010:182). It is explorative in terms of behaviour and feelings, and enormous data is collected from a previously unknown phenomenon; thus, providing the audience with new knowledge and discoveries;
- It is an approach for exploring, describing and understanding the meaning individuals assign to a human problem and lived social experiences, and give explanations in order to give meaning to them (Creswell, 2015:4);
- Due to its complexity of acquired views, the qualitative design is a broad and appropriate approach in acquiring sufficient data, especially regarding an unknown phenomenon;
- It has an emic perspective which may lead to determining what might be important to the participant (Savin-Baden & Major, 2013:12); and

- The multiple forms of data from participants' stories enables the researcher's understanding of complex phenomena of interest (Creswell, 2013:45).

The indigenous stories of pregnant women on ensuring positive pregnancy outcomes are a phenomenon with relatively limited information in South Africa (Atalan, 2018:1700). Therefore, the explorative and descriptive aspect of the qualitative design and its participant-dependent multiple methods approach was deemed relevant in order to reduce the effects of limited information in this regard (Babbie & Mouton, 2010:18). The disadvantage of qualitative research is that it is time-consuming, as the researcher has to commit to extensive time in the field (Creswell, 2013:49). For this study, the researcher opted for qualitative research as the advantages outweigh the disadvantages. The quality and the type of knowledge that was discovered was, more valuable than the time spent on the field.

2.2.2.1. Explorative design

The use of indigenous practices in ensuring positive pregnancy outcomes is a phenomenon that is not well established. It was therefore deemed necessary to make use of an explorative design for investigating the full nature of this phenomenon. Polit and Beck (2012:18) reiterate that the explorative aspect of the qualitative research design is suitable when little is known about the phenomenon of interest.

Little is known about indigenous practices of pregnant women in ensuring positive pregnancy outcomes in the Free State Province ,and by the extent in Botshabelo. As such, documentation of such knowledge is likely to be limited. It was the researcher's intention to understand the standpoints of the concerned women, with the aim of developing an acceptable and efficient intervention from the perspective of those concerned. Explorative studies are considered to be more effective and tolerable for shaping the interventions designed to impact the strategies for specific projects (Polit & Beck, 2012:640), which for this study are positive pregnancy outcomes. The explorative design is advantageous for its flexibility, openness and inductive approach; all of which are key factors in the quest for new and sufficient information regarding a phenomenon about little is known (Terre Blanche, Durrheim & Painter, 2006:44).

2.2.2.2. Descriptive design

It is the researcher's assertion that there should be an affordable and accurate representation of pregnant women's day-to-day lives as they ensure positive pregnancy outcomes. A descriptive design is utilised if the purpose of the researcher is to describe the phenomenon of interest as it happens (Botma et al., 2010:110). Such a design focuses on the "how" and "why" questions in a specific situation or relationship (De Vos et al, 2011:96). In addition, a descriptive design is used for the purpose of discovering the prevalence, frequency and meanings allocated to a phenomenon (Burns & Grove, 2009:237). In this study, the descriptive method was used to discover the occurrence and meaning ascribed to the indigenous way of the lives of pregnant women as they ensure positive pregnancy outcomes.

2.2.2.3. Phenomenological design

A phenomenological design describes individuals' lived experiences of a phenomenon from their very own perspectives, in order to attain a common denominator in the varied lived experiences (Creswell, 2013:76). The study was about the lived experiences of pregnant women regarding their indigenous beliefs, attitudes and practices as influenced by their socio-cultural and religious attributes. The researcher collected indigenous stories from individual women in order to compose a descriptive essence of the subject. In phenomenological research, the researcher permits the participants to express their human experiences regarding a specific phenomenon in order to gather enough information regarding the researched subject (Botma et al., 2010:190). In this study, pregnant women expressed their daily indigenous practices and beliefs in order to ensure safe pregnancies and healthy, live babies as end products of their pregnancies.

2.3. DATA COLLECTION

Data collection is the gathering of information to address the research problem at hand (Polit & Beck, 2012:725). It is a systematic way of gathering information for the study, relevant to the researcher's agenda, and follows a set standard of ethical principles (Burns & Groves, 2009:441). The purpose of this study is to obtain stories about indigenous practices and beliefs of pregnant women in ensuring positive pregnancy outcomes. Both pre-investigative and actual investigative techniques were applied in the collection of data. The pre-investigative technique involved the exploratory interview,

while the actual investigative technique involved the individual in-depth interview and various aspects of field notes.

2.3.1. Explorative Interview/ Pilot Test

An explorative interview is a mini version, or a small-scale version of the research used to test the usability of the measuring tool to be used in a larger study (Botma, 2010:275). The objective of an explorative interview is to assess the capacity of potential participants to comprehend what needs to be done during the actual data collection of the study. Therefore, the exploratory interview tests the appropriateness, clarity, feasibility and the quality of the instrument tool to be utilised by the researcher in order to improve of its applicability in the main research (Gray et al., 2017:48).

As a health professional herself, the researcher has observed the prevalence of insufficient information regarding the indigenous practices of pregnant women. Thus, it was found necessary to first conduct this research by means of an exploratory interview (pre-testing), as the information gained may improve strategies for positive pregnancy outcomes in clinical settings. Consequently, the researcher selected two participants to be part of a pilot study (explorative interview), but were not part of the actual investigative interviews as they would have had the advantage of 'knowing' the questions and responses to the disadvantage of others. These participants were selected from two randomly selected Botshabelo clinics. The participants were chosen on account that they were pregnant women attending antenatal care in one of the six randomly selected clinics offering antenatal care in Botshabelo, as well as the high-risk clinic in Botshabelo hospital.

The explorative interviews with the two pregnant women were conducted in August 2018 and lasted 1 (one) week. The interviews were conducted in the participants' homes, as preferred by them. The advantage of conducting the research at the participants' natural habitat, which was their homes, was to ensure maximum comfort and ease of participation. These explorative unstructured in-depth individual interviews were recorded and transcribed in the same format as in the main study, in order to assess whether the research question was comprehensible and unambiguous.

The central research questions asked was: "*Could you kindly tell me how your cultural practices ensure a positive pregnancy outcome*? The two participants were able to answer this central 'grand tour' question clearly. Interview techniques such as probing,

clarifications and generation of follow-up questions were utilised by the researcher where necessary for purposes of gaining more insight based on their responses. The data generated from the explorative interviews formed part of the main study because there was no need for altering the central question. On this fundamental basis, this data collection instrument was regarded as valid for its purpose in the main study as well with the twelve participants.

2.3.2. Unstructured In-depth Interviews

The essence of unstructured interviews lies in the interest to understand the experience of others, not to test or evaluate a hypothesis (De Vos et al., 2011:348). There are inherent advantages and disadvantages in the interview mode of data collection, as indicated in Table 2.1 below.

Table 2.1: The advantages and disadvantages of unstructured interviews

Source: Polit & Beck, 2012:232

Unstructured Individual Interviews	
Advantages	Disadvantages
Encourages interviewee to answer at length and in detail, ensuring that the researcher acquires rich and valuable information. Good interpersonal relations between the researcher and the participant, because trust has been established. Interviews lead to new discoveries as participants can respond in ways preferred by them, and elaborate upon answers while disagreeing with the questions or raising new issues. Assists to portray ongoing social processes. It ensures privacy and confidentiality	It is time consuming due to the extensive time spent on the field. Participants may be unwilling or uncomfortable to share information, especially when they feel they are burdened with the lengthy explanations due to lack of skills in expressing themselves.

Table 2.1 shows that there are more advantages of unstructured interviews than there are disadvantages. The most common disadvantages of unstructured interviews are that they take time to complete, which may dissuade potential participants from any involvement. Amongst some of the advantages, they build trust, and allow participants to express themselves elaborately, which is a positive development, considering the need for data saturation during interviews (De Vos et al., 2011:308).

Given the sensitivity of some of the cultural practices, revealing them is tantamount to exposing one's confidential, if not private, information. Pregnancy is a sensitive issue in most African communities and is treated in utmost concealment (Ngomane & Mulaudzi, 2010:4). Therefore, the interviews in this study could not be conducted in a group, as participants would be uncomfortable. The main purpose of individual interviews is to ensure privacy and confidentiality (Rubin & Rubin, 2012:33). For this reason, the researcher considered the unstructured individual interviews to be safe for this study. Polit and Beck (2012:536) intimate that unstructured interviews are appropriate if the researcher has limited information regarding the phenomenon of interest. In this regard, therefore, acquire great information by permitting the participants to fully express themselves without being directed by a set of prepared questions.

2.3.2.1. The interview process

In this study, data collection was only conducted after permission was requested and obtained from the following authorities:

- The faculty of Health Sciences Research Ethics Committee (HSREC) for ethical clearance (refer to the Annexure 1);
- The Free State Department of Health (FS DoH) for permission to conduct the study (refer to the Annexure 2);
- CEO of the district hospital and primary health care managers of the local clinics were informed of the study (refer to Annexure 3).

After the permission letters were received from the designated authorities, the recruitment of the participants was initiated, which involved identifying eligible candidates and convincing them to be part of the study (Polit & Beck, 2012:286). The researcher found eligible candidates by going to antenatal care clinics of the randomly selected clinics on Mondays and Wednesdays. Each clinic conducted their antenatal care from Mondays to

Fridays. Mondays and Wednesdays were chosen based on the researcher's availability for recruitment purposes. On arrival at the research sites, full disclosure of the study and its purpose was made to all the pregnant women who were present. Interested individuals who met the inclusion criteria were provided with information leaflets to take home in order to thoroughly read through them and have adequate time to think about it so that they can make an informed decision regarding their participation in this study.

Most participants opted for contacting the researcher once they decided on participating, than giving their numbers to the researcher for follow-up after two days. The follow up was intended for the participants to consult with close friends and families in order to make an informed choice for participation or not to be involved completely. The participants called directly, sent messages, or 'call-back' requests once they decided to be part of the study. The participants would then decide on the locale for conducting the interviews.

Two interviews were conducted at the clinics, and ten other interviews were conducted at the participants' homes. Two interviews were conducted at the clinics because the participants did not disclose to family members that they would be participating in the study out of fear that the elders would not approve due to the sensitivity and confidentiality of the pregnancies and indigenous practices. The rest of the interviews were conducted at home because the participants were most comfortable in their natural habitat. They too were fearful of being seen by the nursing staff who could possibly stigmatise them for taking part in indigenous practices (conceived as 'taboo').

Prior to the signing of the informed consent, the researcher introduced the idea of an audio recorder and its purpose to the participants, which was to ensure that the data is comprehensively collected without missing other aspects while taking notes. In the event of a participant feeling uncomfortable with the use of an audio recorder, it was not used and only notes were taken. The main purpose of individual interviews is to ensure privacy and confidentiality. In most black communities pregnancy is a sensitive aspect that ought to be respected. During the interviews, non-directive probes were used by the researcher to ensure that participants extend their answers and elaborated more.

Thus, a verbal agreement was reached to use an audio recorder prior to the signing of the consent, in order to make clear that these two are different and that one does not automatically authorise the other. No interview was conducted before informed consent was granted by the participant and a consent form was signed.

The interviews were conducted in quiet rooms at the homes and clinics in order to ensure privacy and the ease of the participants. The interviews lasted for 30-45 minutes, after which the researcher informed the participants of the possibility of coming back for clarification if the was a need for that. The clarification issue became apparent during the analysis of data, and the researcher had to follow up on two participants for clarity on their elicited responses.

The constructivism paradigm influenced how the question for the research was typically formulated for the purpose of exploring and describing the indigenous beliefs, attitude and practices of the pregnant women. As Creswell (2014:25) intimates, an open-ended question was used so that the process of constructing one's historical and cultural setting in relation to the phenomenon of interest would be fully explored with no limitation on the part of the participants. Pregnant women narrated their indigenous stories in ensuring positive pregnancy outcomes, and thus, the stories were developed through social interaction with others, as well as historical experiences and cultural norms (Saldana & Omasta, 2018:207).

Congruent with standard practice in unstructured interviews, the researcher used the main question in all interviews, which was (Rubin & Rubin, 2012:31):

Could you kindly tell me how your cultural practices ensure a positive pregnancy outcome?

Translated to Sesotho, the prominent local language in the Botshabelo area, the question was: *Ke kopa o nqoqele ka dintho tsa bo-sechaba le meetlo ya hao tse o di etsang ho netefatsa ho ba le ditlamorao tsa bokgachane tse nepahetseng?*

The above question was also followed by sequential probing questions as directed by the answers for the purpose of clarification until saturation of data was satisfactorily reached (Creswell, 2013:76). The focus was not on the number of participants interviewed, but on the exploration of new data coming forth (Rubin & Rubin, 2012:34). Prompts were used to reassure the participants that the researcher was still paying attention to their

responses. The researcher also used non-verbal communication cues through observation in order to determine the link between the participants' non-verbal expressions and their verbal statements.

To enhance both her questioning and communication skills during the interviews, the researcher employed the following techniques, as advocated by authors such as (Babbie & Mouton, 2012:86; De Vos et al., 2011:303; Rubin &Rubin, 2012:6):

1. Probing: the researcher probed during the interviews, to encourage the participants to keep talking on the phenomenon of interest and providing valuable information;
2. Minimal verbal responses: minimal verbal responses such as nodding or saying "Mhmm", to assure the participants that the researcher was listening, which encouraged continuation;
3. Listening: listening attentively and looking up from the notes to signify interest. Minimal note-taking occurred in order to focus fully on the participants and avoid disruption;
4. Reflective summary: summarising participants' statements for reference and confirmation of mutual understanding;
5. Clarification: the researcher obtained clarity on unclear statements through comments such as: *Could you tell me more about it?* The participants would then elaborate further, and clarity would be obtained;
6. Elaboration: for vague statements, the researcher often asked the participants to keep responding until common understanding was reached. The researcher encouraged lengthier responses to avoid short, but unclear statements.

At the end of each unstructured one-on-one in-depth interview, the researcher thanked each participant for their time and involvement.

2.3.3. Field Notes

Field notes are described as notes that are written by the researcher based on what the researcher hears, feels, sees, thinks about and experiences during the course of the interviews (Botma et al., 2010:217). The researcher compiled the field notes immediately after completing the interviews, so as to avoid forgetting and consequently misrepresenting what transpired. The observational, theoretical, methodological and personal notes were compiled based on the experiences and feelings of the researcher regarding the actions, and behaviour of the participants (Polit & Beck, 2012:547-549).

2.3.3.1. Observational notes

Observational notes describe what the researcher noted while engaging with the participants during the interviews (Ehrlich & Joubert, 2014:350). In this study, the researcher took note of the surroundings of the participants, such as the area they resided in and the distances they travelled to the health care facilities for antenatal care, as well as distances to where they consult for cultural and religious support during their pregnancy periods. The participants' emotions were also noted during the interviews. Some participants would have a blunt effect during the interviews, and the researcher reassured them by proposing cessation or deferment of the interview.

2.3.3.2. Theoretical notes

Theoretical notes document the researcher's efforts to attach meaning to observations made during the interviews (Botma et al, 2010:218). In this case, the researcher attempts to make sense of what is seen as compared to what is said. In this study, the researcher took note of the participants' expressions when narrating their indigenous beliefs, attitudes and practices. The participants were often passionate when narrating their indigenous stories, and to the researcher, which validated their view of culture as an important and meaningful attribute to their existence.

2.3.3.3. Methodological notes

Methodological notes are reflections of strategies used to remind the researcher of the researcher's role in the execution of the study (Yin, 2016:148). In this study, the researcher constantly reminded herself that she was in the research field as a researcher and not as a health care worker, despite her views on the adverse effects of indigenous practices on clinical practices. Nonetheless, the researcher controlled her emotions and continued with the research process.

2.3.3.4. Personal notes

Personal notes comment about the researcher's experiences and feeling while collecting the data (Ehrlich & Joubert, 2014:350). In addition, personal notes explain the feelings, emotions, and assumptions of the researcher while in the research field (Polit & Beck, 2012:549). Amongst others, the researcher noted her discomfort and uneasiness as she went to the participants' homes, located in the sections of Botshabelo that were unfamiliar

to the researcher. Most of the interviews were conducted in the participants' homes. The researcher also noted her own fatigue and emotions during the interviews.

2.4. RESEARCH CONTEXT

Botshabelo is a rural township situated some 50km east of Bloemfontein (Mangaung), the capital city of the Free State Province in South Africa. The township has a variety of tribes, among whom the Basotho are the most dominant. Hence, the dominance of Sesotho language as well. The 2011 population census of the rural township was estimated at 181 712 (Marais, Ntema, Sigenu, Lenka & Cloete, 2015:7). Botshabelo is also amongst the fastest growing townships in South Africa. However, the 2013 census revealed that only 18 328 people (about 10% of the population) were formally employed (Marais et al., 2015:9). Therefore, this rural township is considered one of the poverty-stricken districts in the Free State. Healthcare facilities are mostly public institutions, with an inking of some private doctors that offer family health.

The use of public health care services in Botshabelo is highly demanded and is accessed by the majority of the population, as facilities are all within a 10 km range from their homes. Due to this accessibility and clients being from poor backgrounds, these facilities are overpopulated and the service turnaround time is always delayed and extended. Botshabelo has thirteen clinics all rendering antenatal care, and one high-risk clinic, Botshabelo District Hospital (BDH).

The local antenatal care clinics referred high-risk pregnant women to BDH. Upon assessment by the medical officers in BDH, the high-risk pregnant women who cannot be managed at this level are then referred to Pelonomi Academic Hospital and Universitas Tertiary Hospital, both in Bloemfontein. Patients referred to medical facilities far from home may result in financial issues for the families to visit. Below is a map showing the physical location of Botshabelo.

Figure 2.1: Map of the Free State Province showing Botshabelo

Source: http://www.infosa.co.za/free/state/

2.4.1. Population

The study population is described as the entire set of individuals that have common characteristics of interest for the purpose of the study (Ehrlich & Joubert, 2014:98). Such a population is the fundamental unit or focus of a researcher's analysis regarding individuals to be included in the study (Polit & Beck, 2012:745). The population in this study consisted of pregnant women attending antenatal clinic in Botshabelo.

2.4.1.1. Units of analysis

Characteristically, the unit of analysis possesses the representative qualities or traits according to which a smaller sample could be selected for participation in the study. Botma et al. (2010: 51) affirm that the unit of analysis (study population) is essentially a group from which the researcher intends to draw conclusions. In this study, the unit of analysis (study population) consists of all pregnant women of any gestational age in Botshabelo. This group of individuals is considered to have rich and expansive cultural information and experience regarding indigenous practices that ensure positive pregnancy outcomes. Their experiences and opinions concerning their cultural practices formed a fertile pool for answering the research question. Whereas the study population

relates to a larger group, the sample size relates to the actual number of the representative smaller group selected on account of its possession of the same qualities, characteristics or traits as the larger study population (Ehrlich & Joubert, 2014:107).

Botma et al. (2010:129) assert that in qualitative research, the aim is to understand the phenomenon of interest, and not to generalise the findings to the larger population. In this regard, the sample size 12 women as units of analysis, then influences the feasibility of the study. Following the pre-investigative (explorative interviews), the sample size of the main study eventually consisted of 12 (twelve) participants, although the saturation of data was reached after 8 (eight) participants were interviewed. Notwithstanding, the researcher conducted twelve interviews in an attempt to establish whether or not any new discoveries would emerge following the eighth interview.

2.4.2. Sampling Methods/ Strategies

Sampling is a method or strategy by which participants are selected to represent an entire population in a study on the basis of the criteria determined by the researcher before the study is conducted (Saunders et al., 2009:112). The degree of representativity is mainly determined on the extent of either homogeneity (similarity) or heterogeneity (dissimilarity) of certain qualities or requirements to inform the researcher's decision-making of the final choice or option. For purposes of this phenomenologically oriented qualitative study, the researcher sampled both the research sites and participants, in order to physically obtain the required information at the very places (settings) where the participants experienced the investigated phenomenon (i.e. socio-culturally informed pregnancy outcomes) (Rossman & Rallis, 2012:47). Two different sampling methods were used for both the places (settings) and the people (participants) involved in this study. However, for both the explorative and actual interviews (with the 2 (two) and 12 (twelve) pregnant women), the same sampling method was used.

2.4.2.1. Sampling of research sites

There are thirteen (13) primary health care clinics in various parts of Botshabelo, and one (1) high-risk clinic situated in Botshabelo District Hospital (BDH), all rendering antenatal care. Simple random sampling was used to narrow the thirteen clinics to six (6), in addition to the BDH high-risk clinic.

The advantage of simple random sampling was that all the clinics stood an equal opportunity of being selected or not (Polit & Beck 2012:281). Therefore, no bias occurred as a result of the researcher's professional status as a health care worker in the area. After the random sampling of the clinics in which six local clinics and one high-risk clinic were chosen, the researcher used purposive sampling for the purpose of sampling the participants.

2.4.2.2. Sampling of participants

Once the clinics were selected, the researcher selected prospective participants who were willing to provide and share in-depth understanding of the central phenomenon of the study. In this case, purposive/ judgemental sampling was utilised for choosing participants based on specific characteristics and other pertinent issues concerning the phenomenon of interest (Henning et al., 2004:71). The advantage of purposive sampling is that only the participants with the typical traits the researcher needs, may be sampled (Botma et al., 2010:126). On the other hand, purposive sampling may be disadvantageous for its time-consuming nature in the event that the participants with the desired traits have not been found (Marshall & Rossman, 2016:116).

2.4.2.3. Inclusion and exclusion criteria

Both the research problem and purpose of the study directed the researcher on the requirement/ criteria for inclusion/ eligibility or exclusion/ ineligibility in the study. The importance of inclusion criteria is that only participants with the specific traits required for the study, can be considered for inclusion in the empirical data collection of the study. Only participants possessing the homogeneously representative (similar) traits with the larger study population were selected; and those with dissimilar (heterogeneous) characteristics were not (Ehrlich & Joubert, 2014:488). In this regard, the study's inclusion criteria was based on the following considerations:

- Pregnant women attending antenatal care in any of the six randomly selected clinics offering antenatal care in Botshabelo;
- Pregnant women attending antenatal care at the BDH high-risk clinic;
- Pregnant women above the age of eighteen years, at any gestational age;
- Be resident in Botshabelo and able to read and write in Sesotho and in English.

Since the purpose of the study was to obtain rich information, age was considered as a sign of cognitive maturity; hence its reference as one of the selection factors based on their knowledge of and use of indigenous practices and willingness to share that information for the purpose of the research. The purposively selected women participants were older women within the 20-45 years age range. The ability to read and write in either Sesotho or English was included for the purpose of reading and understanding the information leaflet and signing the consent forms. Although Botshabelo is an area with a variety of tribes, the Basotho tribe is the most dominant one, and Sesotho is the main language spoken. The need for participants to reside in Botshabelo was mainly for the purpose of further consultation in clarifying issues during the process of the research.

For both practicality and logistical reasons, not all prospective participants could be included in the study. Accordingly, pregnant women who were below 18 years of age and not resident in Botshabelo, were excluded. It was envisaged that they were still young and limited in experience and exposure to some of the indigenous practices (Zuma, Wight, Rochat & Moshabela, 2016:4).

2.5. DATA MANAGEMENT AND ANALYSIS

Data management principally relates to the preservation and retention of acquired information (raw data) prior to its conversion into intelligible categories of evidence (Babbie & Mouton, 2010: 112). The purpose of data management is to ensure adequate preparation before the processing and analysis stages take place (Aneshensel, 2015:2). Correspondingly, data analysis relates to the post-management stage in terms of which the raw data is systematically organised according to its main categories or themes in order to provide structure and extract meaning to be used as evidence or findings in the study (Flick, 2014:36). The process of data analysis involves making use and sense of image and text data in order to formulate ideas derived from the collected data (Botma et al., 2010:221).

Polit and Beck (2012:556) illuminate that the collection, management/ synthesis and analysis of data can occur concurrently. The search for important themes and concepts is on-going, and begins from the moment data collection proceeds. Once the interviews were translated, they were sent to the supervisor to check whether the Sesotho transcripts were captured accurately. It was only after every interview was verified for accurate translation and also compared with the audio interviews, that the transcripts

were sent to the co-coder. On the whole, the transcription of the audio-recorded interviews and field notes guided the researcher in following the data analysis process described by Tesch (cited by Creswell, 2009:186):

- Making sense of the entire audio-recorded interviews during transcription. Repeating the process by read the transcripts carefully, and writing down some ideas coming to mind for the necessary background information;
- Identifying topics by focusing on the messages (rather than the content) and writing them in the margins of the transcript;
- Writing a list of all the identified topics and placing them in columns on one sheet of paper. Making a comparison of all topics and clustering or grouping similar topics was arranged as major themes;
- Revisiting data and abbreviating the topics as codes, which were then written next to the appropriate segments of the text;
- Codes were converted into inter-related and alphabetic categories; and
- Following the completion of the coding process, each category of data materials was checked and assembled in one place.

The researcher sent the raw data, the transcripts of the interviews and field notes to an experienced co-coder in qualitative research, who converted assigned codes and themes into smaller, more manageable data that was easily retrieved. The researcher then met with the co-coder after three weeks to discuss the findings, and consensus was reached that the findings and the process followed were valid and authentic.

2.6. CONCLUSION

The chapter essentially detailed the foundational research design and methods adopted in this study. The constructivist/ phenomenological design approach was opted for the qualitative, explorative and descriptive orientation of the study, which opted for unstructured individual interviews as mode of data collection supported by field notes. The chapter also outlined the sampling framework, as well as the data collection and thematic analysis processes. In the next chapter, the outcomes of the collected data are presented in conjunction with the literature control.

CHAPTER 3

PRESENTATION AND DESCRIPTION OF FINDINGS AND LITERATURE CONTROL

3.1. INTRODUCTION

The preceding chapter outlined the research design and methodology adopted in this research. The current chapter presents an analytic perspective of the findings in conjunction with the literature reviews, which have been weaved in this chapter in order to support both the collected data and the methods according to which the collected was synthesised and analysed (Almalki, 2016:287). The research contexts is also outlined briefly in order to provide a framework and environment against which the participants' stories and experiences were articulated (Aneshensel, 2015:2).

The chapter is logically structured such that it captures the relevant characteristics of both the participants and the research environment, as well as the categorisation of the key findings emanating from the collected data in terms of the research instrumentation highlighted in the previous chapter.

3.2. DESCRIPTION OF LOCATION

Botshabelo is a rural township with a variety of ethnic groups, with the Basotho and the Sesotho language dominating. It is one of the fastest-growing townships in South Africa. The public health care facilities are all within a 10 km radius from each other. Both the purposively selected participants and the researcher travelled this distance for antenatal care consultations, participant recruitment and conducting of interviews at the participants' homes. The sampled six clinics and one high-risk BDH clinic were selected according to the simple random sampling technique.

3.3. DESCRIPTION OF THE SAMPLE

The sample of the study was twelve (n=12) pregnant Botshabelo women, all of whom were included in the empirical research process on account of their experiences and knowledge of pregnancy-related indigenous stories, and were willing to express these

stories. Moreover, the participants were those at any gestational age of their pregnancies, and aged 20-45 years.

3.3.1. Demographic Information of the Sample (N=12)

The demographic information of the participants pertained mostly to their age, ethnic and gestational backgrounds. Both Table 3.1 and Figure 3.1 depict the age dynamics of the twelve pregnant women participating in the study.

3.3.1.1. Ages of the pregnant women

Figure 3.1. below is a representation of the participants' age distribution.

Figure 3.1: Ages of pregnant women

a

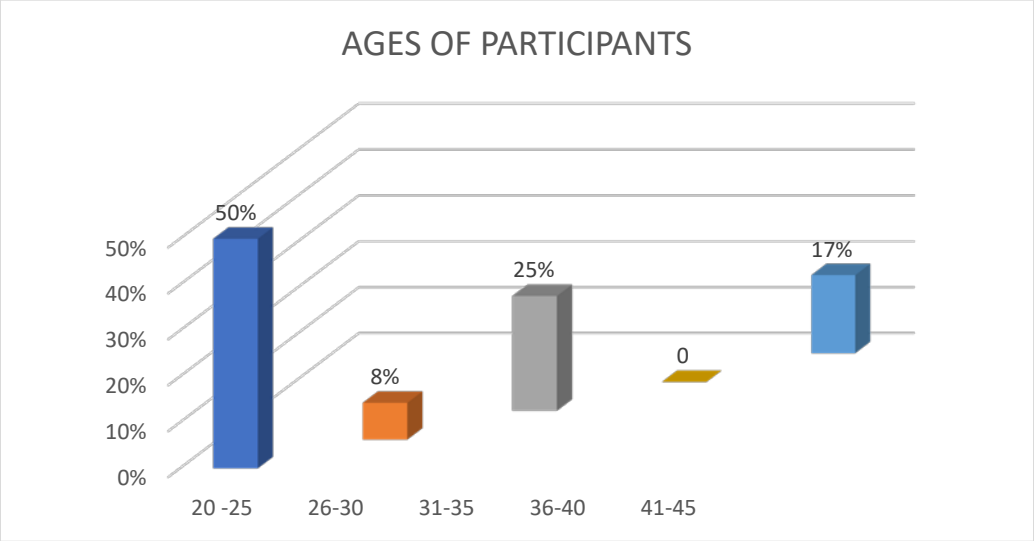

Table 3.1. below is also reflective of the age distribution of the participating twelve women in the study.

Table 3.1: Ages of pregnant women

CRITERION	CHARACTERISTIC	FREQUENCY	PERCENTAGE
Age	20 to 25 years	6	50%
	26 to 30 years	1	8%
	31 to 35 years	3	25%
	36 to 40 years	0	0
	41 to 45 years	2	17%
Total		**12**	**100%**

In terms of both Figure 3.1 and Table 3.1 above, there were more pregnant women aged 20-25 years (n=6, 50%), followed by those aged 31-35 years (n=3, 25%), and two (n=2, 17%) pregnant women aged between 41-45 years. Only one (n=1, 8%) was aged between 26-30 years, and there was no pregnant woman aged between 36-40 years. That there were fewer woman above the age of 40 years indicates that there were few of them who were thoroughly conversant with the cultural aspects of pregnancy.

3.3.1.2. Ethnicity of the participants

The ethnicity of the participants was *fait accompli,* given the dominance of Basotho and Sesotho in Botshabelo. Figure 3.2 represents the ethnic distribution of the participants.

Figure 3.2: Ethnicity of the participants

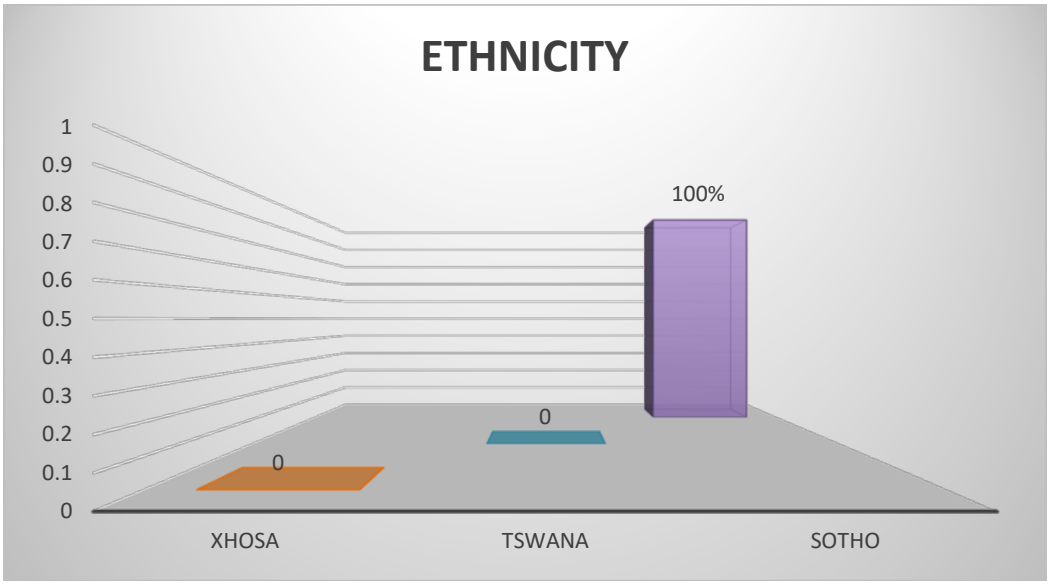

Table 3.2. below is also a depiction of the ethnicity of the participants.

Table 3.2: Ethnicity of the participants

CRITERION	CHARACTERISTIC	FREQUENCY	PERCENTAGE
Ethnicity	Xhosa Tswana Sotho	0 0 12	0 0 100%
Total		**12**	**100%**

Both Figure 3.2 and Table 3.2 above show that all the participants (n=12, 100%) were ethically Basotho, which confirms that Botshabelo has a high prevalence of Basotho and Sesotho language compared to any other ethnic group. However, the complete dominance of Basotho women in the study does not necessarily imply that Sesotho is the only language spoken in Botshabelo. Neither does it imply that everybody in Botshabelo is mo-Sotho.

3.3.1.3. Gestational period of participants

Figure 3.3. below indicates the gestational period of the participants.

Figure 3.3: Gestational period of participants

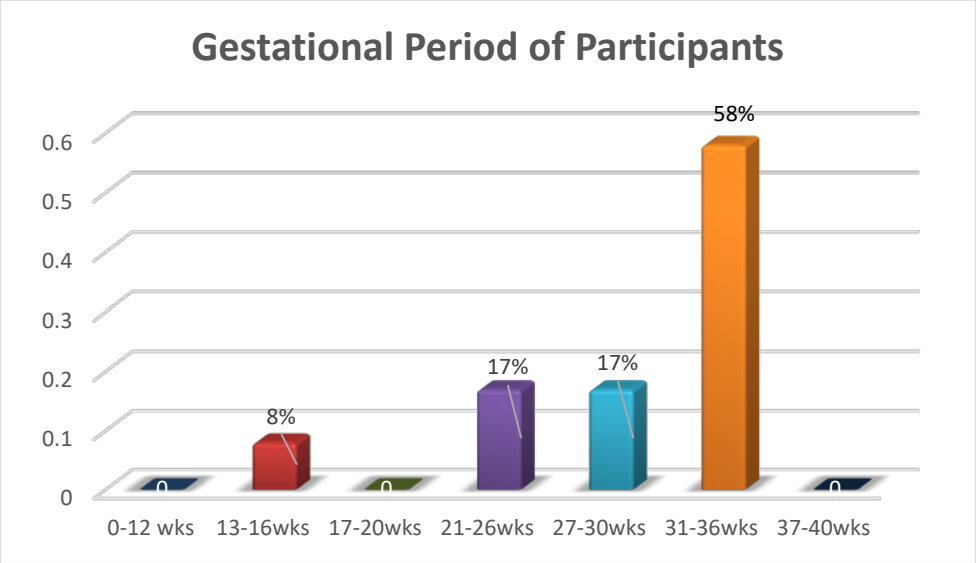

Table 3.3. below is an indication of the participants' gestational periods.

Table 3.3. Gestational period of participants

CRITERION	CHARACTERISTIC	FREQUENCY	PERCENTAGE
Gestational Period	0 to 12 weeks	0	0
	13 to 16weeks	1	8%
	17 to 20	0	0
	21 to 26	2	17%
	27 to 30	2	17%
	31 to 36	7	58%
	37 to 40 weeks	0	0
Total		**12**	**100%**

Figure 3.3 and Table 3.3 above shows more women within the period of 31-36 weeks, (n=7, 58%), followed by an equal number of participants whose gestational period was between 21-26 weeks (n=2, 17%), 27-30 weeks (n=2, 17%). Only one (n=1, 8%) woman's gestational period was between 13-16 weeks.

3.4. THE PROCESS OF DATA ANALYSIS

As stated in Chapter 2, the fundamental aim of data analysis is to systematically organise, provide structure to, and derive meaning from data (Polit & Beck, 2012:556). The data analysis process brings a directive to the structure and interpretation of the hugely collected data (Marshall & Rossman, 2016:214). Data analysis in qualitative research is described as a process of scientifically organising the interview and field notes until comprehended by the researcher in order to address the research question (Marshall & Rossman, 2016: 214). During the empirical engagement with the sampled pregnant women, the researcher listened to the interviews and transcribed them, then read the transcripts and compared them with the field notes taken during the interviews. An independent co-coder was utilised for data coding. Tesch's (1990) method was the technique used for analysing the data (Creswell, 2009: 186).

Transcribed interviews and field notes were provided to the co-coder together with the protocol for analysis, as described by Tesch (1990). The co-coder and the researcher analysed the data independently. From the twelve (n=12) verbatim transcripts, significant statements and concepts were extracted and arranged into categories based on their underlying meanings (Flick, 2014:36). This process was undertaken to enable a comprehensive description of the messages drawn from the interviews. The co-coder and the researcher clustered the ideas based on their structural meanings and developed the themes and sub-themes.

The sub-themes were developed and organised based on the underlying meaning, their relationship and the essence they have with other groups of codes. The themes and sub-themes were established within the premises of answering the research question (Babbie & Mouton, 2010: 118). The illustrative responses were drawn from the data as the supporting evidence. After three weeks, a meeting was held between the researcher and the co-coder to discuss and reach consensus on the descriptions embedded in the interviews and field notes. This consensus meeting was essential for the credibility and

dependability of the findings; *ergo*, the rigour of the study. The main themes identified during the transcription of the collected data were:

1. Social Support System;
2. Belief System; and
3. Cultural Practices.

Each of the three main or global themes (also referred as the superordinate themes) is explained below, in the context of its corresponding sub-theme(s) generated from the accompanying illustrative statements (Ehrlich & Joubert, 2014:411).

3.4.1. Social Support System

Table 3.4 below is a summary depiction of the above-cited themes, sub-themes (categories) and representative or illustrative responses supporting the global/ superordinate theme of social support systems.

Table 3.4: Summary of social support system themes

Themes	Sub-themes	Illustrative responses
Social support system	**Source of information**	• I learned from my in-laws where I got married to. • Mother-in-law. When you arrive at her home, she is the one who will teach you. • I learned from my mother at home and my elder sister who went through pregnancy. • There are a lot of “doctors” from the neighbourhood who are unqualified…..They give us information • I am not a person of healers, I was told by my parents. • The knowledge was taught by my maternal grandmother. Yes, it started there because even my mother did those things.
	Disclosing pregnancy	• I told my family about my pregnancy. • My mother discovered that I am pregnant at about 3 months. I was scared because I know they are cultural people. • After I told my parents, they sat me down and they explained to me about how they are going to do things now that I am pregnant.

	Consulting traditional healers	• I was not even aware that at home, they were people who believe in cultural things. But once they knew about my pregnancy they took me to a healer • I knew that my family is cultural and that they would take me to traditional healers. I ended up going. • After missing my period for two to three months, I went to my traditional healer. • At 7 months, parents took me to a traditional healer because I started struggling a lot. I was always admitted to the hospital. • I always go to a Sesotho healer, I only go so that I can protect the baby.
	Attending antenatal care clinic	• I ask for a check-up to confirm if I am pregnant or not. • I still go to the clinic, nurses should still check that the baby is growing well. • I start going to the clinic at 7 months because I know I am only left with 2 months, then my baby is here. • I went to the clinic at 4 months

In terms of Table 3.4, social support systems were closely associated with the source of information (relating to pregnancy in a cultural context), consulting with traditional healers, and attendance of antenatal care clinic.

3.4.2. Belief System

Table 3.5 depicts sub-themes and illustrative statements associated with the global theme of belief system.

Table 3.5: Summary of belief system themes

Themes	Sub-themes	Illustrative responses
Beliefs system	**Protection against witches**	• At home we are not traditional people, however, now I have a towel wrapped on my stomach because they believe that people should not see your belly button • After coming back from the clinic, and nurses explained to me that I am pregnant, I have to wrap my stomach. • Because I am still a scholar, I go to school with my stomach wrapped underneath my school uniform. • I wrap my abdomen that the baby should always be warm. I should hide my belly button (umbilicus) so that I am always safe from bad things.

Themes	Sub-themes	Illustrative responses
		• I have to wrap my stomach underneath ….people should not see my belly button… I might lose the baby in that way.
	Behavioural taboos	• When you are pregnant, you are not supposed to be sleeping a lot. • They told me that I was not supposed to be walking around a lot when I am pregnant because I will step on things like evil spirits and "mehato" (*evil not meant for one but enters through stepping on it without knowing).* • I should not wear light t-shirts. They don't want people to see the belly button. • My mother restricts me from sleeping. She believes by the time I go to give birth, the child will be born a stillborn due to sleeping every day. • I am not supposed to stand on the door and peep outside. • You should wrap yourself so that your waist will always be warm.
	Inappropriate foods	• I am not supposed to eat eggs while pregnant, because…when it's time for me to deliver the baby, the egg will appear before the baby and I will be in great pain. • They don't recommend oranges, because the baby will be born yellow, and will have to be placed in an incubator for a few days, in order to recover and regain his/her pigmentation
	Appropriate behaviours	• While wrapping yourself you should not use a safety pin, because the safety pin makes a knot, and as Basotho, we believe that the safety pin, once it is used you will struggle during delivery, the baby will be tied. • I am not supposed to tell people how far I am with the pregnancy. • I am not supposed to plait my hair, actually going to the salon and plaiting your hair will tie the baby. • According to my parents' culture, I was supposed to drink traditional medicine and leave out the pills from the western doctor

Table 3.5 above shows that the major theme of belief system was associated with protection against witches, behavioural taboos, inappropriate foods, and appropriate behaviours.

3.4.3. Cultural Practices

Table 3.6 is a representation of cultural practices as they relate to pregnancy outcomes in an indigenous context.

Table 3.6: Summary of cultural practice themes

Themes	Sub-themes	Illustrative responses
Cultural practices	**Herbal brews**	• Pitsa is boiled ostrich eggshell, mixed with a LP Record. It just helps that my baby will be well-formed. It forms the baby well in the first three months. • After 3 months, he gives me the powder. That powder is the one that makes the baby grow. • I drink water from there at church. • I was struggling. The healer made me pitsa, I drank pitsa. • I only saw herbs, he boiled them then just gave me water from them. • He gave me a lot of medicines that had seed and trees and it's very bitter. • I had problems, as instructed he said on the expected day of birth I should drink sefutho and I didn't as I was already in pains. • The healer brought me a bottle that has traditional medicine, and then he told me that in there he put a tree.
	Body massages	• At church, I am being massaged, by the older women at church. • The healer massages me on the stomach with an ointment that he applies oh his hands so that the baby should not struggle to be born. After he massaged me, I became well. I am able to sleep…at night.
	Body baths	• The traditional healer appoints a lady who is going to enter with me there and help me bath with sehwasho because they said my baby is positioned at the back, so they have to put him/her at the front. • After bathing, the traditional healer massaged my body with oils. • I bathed with sehwasho to chase all bad spirits.

According to Table 3.6, herbal brews, body massages and body baths were closely linked to cultural practices concerning pregnancy outcomes.

3.5. DISCUSSION OF FINDINGS AND LITERATURE CONTROL

The period of pregnancy is defined by both physiological changes and psychological adjustments that are affected by the social, cultural religious and political dimensions of the environment (Sellers, 2012: 125). Bjelica, Cetkovic, Trninic-Pjevic and Mladenovic-Segedi, (2018:102) point out that a pregnant woman is indeed confronted with her biological femininity, and this influences her self-concept. In many other ways, the pregnant woman also experiences a number of anxieties pertaining to the course and outcome of pregnancy.

Bjelica.et al. (2018:104) attest further that anxieties expose the pregnant woman to more vulnerability because her condition causes her to develop adaptive behaviours consistent with her personality, lifestyle, and status in society. Besides the bio-psycho-social complexity, there is also a transition into motherhood, which comes with certain social roles and responsibilities (Kim et al. 2014: 1). It is from this multi-faceted complexity of pregnancy that women in Botshabelo were asked to provide indigenous stories that are aimed at ensuring positive pregnancy outcomes.

The results accruing from these stories are discussed below within the context of the literature (Botma et al., 2010:197). According to Kumar (2012:208), literature control is used as a mechanism to enhance understanding of the results. The themes (social support system, belief system, cultural practices) and their sub-themes are also discussed. Some excerpts from the interviews are used to illustrate evidence from raw data.

3.5.1. Social Support System

One of the themes emanating from the interview was the social support system. Being pregnant is seen as a movement in which a mother shifts from a known state of affairs to a reality filled with unknown events (Baker & Yang, 2018:31). Due to the overwhelming transition, a social support system is essential in pregnancy. Social support is defined as interpersonal transactions or operations that contain emotional support, provision of

information or advice as well as instrumental aid and encouragement (Baker & Yang 2018: 31).

According to Ozbay, Johnson, Dimoulas, Morgan, Charney and Southwick (2007:1), social support is responsible for maintaining both the physical and psychological health of pregnant women. It is not surprising that indigenous stories of the study's women participants dwelled on this issue. Women may require a combination of support systems depending on their diverse needs. For this study, sources of information were mentioned with regard to the transfer of indigenous knowledge and practices that participants relied on during pregnancy for purposes of ensuring the well-being of both the mother and her child.

3.5.1.1. Sources of information

Source of information relate to the people, places and things from which information is derived (Grimes & Newton, 2014:27). Information is regarded as knowledge and facts provided about something (Madden, 2000:344). In this study, the participants highlighted that trusted family members were the main sources of information regarding the passing of indigenous knowledge and practices during their pregnancies. This is what some of the participants stated:

Participant 10: *I learned from my in-laws where I got married to*.
Participant 8: *I learned from my mother at home and my elder sister who went through pregnancy.*
Participant 4: *The knowledge was taught by my maternal grandmother*.
Participant 1: *I am not a person of healers, I was told by my parents.*

The above extracts accentuated the intergenerational transmission of indigenous knowledge and practices. Senanayake (2006: 87) attests that "indigenous knowledge is passed from one generation to the other by word of mouth", cultural rituals and values. It is obvious from the above extracts that the elders within society are responsible for the generational knowledge transfer aimed at preserving and sustaining their cultures.

The participants relied on knowledge passed to them from their mothers and grandmothers. The researcher was cognisant of the fact that a trusted member of the family still remains the source of information, especially when addressing sensitive issues

such as pregnancy. This was also emphasised by Liamputtong, Yimyam, Parisunyakul, Baosoung and Sansiriphun (2005: 139) in their study carried out in Northern Thailand. The results of Liamputtong et al. (2005: 139) highlighted that family members are the main transmitters of traditional beliefs and practices, and these are still commonplace among the communities of pregnant women.

This process of knowledge transmission and cultural practices is regarded as vital by families and pregnant women. Although the focus is on family members as sources of information, it became obvious that the more authority the member held in the family and society, the more influential is such a member in accentuating the variety of their experiences. Participants in this study pointed to their mothers and mothers-in-law as the main transmitters of indigenous knowledge. Simkhada, Porter, and van Teijlingen (2010:2) affirm that decisions regarding "the management of pregnancy and childbirth often come within the purview of older women, especially mothers-in-law".

As the excerpts illustrate, some of the participants obtained relevant information from their mothers and maternal grandmothers, and not from their in-laws *per se*. The involvement of mothers and maternal grandmothers may flow from the findings by Statistic SA (2016), in which it was reported that 47.6% of children in South lived in single-parent families. According to Mkhize and Msomi (2016:326), South Africa is experiencing a decline in marriages; hence, some of the participants relied on their maternal parents. Sahin and Sahin (2018:98) attest that pregnant women are expected by society to follow indigenous practices encouraged by trusted members in the household from the onset of the pregnancy until delivery.

The above-mentioned extracts do reveal the disparity is between the indigenous knowledge outlook and the patient education in the current health care system with regard to the acquisition of information. One may question whether the antenatal care policies in our current healthcare system are truly informed and influenced by local cultural attitudes, beliefs and practices of the communities as suggested by Hamid, Malik and Richard (2014:331). According to Hamid et al. (2014:331), positive pregnancy outcomes emanate from the mutual collaboration between the viewpoints of the society and the healthcare providers in a specific cultural context. What is not known is whether the current patients' education considers the *how, what*, and *who* regarding the transmission of health education.

The current health education relies only on nurses and midwives to provide health education that necessarily aims at lifestyle modifications on the basis of the antenatal care (ANC) guidelines (Oshinyemi, Aluko & Oluwatosin, 2018:96). Such an approach may ignore the need for cultural brokerage. According to Jang (2017:1), cultural brokerage is a framework that empowers the multicultural teams by way of leveraging their diverse knowledge for the purpose of engendering creative outcomes. The model of cultural brokerage may facilitate interactions between actors across cultural boundaries (Jang, 2017:1). In this study, the health professional culture and the participants' culture are likely to collide.

3.5.1.2. Pregnancy disclosure

Pregnancy disclosure was one of the critical outcomes of the study, which is concerned with revealing one's positive pregnancy state to the public (Brandao, 2013:227). The latter author asserts that disclosing pregnancy is a process whose first step is initiated when the pregnant woman receives the first probable signs of pregnancy. The second step is to communicate the pregnancy to family members or loved ones. Within the context of the ethnic beliefs of the pregnant women in Botshabelo, the disclosure of the pregnancy was first made to one of their family members.

In this study, the participants described that the first members to be trusted with the news of pregnancies are family members. Due to the sensitivity of pregnancies, participants stated that it is taboo in their cultures to inform non-family members about their pregnancies, especially in the first trimester because of the belief that she may experience a miscarriage. The following responses highlighted that pregnancy disclosure cannot be revealed to anyone except trusted family members.

Participant 6: *I told my family about my pregnancy*.
Participant 3: *After I told my parents, they sat me down and they explained to me about how they are going to do things to me now that I am pregnant*.

As previously stated, pregnancy is a sensitive subject in most African traditions. Therefore, it is addressed in the utmost secrecy (Mogawane et al., 2015:6). Roberts, Mashak, Sealy, Manda-Taylor, Mataya, and Gleason (2016:3) affirms that the non-disclosure of pregnancy to non-family member and distant relatives early in pregnancy is

undertaken to prevent the dangers associated with witchcraft within the African beliefs and preventing harm such as miscarriages. Pregnant women in Botshabelo perceive that miscarriages do not occur spontaneously or due to medical predicament, but are a result of witchcraft. It is for this reason that disclosing pregnancy to strangers is considered a risk to the wellbeing of the foetus and the mother. Although disclosure is always made to the trusted members, help is also sought to ensure good pregnancy outcomes. These women went for consultations.

One of the routine customs mentioned in this study was attendance of consultation visits, which entails a discussion between a health care practitioner and a patient regarding the aspect of a certain condition of the patient (Blackwell's Nursing Dictionary, 2005:146). According to Tarrant, Stokes and Colman (2004:1), the Western conceptualisation of consultation, entails a collaborative interaction in which the doctor obtains information, offers a diagnosis or opinion and discusses treatment. The outcomes of such a consultation are influenced by the choices and actions of the patient and the doctor (Tarrant et al., 2004). Therefore, consultation within the realm of childbirth is shared decision making between the midwives, patients and their families.

Besides the medical view of interpreting phenomena, there is alternative medicine, which includes traditional healers, spiritual or religious advisors. In culturally-steeped communities, consulting traditional healers is so rife due to the credibility, cultural acceptability and respect that these healers hold among the societies they serve. The approach of the traditional healers is more holistic in the sense that it relies on the comfort of the one seeking care, while the final analysis to such consultation is the cure or relieve (Gumede 1987:369). Reiterating the same notion regarding persistent use of traditional healers, Nxumalo, Alaba, Harris, Chersich and Goudge (2011: 2-3) indicate that clients mention issues such as the continuity of care, dignified treatment, distance and availability of healers. In this study, the participants made use of two types of consultations; one was with traditional healers while the other was with Western medical care.

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3.5.1.3. Consulting traditional healers

By definition, a traditional healer is recognised in the community as highly knowledgeable in the provision of herbal care, use of animal and mineral substances, as well as other social, cultural and religious methods (Zuma, Wight, Rochat & Moshabela, 2016: 2). In this study, participants stated that as soon as they discovered that they were pregnant, their first consultation was with the traditional healer trusted by the family. One of the extracts highlighted it thus:

Participant 4: *After missing my period for two or three months, I went to my traditional healer.*

It was also noted that consulting traditional healers was even undertaken prior to medical confirmation of pregnancy according to Western practices at health care facilities. The early consultation with traditional healers is an indication of the trust the pregnant women have in them. The present study's findings corroborate the results of Roberts et al.'s (2016:6), that pregnant women believe that traditional and spiritual healers are far more equipped to care for them during their pregnancy period. For this reason, they do not attend ANC earlier and frequently if under the care of the healers.

This trust in traditional healers is reiterated by Gumede (1987: 369), who highlights that the functioning of healers transcends the cure and relief from pain, but extends more to providing comfort. When scrutinising our ANC guidelines, the function is more instrumental and falls short of the comforting aspect. It is from this background that the notion of un-booked patients prevalent in many patients' hospital records could be scrutinised. Pregnant women trust their indigenous practices and beliefs; therefore, it is our duty as healthcare providers to conceptualise this from the context of the patients (Zuma et al., 2016:9). Traditional healers and pregnant women believe that traditional practices protect their unborn babies and ensure positive pregnancy outcomes.

In this study, pregnant women trust in the abilities of the traditional healers. Basing their viewpoint on Western medical practices, Audet, Hamilton, Hughart and Selato (2015:1) state that indigenous practices result in delayed, interrupted or possibilities of abandonment of therapy considered essential by health care practitioners. The delay may result in compromised foeto-maternal wellbeing due to unknown pregnancy complications that may have been delayed during diagnosis. The influence of, and trust in traditional healers emanates from family members. As previously stated, they are the main influencers behind the transfer of indigenous knowledge and practices to pregnant women, as demonstrated in the following excerpts:

Participant 6: *I know that my family is cultural, even if I don't want to be that cultural, I know they would take me to traditional healers, and I ended up going*.

Participant 1: *I was not even aware that they were traditional people that believe in cultural things until I fell pregnant and they took me to a traditional healer*.

In this study, the participants highlighted that the decision to consult the traditional healers was not theirs. The decision was taken on their behalf by trusted family members. However, the participants attest that the consultations with traditional healers had a positive impact and there were no regrets expressed regarding these consultations. According to a study by Esienumoh, Akpabio and Etowa (2016:3), pregnant women do not participate in decision making regarding the process of their pregnancies. The results of the pregnancy decisions become binding to the women and are done by significant family members on behalf of pregnant women. During the interviews in this study, one participant stated that the in-laws emphasised the importance of attending the traditional healers' sessions early in her pregnancy as customary in that particular family. This is how the participant focused on the authority of the in-laws:

Participant 11: *I got married, and my mother-in-law is the one who taught me to go to the healer as soon as possible.*

In this study, the researcher noted the influence of the trusted family members is based on the fact that in African cultures, the elders' decisions are never deemed wrong or questioned. Therefore, regardless of the participant women's unbelief in traditional healers, they finally consulted traditional healers due to the influence of trusted members

3.5.1.4. Attending antenatal care (ANC)

Antenatal care (ANC) relates to the care given to mothers during pregnancy. ANC is defined as the assessment and risk management of pregnant women by health care providers in order to classify low to high-risk pregnancies, and to ensure good foetal growth and maternal wellbeing (Ewunetie, Munea, Meselu, Simeneh & Meteku, 2018:2). In this study, late booking at ANC facilities was noted. In the South African context, late ANC booking is classified as booking later than twelve weeks' gestation for women without any risk factors (DoH, 2015:38). The participants expressed that they attended ANC clinics in the second or third trimesters of their pregnancies. Late booking was confirmed by some participants who indicated that:

Participant 12: *I went to the clinic at 4 months.*
Participant 3: *I started attending the clinic on the 7th month.*
Participant 9: *Well honestly, I am starting to attend the clinic today, I have been going to the healer ever since my pregnancy started.*

Emanating from the statements above, is that the reasons for late booking was that they did not want to start ANC in the first trimester, as they did not want to attend the clinics for a long time preceding child birth. They were discouraged by monthly antenatal care consultations and numerous scheduled visits, as highlighted in the following extracts:

Participant 4: *I start attending the clinic on the 7th month because you will sit at the clinic the whole day, so from the 3rd month that is not what I can do.*
Participant 8: *Going to the clinic every month is exhausting.*

The results of a study by Roberts et al. (2016:5) indicated that pregnant women in Malawi did not value the adherence to monthly ANC, as they deemed it unnecessary to visit the clinic frequently. The second reason was the secrecy around their pregnancies in order to prevent witchcraft-induced misfortunes such as miscarriages and stillbirths. They believed that the less people knew about the pregnancy, the better. Therefore, attending ANC early would disclose their pregnancy statuses to non-trusted members, as they would be seen when visiting the clinics and have to reveal their pregnancy status. One participant expressed it thus:

Participant 3: *If you go to the clinic early, the witches will know and have time to plan to harm your baby.*

According to Ragolane (2017:25), it is not customary for Africans to publicise their pregnancies too early, out of fear of being bewitched. The third reason disclosed for late booking in this study is that participants trusted more in traditional healers than health care facilities as the first line of treatment. This is how the participants expressed their trust in traditional healers:

Participant 12: *If I miss my period for two months, I go to my traditional healer*.
Participant 5: *Immediately when I became pregnant, my mother took me to a traditional healer*.
Participant 3: *In my culture when you find out that you are pregnant, you go to a traditional healer first for protection, and you will go to the clinic later.*

According to Dako-Gyeke, Alkins, Aryeetey, Mccough, and Adongo (2013:6), pregnancy is perceived as a dangerous period in some African customs, requiring intensive forms of support such as spiritual, medicinal and psychosocial support. In this study, participants expressed that their late ANC booking did not attenuate the significance of antenatal care in ensuring the baby's growth and safe delivery when the pregnancy is term. The extract below accentuates this fact:

Participant 10: *You still go to the clinic, nurses should still check that the baby is growing well.*

All the participants identified and valued the duality of consultations. Their main trust was in their indigenous practices, but they still felt that not attending ANC altogether would not be ideal and would put their babies' lives in danger. They stated that it was vital for health care professionals to still monitor the progress and wellbeing of their unborn babies.

3.5.2. Belief System

Usó-Doménech and Nescolarde-Selva (2016: 1) are of the opinion that every human person has a belief system, a mechanism to make sense of the world around them. Accordingly, these belief systems are reinforced by culture, experience, political viewpoints and training, which in most cases feature personal commitment and elements of rules. Belief systems are based on the interrelated elements of structures of norms and values, orientation and language (Asare & Danquan, 2017:2). It is what societies live by and utilise as points of reference to conduct their everyday lives. In this study, the

pregnant women revealed the set of norms and values that they were expected to follow from the beginning to the end of their pregnancies.

The belief structure of norms and values for ensuring positive pregnancy outcomes were related to protecting the unborn child and the mother. According to Jenkins-Smith, Silva, Gupta and Ripberger (2014: 485), the belief system consists of ontological axioms that are so deep-rooted and fundamental to a point where they become resistant to change. In this study, the sub-themes that emanated from the belief system range from protection against witches, as well as the do's and don'ts during the period of pregnancy.

3.5.2.1. Protection against witches

Witchcraft is within the African belief system, and is signified by the belief that there is magic or evil that may be directed towards vulnerable individuals (Agbanusi, 2016:117). In African cultures, pregnancy is viewed as a sensitive issue and pregnant women are considered vulnerable during such a period, and so is the unborn baby (Roberts et al., 2016:6). Africans believe also that measures should always be in place to protect the mother and the unborn child. In this study, participants illuminated that they had to deal with their pregnancies with secrecy by not revealing their pregnancy status to other people outside the family for fear of being bewitched. Makoae (2000:38) affirms that the delay in announcing news of the pregnancy assists in avoiding jealous witches, who are likely to sabotage the pregnancy. Pregnant women are instructed not to tell or show their pregnancy bumps. Almost all the participants highlighted that they had to protect their pregnancy. These are some of their extracts:

Participant 4: *At home, we are not traditional people, however, I now have a towel wrapped on my stomach because they believe that people should not see your belly button.*

Participant 2: *After coming back from the clinic, and nurses had explained to me that I am pregnant, I have to wrap my stomach*.

Participant 7*: Because I am still a scholar, I go to school with my stomach wrapped underneath my school uniform*.

Participant 1: *I have to wrap my stomach underneath... your belly button, they will see how far you are or the child... you might lose the baby in that way*.

The excerpts above illustrate that the participants believed that they are likely to be victims of witchcraft because of their pregnancies. For that reason, they were obliged to protect themselves and their unborn children. One such duty concerns the hiding of their navel. The participants' believed that if their clothes are revealing, the navel is likely to be visible. This is one of the physiological changes due to the pregnancy, and it needs to be concealed to the outside world by covering the stomach. They believed that the witches would predict their pregnancy status by merely looking at their navels; and because of their magical powers, were likely to harm the unborn babies and cause negative pregnancy outcomes.

According to Finlayson and Downe (2013:5), certain things are perceived as a public revelation of the pregnancy. In African customs, an unwrapped pregnancy stomach is one of them. Some of the participants were educated and literate and some declared that their families were no longer traditional. Nonetheless, the excerpts demonstrate that the belief is deep-rooted, as they also wrapped their abdomens for protection. As explained by Lumwe (2013: 84), strong media and educational influences did not erode belief in witches.

The researcher observed that all the participants had wrapped towels on the stomachs, either under or on top of their clothes. The participants indicated that they are instructed to wrap their stomachs for the entire nine months of their pregnancies. It is well known that hormonal changes caused by relaxion, progesterone and oestrogen are likely to generate a deficit in the support of the pelvic abdominal organs (El-Mekawy, Eldeeb, El-Lythy & El-Begawy (2013:75). Furthermore, it has been identified that "the abdominal belt improves the strength of the abdomen, contributes to mechanical spine stability through co-activation of trunk flexors and extensors musculature" (El-Mekawy et al. 2013:75). Despite their stated reasons for the use of abdominal wraps, the participants disclosed that they were ridiculed by midwives in the ANC clinics for their wrapped stomachs.

3.5.2.2. Behavioural taboos

Behavioural taboos are defined as culturally forbidden practices in certain ethnic groups according to their cultural beliefs (Fershtman, Gneezy & Hoffman, 2011:139). Societies set standards of accepted behaviours to which members have to adhere. In this study, there are behavioural taboos that the participants stated during the interviews, relating to

how their pregnancies are governed according to the elders' cultural prescripts. There are restrictions on what they can and cannot do while pregnant in order to avoid negative pregnancy outcomes. Participants reflected on this aspect in the following extracts:

Participant 3: *When you are pregnant, you are not supposed to be sleeping a lot.*
Participant 7: *They told me that I am not supposed to be walking around a lot when I am pregnant because I will step on things like 'mehato' and evil spirits*.

Participants stated that they were prohibited from sleeping excessively, as the babies would also be born asleep. Restrictions to the movement were also expressed by the participants, who stated further that they are forbidden to walking a lot, as they may end up stepping on evil traps against their unborn babies. According to the participants, restrictions to movement are encouraged by elders in order to prohibit religious or cultural complications to the unborn baby that may be a result of witchcraft. Notwithstanding the un-scientific claims of these taboos, the women's cultural beliefs implied these were preparation to ensure safe birth when the due date arrives. The following extracts emphasise that fact.

Participant 5: *I am not supposed to stand on the door and peep outside, because the baby at the time of birth will keep peeping and going back.*
Participant 4:*You must always wrap your waist so that it will be warm, the baby should not get cold and you struggle to give birth.*
Participant 11*:My mother restricts me from sleeping. She believes by the time you go give birth, the child will be born a stillborn due to sleeping every day.*

In this study, the participants were of the view that sleeping a lot during pregnancy would result in prolonged delivery time. They expressed that peeping through the door results in prolonged labour in the maternity wards. This concurred with the results of a study by Riang'a, Nangulu and Broerse (2018:7-8) according to which Kenyan pregnant women also believed that oversleeping and being idle during pregnancy may cause the unborn baby to sleep a lot during delivery, resulting in prolonged labour.

3.5.2.3. Inappropriate foods

Culturally imposed food restrictions were noted in the study. Pregnant women are prohibited from consuming certain foods from the moment of conception until delivery. Culturally, prohibited foods are often associated with harm, despite their nutritional benefits. The researcher noted that foods with high nutritional value such as eggs, which is one of the major protein sources, are denied pregnant women for consumption due to fear of pregnancy or labour complications. The following responses were expressed to that effect by the participants:

Participant 9: *I am not supposed to eat eggs while pregnant, when it is time for me to deliver the baby, the egg will appear before the baby and I will be in great pain*.

Participant 1: *I am not supposed to eat food like eggs*.

The participants complied with the food prohibitions. According to Diana, Rachmayanti, Anwar, Khomsan, Christianti, and Kusuma (2018:246), there is a belief that cultural food prohibitions and taboos exist to protect the health of the mother and the unborn baby. Every pregnant woman wants a safe pregnancy and delivery, and the researcher noted that the participants refrained from consuming certain foods to avoid negative pregnancy outcomes associated with those foods. One participant expressed that:

Participant 6: *They don't recommend that I eat oranges. Because the baby will be born yellow.*

The researcher noted that participants were focusing on the non-consumption of the foods regarded as taboos during pregnancy and ignorant of nutrient deficiencies that could occur as a result. Nutritional restrictions deprive women of essential nutrients vital in pregnancy (Esienumoh et al., 2016:5). The restrictions may serve as predisposing factors for maternal nutritional complications such as malnutrition and anaemia. Sahin and Sahin (2018:100) also oppose the notion of food restrictions in pregnancy because of the possibility of an insufficient amount of nutrients for both the mother and the foetus. Although participants in this study received nutrition health education, it is clear that they did not consider such information as essential. Feto-maternal complications in pregnancies and deliveries may be predisposed to nutritional deficiencies as a result of cultural debates related to food, despite the harm the restrictions may cause. Nutritional

health education may need to be emphasised more during antenatal care. Otto, Habib and Ankomah (2015:48) state that nutritional health education should be emphasised, but indigenous practices should also be considered as they cannot be disregarded entirely

3.5.2.4. Appropriate behaviours

In this study, appropriate behaviours are defined as actions and conduct approved by a certain group based on cultural considerations (Idang, 2015:102). The participants highlighted that during the first trimester of the pregnancy and prior to the obvious physical alterations, the pregnancy is a family matter and not open for public knowledge. The rationale is that people in the neighbourhood may cause harm to the unborn baby and result in miscarriages and stillbirths. According to the participants, pregnancy is a biological process shrouded with uncertainties, which is the main reason why it is kept as a family affair to avoid witchcraft- induced miscarriages or stillbirths. The participants expressed the issue of secrecy thus:

Participant 2: *I am not supposed to tell people how far am I ….they believe that people will tie my pregnancy*.

Participant 10: *Our parents don't want people to know how far in our pregnancy are we……by the time you give birth the baby will struggle being born*.

As stated earlier, fear of witchcraft is one of the causes for late booking in ANC, and women consult with traditional healers, immediately they realise that they are pregnant for protection of the mother and the unborn baby before visiting health care facilities. The participants further expressed that indigenous measures taken were to ensure safe pregnancy and delivery. Fear of complications of delivery propelled the participants to abide and oblige with the practices. The following is the extract as expressed by the participant:

Participant 9: *While wrapping yourself, you should not use a safety pin. Safety pin makes a knot……. you will struggle during the delivery, the baby will be tied*.

It was observed that complications such as prolonged labour, possible caesarean sections and stillbirths are the participant's greatest fears during their pregnancies, and they would take any indigenous suggestions and perform all the rituals to ensure safe

pregnancies and deliveries Dako-Gyeke et al. (2013:8) state that women who believe in indigenous practices fear the consequences of disobeying these practices. They believe there will be unfavourable perinatal and neonatal health problems if they fail to abide by the practices. Hence, indigenous practices were more important, even if they did not understand them. They trusted their elders to know better.

3.5.3. Cultural Practices

Cultural practices are perceptions of the common behaviour of others, as set by ethnic prescriptions (Frese, 2015:328). It determines how people think and act about certain things. In this study, pregnant women perceived that successful pregnancies and positive pregnancy outcomes were shaped by cultural imperatives. Participants perceived that negative outcomes of pregnancies were a result of defiling and defying indigenous practices as Africans. In this study, the researcher noted that Indigenous practices include drinking of herbal brews, baths and body massages.

3.5.3.1. Herbal brews.

Herbal medicine is founded on the use of healing plants to treat and prevent diseases. The practice of herbal medicines ranges from traditional and popular medicines in every country, to standardised and titrated herbal extracts (Fabio & Gori, 2007:37). According to Nalumansi, Kamatenesi-Mugisha and Anywar (2017:33), herbal medicines are commonly used by Africans to combat minor ailments during pregnancy. In this study, the participants stated that they were offered herbal brews for their consumption and protection of the unborn baby during pregnancy. The traditional brews are differentiated by name, function and stages of consumption during pregnancy. In this regard, the participants stated:

Participant 1: "*Pitsa" is a boiled ostrich eggshell mixed with a LP Record, I drank it because it just helps that my baby will be well-formed. It forms the baby in the first three months.*

Participant 7: *The healer brought me a bottle that has traditional medicine, then he told me that in there he put a tree*.

Participant 3: *I had problems, as instructed he said on the expected day of the delivery, I should drink "sefutho" and I didn't as I was already in pains*.

The function of herbal brews mentioned here varies from assisting with foetal development and protection, as well as shortening the birth process. These statements are supported by Bayisa, Tatiparthi and Mulisa (2014:1), who stated that pregnant women trusted traditional medicines more than Western medicine. Traditional medicine is reputed for treating medical problems and improving health status during pregnancy, at birth and postpartum care in many rural areas around the world. Otoo et al. (2015:42) affirm that traditional medicines are used to reduce medical interventions in health care facilities. Ahmed, Nordeng, Sundby, Aragaw and de Boer (2018:308) mention that medicinal plants are used in different parts of the world with varying degrees of effectiveness. However, prioritising studies on efficacy and safety should be a factor for the researchers to investigate (Ahmed et al., 2018:308).

The participants in this study confirmed that they were not familiar with the herbal brews they consumed. The traditional healers brewed them themselves and handed the end products to pregnant women. However, all the participants highlighted that the herbal brews were effective. The researcher discovered that pregnant women would not disclose the use of herbal brews in ANC facilities, out of fear of stigmatisation by health care professionals. The perceived tensions between conventional and traditional medicines is the main reason for the pregnant women's non-disclosure at health care facilities, of their consumption of herbal brews (James, Bah, Tommy, Wardle and Steel (2018:308).

3.5.3.2. Body massages

Pregnancy is a period that has the effect of changing a woman's body, and minor ailments may occur as a result (Urtnowska, Bulatowics & Ludwikowski, 2016:1). Body massages are often used as a therapeutic mechanism to prevent or alleviate symptoms associated with these minor ailments. In this study, the practice of traditional and religious body massages during pregnancy was noted. According to the participants, the massages are intended for therapeutic, and not recreational purposes. Following are extracts to that effect:

Participant 5: *There at church, I am being massaged by older women.*

Participant 8: *The healer massages me on the stomach with an ointment that he applies on his hands so that the baby should not struggle to be born. After he massaged me, I became well. I am able to sleep at night*.

The researcher discovered that, according to the participants, the significance of the massages is to ensure the wellbeing and protection of the foetus. One participant stated that the massages assisted with the turning of her baby in-utero:

Participant 4: *They [health care practitioners] said my baby is positioned at the back, so they have to put him/her at the front*.

The massages are performed by elderly women at churches and traditional settings. The massage consultations are routine. The perception of the researcher was that the massages are used by church leaders and traditional healers to monitor the growth of the baby in-utero. Traditional healers utilised therapeutic herbal oils to massage the pregnant women. Participants who preferred religious massages at churches highlighted that they were massaged with '*holy ointments'*. The extract below emphasises the issue thus:

Participant 5: *Yes, there are ointments that I use, just like this Vaseline from church, labelled ZCM.*

According to Mesele (2018:4), abdominal massages in rural areas are performed to provide pregnant women with relief from pregnancy complications. As it is uncommon for pregnant women in rural places like Botshabelo to attend ANC early, abdominal massages create relief to minor pregnancy ailments in the first trimester. Adokiye, Isioma and Levi (2016:2) oppose traditional abdominal massages and highlight their dangers, despite that more pregnant women prefer them. The latter authors cite dangers such as rubbing the abdomen with no maternal history and professional knowledge. They contend further that the massages could lead to feto-maternal mortality if there were underlying conditions such as placenta previa, previously scarred uterus and ectopic pregnancy. However, participants in this study were in admiration of the traditional healers' services, as no complications ever occurred to them due to any of the indigenous practices. All the pregnant women in the study attested further that indigenous practices were effective and efficient.

3.5.3.3. Baths

According to Ozioma and Chinwe (2019: 199), spiritual cleansing is a process where a sick or pregnant person is subjected to bath, by water or animal blood as a religious or cultural activity. Participants in this study expressed that during their routine check-ups

with the traditional healers, being bathed was one of the activities performed. The bathwater was mixed with traditional medicine. The herbs were expressed to be for the protection of the mother and the baby Some of the participants expressed the procedure performed thus:

Participant 9: *Traditional healer appoints a lady who is going to enter with me in there and help me a bath with ''sewasho''.*

Participant 6: *After bathing, the traditional healer massaged my body with oils. I bathed with seshwasho to chase all bad spirits*

The results of a study conducted in Ghana by Aziato, Odai and Omenyo (2016:6) revealed that ritual baths can vary from bathing with urine or blessed water for the religious pregnant women. The baths are believed to exhort evil spirits and protect the mother and unborn baby against such evil spirits. In this study, the participants expressed that the traditional healers would bathe them with herbally mixed water. The researcher discovered during the interviews that 'sewasho' was the name of the dominant herb used to bath the pregnant women.

3.6. FIELD NOTES

Field notes are described as the notes taken by the researcher to document the unstructured observations and their interpretations noted in the field (Dean et al., 2014:1). In this study, the field notes were gathered during the recruitment of the potential participants as well as the visits to their homes in which interviews were scheduled and executed. Accordingly, the observational, theoretical, methodological, and personal notes were compiled, as advocated by Polit and Beck (2012: 548-549).

3.6.1. Observational Notes

Observational notes reflect the researcher's objective description of the observed events, dialogues and information about actions in context (De Vos et al., 2011:108). The researcher noted that in all the ANC clinics in which the participants were recruited, the healthcare professionals were older women. The researcher also noted the reluctance of participants to be part of the study during recruitment in ANC due to the fear of stigmatisation by the health care providers. The researcher encouraged the use of her telephone numbers shown on the information leaflet in the event that they were interested

in taking part in the study. Only then did it provide comfort to the potential participants in them knowing that the interviews would be conducted in their own homes irrespective of the health care services they were receiving.

3.6.2. Theoretical Notes

Theoretical notes documented the researcher's efforts to allocate meaning to the observed developments (Given, 2008:342). In this study, the researcher observed that the older midwives in ANC tended to be intimidating. Hence, potential participants were averse to revealing whether or not they were interested in taking part in the study in front of these elderly midwives. The 'intimidation factor' coheres with the information shown in both Figure 3.1 and Table 3.1, in which the majority of the participants were younger women whose ages ranged between 20-25 years. Such an age group were most likely to be intimidated.

3.6.3. Methodological Notes

Methodological notes are reflections of strategies used to remind the researcher of the researcher's role in conducting the study (Marshall & Rossman, 2016:29). The researcher noted the potential participants were uncomfortable to reveal their participation interests in the study for fear of being judged by healthcare providers. The researcher provided the telephone numbers to be contacted by participants once they had decided to participate without bearing the stigmatisation pressure in the healthcare system. In research, the researcher should enter and exit the research field without any destabilisation of the research milieu prior to the execution of the study (Ehrlich & Joubert, 2014:109). However, in this case, the researcher may not be able to exit the research field due to the personal telephone numbers provided to potential participants who may even use them for other purposes unrelated to the study.

3.6.4. Personal Notes

Personal notes explain the researcher's experiences, feelings, and assumptions while collecting the data in the research field (Botma et al, 2010:218). Virtually all interviews were conducted at the participants' homes. The researcher also experienced emotional discomfort and uneasiness by travelling to areas of Botshabelo unfamiliar to her.

3.7. CONCLUSION

The literature review in this chapter demonstrated that pregnant women in most African cultures have indigenous practices they adhere to during their pregnancies in order to ensure positive pregnancy outcomes. The findings of this study revealed that the trusted first line of treatment for pregnant women in Botshabelo was their indigenous beliefs as they were acculturated to the knowledge, attitude, and practices prevailing in their communities. Culture is vital in determining the actions of individuals, and it is the compass that navigates how life should be lived (Asare & Danquah, 2017:3). In the next chapter, discussions of the main findings, as well as limitations and recommendations are presented.

CHAPTER 4
DISCUSSIONS, CONCLUSIONS, RECOMMENDATIONS AND LIMITATIONS

4.1. INTRODUCTION

The preceding chapter presented and described the study's findings substantiated with relevant literature. The present chapter presents a summary of the main findings, conclusions, recommendations, and limitations of the study as a whole.

4.2. DISCUSSION OF FINDINGS

The results emanating from the participants' stories in ensuring positive pregnancy outcomes revealed the indigenous practices relating to pregnancy, as well as the accompanying belief system and associated cultural practices. The main themes of social support systems, belief systems, and cultural practices are discussed briefly below.

4.2.1. Social Support System

The results show that pregnant women rely on various sources of social support during the process of pregnancy. This is plausible, given that pregnancy makes women vulnerable due to the physiological and psychological changes taking place in their bodies. Maharlouei (2016: 1) states that women become vulnerable due to uncertainties that come with pregnancy, as well as the expectation of upcoming new circumstances of motherhood. It is from the background of vulnerability that social support was deemed vital and necessary by the participants. The four main sources of social support systems included, amongst others, sources of information, disclosing the pregnancy, consulting traditional healers and attending antenatal care clinics.

4.2.1.1. Sources of information

The results pertaining to sources of information reveal that older women within the family structure are the main influencers and transmitters of indigenous knowledge and

practices. The findings confirm that the participants relied on these older women as the main sources of support during pregnancy. In this study, the participants mentioned that their mothers, maternal grandmothers and their mothers-in-law facilitated the pregnancy process from beginning to the end.

Pregnant women trusted the older women's judgment and support in the belief that they knew better. Although old age is deemed as a determinant of wisdom and support, it is still mired in controversies. According to Raz and Rodrigue (2006), old age is associated with declines in many aspects of cognition that are accompanied by numerous stereotypes. Nonetheless, the wisdom of old people remains the source of support in many cultures (Lim & Yu, 2015:2). According to the latter authors, wisdom is concerned with the promotion of common social good, which is the reason for older people being considered as caring for the well-being of the other (Lim & Yu, 2015:2).

The results revealed that older and experienced women are the initial sources of information. They pass the information to the younger generation as it was done unto them. Older women are responsible for ensuring that they preserve their culture. Atalan (2018:1700-1701) states that culture is transferred from one generation to the other, therefore, protecting and maintaining the cultural aspects of the society depends on this transfer. One noteworthy factor is that pregnant women's initial pregnancy information is indigenous, and this comes from the people that they trust and respect. As such, it is possible that the information they receive in antenatal care may often be considered unimportant or less crucial. Pregnant women in this study deemed indigenous knowledge as more vital than conventional Western knowledge.

The participants' demographics revealed that they were either young, married or unmarried women, but they all had older female authorities that influenced their decisions. Sanders and Crozier (2018:2) also confirm that pregnant women's decision-making ability regarding their pregnancy is influenced by age, societal environments, demographic aspects, as well as cultural beliefs of the society. It is evident that the influence of the older generation in a society cannot be ignored where the provision of information is concerned with regard to pregnancy and parenthood.

The results demonstrate that prior to the formal health education provided by the healthcare practitioners at ANC, pregnant women are already influenced by their indigenous belief, knowledge and practices. In this way, Western health education becomes second-hand information with limited impact. Hicks (2018: 6) states that indigenous knowledge, values and practices are overvalued and prioritised within the consultation approaches. Healthcare professionals during the healthcare education sessions should be cognisant that pregnant women are not empty vessels. Rather, they should know that certain information has already been provided to the patients prior to the consultation that may cause an affirmation or discrepancy with the ANC.

In an ideal health care system, the first source of pregnancy information is always healthcare professionals. The observational field notes regarding the behaviour of midwives during the recruitment of participants at clinics revealed that the source of information was female midwives. What was intriguing about these female midwives was their maturity. They seemed older, and this is congruent with aspects of older women as information sources in the indigenous belief system. The only difference was the provision of cultural and spiritual aspects that need to be considered.

4.2.1.2. Disclosing the pregnancy

As indicated by participants, pregnancy disclosure is a sensitive issue amongst these women in Botshabelo, which is the reason it cannot be made known to non-family members. The participants believed that the secrecy around their pregnancies is beneficial as it ensures that the protection of the unborn baby against witchcraft, a feared phenomenon in many African societies. Non-family members or untrusted people are deemed capable of harming the unborn baby.

They believed that premature disclosure of the pregnancy to the outside world would cause negative pregnancy outcomes. In this study, the disclosure of pregnancy to healthcare practitioners was only made after the necessary protective measures for the mother and the unborn baby, which was rendered by traditional healers. It became obvious from the stories that these pregnant women want to preserve their cultural beliefs and practices in order to ensure positive pregnancy outcomes, as some followed the indigenous knowledge system while at the same considering themselves as un-traditional.

4.2.1.3. Consulting traditional healers and attending antenatal care clinics

It was apparent from the results that pregnant women consulted traditional healers more often than the healthcare professionals. They had monthly consultations with the healers and felt no need or urgency to visit the ANC clinics. This may answer many pregnant women who book late or turn up un-booked at maternity wards with dire consequences. Most healthcare practitioners do not trust the care rendered by traditional healers, and this has caused a rift between these two systems of care.

Healthcare practitioners ridicule the healers' services as redundant and dangerous. This notion was revealed by the observational notes, as the participants were reluctant to be included in the study, but accepted the invitation per personal phone. Mokgobi (2014:1) also attests that despite WHO's encouragement of governments to actively recruit traditional healers into the primary health care regime, there are still mixed feelings amongst the health professionals. However, the fact cannot be ignored that in most cultures, the most preferred and first line of treatment is with the healers. The researcher noted that consulting traditional healers was not entirely their decision, because the older women as a support system in the family, make such decisions, and is considered as culturally correct.

The results reveal that, despite consulting with traditional healers, these women were still attending the ANC clinic. Although these dual consultations are normal and significant for these women, there is often a malalignment between the two systems concerning health educations and practices. The results demonstrate that even though pregnant women comprehend the health education emphasised in antenatal care, the societal environment in which they lived, particularly the support system, had a greater influence on how that knowledge gained from the antenatal consultations is comprehended and applied. Pregnant women, therefore, encountered some difficulties in aligning the messages from healthcare practitioners and also having to adapt to indigenous knowledge imparted in their homes. In most cases, the indigenous knowledge was in conflict with the knowledge provided to them at antenatal care consultations.

This was also identified by Finlayson and Downe (2013:1), who discovered that there is a malalignment between the current antenatal care provision, and socio-cultural practices of pregnant women in low and middle-income countries. The researcher noted that even

though health education may be well executed in antenatal care facilities, there is non-compliance in applying what was emphasised in the conventional health education system in the clinics. The findings show that the indigenous habits of pregnant women exerted on them by their cultural beliefs were more forceful than the normal ANC information. For example, the results revealed that some pregnant women received iron supplements from the clinics, but they did not consume them as they were taking herbal brews that were deemed more potent.

4.2.2. Belief System

The results of the study indicated that the cultural belief system drives the pregnant women's process of pregnancy. The participants had a set of cultural do's and don'ts that directed and dictated their process of pregnancy in order to ensure positive pregnancy. In this study, protection against the witches, behavioural taboos, inappropriate food, and appropriate behaviour were identified as aspects of the belief systems accompanying the process of pregnancy.

The results of the study revealed further that witchcraft is feared by all the participants. Negative pregnancy outcomes such as miscarriages and stillbirths are associated with it. With regard to the protection against the witches, the participants' activities range from having to wrap their stomachs to hide the navel and not telling non-family members about their pregnant status. The fear of witchcraft may be considered as one aspect contributing to late booking at ANC, as pregnant women fear being seen in the clinic and obviously revealing their pregnancy. In the South African primary health care services, the infrastructure of clinics is allocated according to the type of service provided. This division of services may be account for the reluctance of pregnant women to attend early ANC, as they would be seen going to the antenatal care section. Delayed antenatal care may be perceived as a mechanism of safeguarding the pregnant woman and unborn baby against witches.

It was discovered that pregnant women had specific things that they could do, and others they could not. Some of the restrictions were that they should not sleep or walk a lot. It was believed that excessive sleep would result in prolonged labour, or stillbirths as the unborn baby would be sleeping a lot as well during delivery. The pregnant women were expected to be active during pregnancy and not sleep a lot during the day. Such a belief

may be associated with the idea that if they slept a lot, they would be oblivious to foetal activity. Although this may be seen as sleep deprivation for pregnant mothers, they are also permitted to rest a lot and sleep during the night. Micheli, Komnions, Bagkeis, Roumeliotaki, Koutis, Kogevinas and Chatzi (2011: 742) indicate that sleep deprivation during pregnancy may result in premature labour and low birth weight. Such an observation was not noted in this study. Contrariwise, participants in this study complied with the behavioural taboo despite the negative possibilities that may follow. The researcher noted that the pregnant women in the study were adamant to comply with this taboo, as none of the negative pregnancy outcomes has been associated with it.

One of the beliefs emanating from the results was that of restricting pregnant women from eating certain foods, such as eggs. Despite that eggs are a good source of protein, pregnant women in this study were under the impression that eggs may cause unbearable pain during labour. Al-Ateeq and Al-Rusaiess (2015:240) attest that most foods avoided by pregnant women due to cultural beliefs are highly nutritious and great sources of protein. Their indigenous sources of information and knowledge have taught them that the eggshell will appear on the perineum prior to the head of the baby during delivery, and that may prolong labour or cause excruciating pain.

This practice was transmitted from one generation to another, and like many others, pregnant women are not expected to question the origin and the reasons for its practice. One pregnant woman expressed that she was not allowed to eat oranges, as they would supposedly cause jaundice to the new-born. Citrus fruits are known to facilitate the absorption of iron. Pregnant women are given iron supplements at ANC, therefore healthcare providers should be aware of the restricted aids of absorption for those supplements. The disparities between the health and indigenous systems may cause healthcare providers to overlook factors that could be a hindrance to optimum care in ensuring positive pregnancy outcomes.

The results of this study revealed that pregnancies are a family matter, and not open to the public until the family is assured that the pregnant mother and unborn baby are protected and safe. The researcher noted that family members are part of the rigid structures of support that the pregnant women rely on during their pregnancies. Pregnant women are expected to be secretive, including their consumption of herbal brews as well as the numerous other things they are allowed, or not allowed to do. In this study, the

appropriate behaviours were determined according to cultural norms and experiences that the pregnant women had to comply with.

The results of this study revealed that norms and values are deep-rooted and influenced the pregnant women's knowledge, attitude, and practices regarding their pregnancies. Compliance with cultural practices is guaranteed with the pregnancy gestation. Healthcare providers ought to acknowledge the indigenous beliefs in order to eliminate health disparities that are influenced by culture. Stephen and Thomas (2004:1) attest that matching cultural characteristics with public health interventions may enhance interest and acceptance of public health.

4.2.3. Cultural Practices

The results of the study were indicative of the fact that there are many cultural practices to be observed during pregnancy. The traditional rituals are considered vital for ensuring feto-maternal protection. In this regard, three practices were noted, namely, herbal brews, body massages, and baths.

The results of the study revealed that pregnant women were consuming herbal brews prepared by their traditional healers. It was notable that none of the participants in this study had insight into the ingredients of the brews. There were different brews, for various purposes. The different functions that were expressed in this study were for foetal development and protection, and shortening the birth process. The researcher noted that other herbal brews were trusted for the treatment of minor ailments. Due to late booking in ANC, participants are often given herbal brews, especially in the first trimester to assist with minor ailments such as nausea and vomiting, which is common in the first trimester. The pregnant women in this study expressed the efficiency of these brews. However, they did not disclose the use of herbal brews in the ANC clinics, for fear of stigmatisation by healthcare providers. The danger of non-disclosure of herbal brews could be that healthcare providers are deprived of this information, and unable to be vigilant for possible danger especially during labour.

In this study, pregnant women were massaged by their traditional healers or spiritual leaders. The massages were considered therapeutic and traditional ointments were used as lubricants. The purpose of the massages was to monitor the growth of the baby in-utero. The researcher noted that abdominal massages were also used to relieve

pregnancy-associated discomforts such as backache, fatigue and oedema and provide therapy and relaxation. The body massages were part of the monthly routine or as needed by pregnant women. Although more pregnant women prefer traditional abdominal massages, there are still dangers associated with it (Adokiye, et al., 2016:2). Dangers such as rubbing the abdominal with no maternal history and professional knowledge posed a threat to the pregnant woman and her unborn child; for instance, if there were underlying conditions such as placenta previa, previously scarred uterus and ectopic pregnancy. In such cases, the massages could lead to feto-maternal mortality. Therefore, healthcare providers in the ANC clinic should emphasise the importance of transparency, in order to address and provide health education concerning the dangers associated with the act of massaging.

In this study, the researcher noted that pregnant women were routinely bathed during their traditional healers' check-ups. The bathwater was mixed with traditional medicine called 'sehwasho'. The baths were intended for the protection of the mother and the unborn baby against witchcraft-induced misfortunes such as stillbirths and miscarriages.

4.3. CONCLUSIONS ON THE DISCUSSION

From the results of the study, it is evident that culture is an enormous part of a person's existence, especially in tradition-steeped societies or communities. The study results indicate that every person believes in something, and the beliefs are deep-rooted within them. Resistance to change from what is perceived as the correct way of living is greatly noted. Jenkins-Smith et al. (2014:486) confirms that change associated with deep-rooted core beliefs is unlikely to happen, due to a formidable array of cognitive defences. In this study, the results indicate that pregnant women in Botshabelo have indigenous practices that are culturally rooted and have been transmitted from one generation to the other in order to ensure positive pregnancy outcomes. In ideal health sector practices, the first line of preferred treatment or trusted health system would be expected to be the healthcare system or facilities. However, pregnant women believe and trust more in their cultural practices.

Notwithstanding the ubiquity of cultural practices, especially in rural areas, healthcare workers are of the belief that current radical global transformations attenuate any possible prominence of the indigenous practices as an element worth focusing on, especially on

assessments and history taking. More so that health care workers focus on current guidelines of antenatal history taking and not fully attentive to the indigenous knowledge, attitudes, and practices that could influence the comprehension of health education rendered. In this study, the participants emphasised that during ANC, they do not disclose their belief systems and practices due to fear of being stigmatised by health care providers for their rooted beliefs and trusted practices.

4.4. CONCLUSIONS ON THE STUDY

The study concludes that the research question provided the desired results of the study. As such, the purpose of the study has been achieved. The results of the study revealed that pregnant women do not partake in the decision making regarding their pregnancies. The decisions are solely taken by structures of authority such as elderly women in their families.

Most participants did not believe in cultural practices, but had complied with indigenous practices due to the influence of the trusted family members; especially elderly women such as mothers, maternal grandmothers as well as the mothers-in-law. The researcher noted that health education is provided to individuals with less power over their pregnancies.

Providing health education to pregnant women is one aspect of care in the current ANC practice. However, the information received by pregnant women in ANC is not comprehensible for most pregnant women in Botshabelo because of the indigenous practices taught and practiced at their homes. The health information to the pregnant women is disregarded by trusted family members as soon as the pregnant woman goes back post-ANC consultations.

4.5. RECOMMENDATIONS

The recommendations are presented to address the findings as discussed in Chapter 3. Accordingly, the recommendations emanating from the results include integrating health dialogues and collaboration of health and traditional systems of care.

4.5.1. Integrated Health Dialogue Systems

The health dialogues are recommended between healthcare providers, trusted family members and pregnant women. The healthcare system should integrate the trusted family members as main decision-makers at home, to form part of the ANC consultations. Each pregnant woman should come with a trusted family member during the first ANC consultation. From observations, the researcher - who is also a healthcare provider - noted that most healthcare providers opt for health education rather than health dialogue. Health providers convey information without allowing the patients to state their views or ask for clarity. With the inclusion of trusted family member to the first ANC, a health dialogue is recommended in order to educate, learn the indigenous practices as well as advice in order to ensure positive pregnancy outcomes.

4.5.2. Collaboration Between the Conventional Health System and Traditional Systems of Care

The results of the study revealed that traditional healers are the first trusted line of treatment in Botshabelo. It is a norm to go to a traditional healer first, then consult at healthcare facilities thereafter. The recommendation is that traditional healers formally collaborated with healthcare practices in order to assist with ANC by fast-tracking the process to involve traditional healers in health systems. The South African government committed itself to involve traditional healers in official healthcare practices (NDoH, 2016:1). Such collaboration will assist in reducing late ANC booking. The other benefit of this collaboration is that healthcare providers will oversee and ensure safety, efficacy, and quality of services provided by traditional healers; contrary to functioning independently with no one informed of the medicines or techniques they are using.

4.6. FURTHER RESEARCH

This study was conducted in Botshabelo with twelve participants, which is a small portion and does not represent the whole population. Various indigenous practices may be happening throughout the country. Therefore, the findings of this study may not be significant to address all cultural practices of pregnant women in the country. The indigenous stories might vary from one part of the country to the other, and from one tribe to another. Among others, the recommendations for further research projects may include:

- Conducting a study on a larger scale across the provinces of South Africa;
- Explore indigenous stories of other tribes other than the Basotho tribe; and
- Exploration of the cultural reasons for late booking in antenatal care.

4.7. LIMITATIONS OF THE STUDY

The limitations of the study are noted as follows:

- The recruitment of participants was very contextual. As such, some pregnant women who are visitors in Botshabelo were left out and they may have had more indigenous stories to tell; and
- The researcher may have been overwhelmed by the demands of the qualitative research, especially on its empirical aspects.

4.8. VALUE OF THE STUDY

It is anticipated that the study will impact and bring about the following changes in healthcare systems:

- The provincial government will use the findings and recommendations of the study to plan and improve health services; and
- The findings of the study might assist in the total eradication of negative pregnancy outcomes.

4.9. CONCLUSION

The purpose of the study was to explore indigenous stories of pregnant women in Botshabelo aimed at ensuring positive pregnancy outcomes. Explorative, descriptive and phenomenological designs were applied in this study. In-depth individual interviews were opted for the data collection. The recommended propositions were articulated on the basis of the findings of the study. In conclusion, this study has successfully met its purpose.

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APPENDIX 1: UNIVERSITY OF FREE STATE ETHICAL CLEARANCE

UNIVERSITY OF THE FREE STATE
UNIVERSITEIT VAN DIE VRYSTAAT
YUNIVESITHI YA FREISTATA

UFS·UV
HEALTH SCIENCES
GESONDHEIDSWETENSKAPPE

Health Sciences Research Ethics Committee

01-Aug-2018

Dear **Miss Ditsietsi Kortman**

Ethics Clearance: **Indigenous stories of pregnant women in Botshabelo on ensuring positive pregnancy outcomes**
Principal Investigator: **Miss Ditsietsi Kortman**
Department: **School of Nursing (Bloemfontein Campus)**
APPLICATION APPROVED

Please ensure that you read the whole document

With reference to your application for ethical clearance with the Faculty of Health Sciences, I am pleased to inform you on behalf of the Health Sciences Research Ethics Committee that you have been granted ethical clearance for your project.

Your ethical clearance number, to be used in all correspondence is:**UFS-HSD2018/0615/2808**

The ethical clearance number is valid for research conducted for one year from issuance. Should you require more time to complete this research, please apply for an extension.

We request that any changes that may take place during the course of your research project be submitted to the HSREC for approval to ensure we are kept up to date with your progress and any ethical implications that may arise. This includes any serious adverse events and/or termination of the study.

A progress report should be submitted within one year of approval, and annually for long term studies. A final report should be submitted at the completion of the study.

The HSREC functions in compliance with, but not limited to, the following documents and guidelines: The SA National Health Act. No. 61 of 2003; Ethics in Health Research: Principles, Structures and Processes (2015); SA GCP(2006); Declaration of Helsinki; The Belmont Report; The US Office of Human Research Protections 45 CFR 461 (for non-exempt research with human participants conducted or supported by the US Department of Health and Human Services- (HHS), 21 CFR 50, 21 CFR 56, CIOMS, ICH-GCP-E6 Sections 1-4, The International Conference on Harmonization and Technical Requirements for Registration of Pharmaceuticals for Human Use (ICH Tripartite), Guidelines of the SA Medicines Control Council as well as Laws and Regulations with regard to the Control of Medicines, Constitution of the HSREC of the Faculty of Health Sciences.

For any questions or concerns, please feel free to contact HSREC Administration: 051-4017794/5 or email EthicsFHS@ufs.ac.za.

Thank you for submitting this proposal for ethical clearance and we wish you every success with your research.

Yours Sincerely

Dr. SM Le Grange
Chair : Health Sciences Research Ethics Committee

Health Sciences Research Ethics Committee
Office of the Dean: Health Sciences
T: +27 (0)51 401 7795/7794 | E: ethicsfhs@ufs.ac.za
IRB 00006240; REC 230408-011; IORG0005187; FWA00012704
Block D, Dean's Division, Room D104 | P.O. Box/Posbus 339 (Internal Post Box G40) | Bloemfontein 9300 | South Africa
www.ufs.ac.za

APPENDIX 2: REQUEST FOR PERMISSION TO CONDUCT THE STUDY

566 J Section
Botshabelo
9781
10. May 2018

The Director: Dr. P. Chikobvu
Health Information and Research
Free State Department of Health
Bloemfontein
9300
Dear Sir/Madam

PERMISSION TO CONDUCT RESEARCH: INDIGENOUS STORIES OF PREGNANT WOMEN IN BOTSHABELO ON ENSURING POSITIVE PREGNANCY OUTCOMES.

The researcher kindly requests permission to conduct a research study on pregnant woman in Botshabelo. The purpose is to explore and describe their indigenous stories on ensuring positive pregnancy outcomes.

In-depth individual interviews will be conducted for collection of data, either in the local antenatal clinics in Botshabelo, or in their homes depending on their preferences to ensure comfort. Consent forms will be signed by the participants prior to the commencement of interviews.

The researcher intends to commence with data collection from June 2018 to end of September 2018 provided that permission is granted. The results of the study will establish socio-cultural aspects that could hinder comprehension of clinical information communicated to pregnant women during antenatal care. Based on the results, relevant recommendations will be made to the FSDOH.

The researcher has submitted the proposal to the Faculty of Health Sciences Research Ethics Committee and awaits approval.

Thank you in advance for your assistance.

Regards,

D.P. Kortman

Palesa Kortman : 081 009 1592
: Kortmanpalesa@gmail.com
Mrs M Mpeli (Supervisor) : MpeliRM@ufs.ac.za
Mrs M Motlolometsi (Co-supervisor): MotlolometsiMWA@ufs.ac.za

APPENDIX 3: FREE STATE PROVINCIAL DEPARTMENT OF HEALTH APPROVAL

health
Department of Health
FREE STATE PROVINCE

26 July 2018

Miss. D Kortman
Dept. Of School of Nursing
UFS

Dear Miss D Kortman

Subject: Indigenous stories of pregnant women in Botshabelo on ensuring positive pregnancy outcomes.

- Please ensure that you read the whole document. Permission is hereby granted for the above – mentioned research on the following conditions:
- Participation in the study must be voluntary.
- A written consent by each participant must be obtained.
- Serious Adverse events to be reported to the Free State department of health and/ or termination of the study
- Ascertain that your data collection exercise neither interferes with the day to day running of the selected facilities nor the performance of duties by the respondents or health care workers.
- Confidentiality of information will be ensured and please do not obtain information regarding the identity of the participants.
- **Research results and a complete report should be made available to the Free State Department of Health on completion of the study (a hard copy plus a soft copy).**
- Progress report must be presented not later than one year after approval of the project to the Ethics Committee of the University of Free State and to Free State Department of Health.
- Any amendments, extension or other modifications to the protocol or investigators must be submitted to the Ethics Committee of the Free State and to Free State Department of Health.
- **Conditions stated in your Ethical Approval letter should be adhered to and a final copy of the Ethics Clearance Certificate should be submitted to** scholarly@fshealth.gov.za or lifelearn@fshealth.gov.za **before you commence with the study**
- No financial liability will be placed on the Free State Department of Health
- Please discuss your study with the institution manager/CEOs on commencement for logistical arrangements
- Department of Health to be fully indemnified from any harm that participants and staff experiences in the study
- Researchers will be required to enter in to a formal agreement with the Free State department of health regulating and formalizing the research relationship (document will follow)
- You are encouraged to present your study findings/results at the Free State Provincial health research day

Trust you find the above in order.
Kind Regards

Dr D Motaung
HEAD: HEALTH
Date: 27/07/18

Head: Health
PO Box 227, Bloemfontein, 9300
4th Floor, Executive Suite, Bophelo House, cnr Maitland and Harvey Road, Bloemfontein
Tel: (051) 408 1846 Fax: (051) 408 1556 e-mail:

www.fs.gov.za

APPENDIX 4: PARTICIPANT INFORMATION LEAFLET

Study title:
Indigenous stories of pregnant women in Botshabelo on ensuring positive pregnancy outcomes

Introduction:
My name is Palesa Kortman, a Master's Degree student in the School of Nursing at the University of the Free State. I am doing research on tradition-based practices of pregnant women in Botshabelo.

Invitation to participate:
I am kindly asking you to take part in my research. I want to hear your way of life during your pregnancy as a way to make sure you have a safe pregnancy and a healthy baby.

What is involved in the research?
I will do one on one interviews with you ensuring your privacy. The interviews will be done at the clinic or your home, depending on your preference.

Benefits:
The results of the research might help in reducing the number of negative pregnancy outcomes. Recommendations will be made to the Department of Health regarding the results.

Risks: There are no associated risks.

Confidentiality: Confidentiality will be highly maintained at all times.

Costs: Participation in this research is free from any cost.

Results: The results of this research may be published without making use of your real names.

Time: The interview will take approximately 45 minutes to 1 hour

Participation in the study:
Participation is voluntary. You have a right to refuse participation or withdraw at any stage of the study.

For clarity or any queries, please contact the researcher or the Health Sciences Research Ethics Committee on the following numbers:

Researcher's contact details**:** 081 009 1592

Health Sciences Research Ethics Committee: (051) 4017794/5

APPENDIX 4: PAMPIRI YA DINTLHA

Sehloho: Dipale tsa bo-setjhaba bokhachane ba basadi ba Botshabelo bakeng sa ho nefefatsa bokhachane bo bolokehileng.

Boitsebiso:
Lebitso la ka ke Palesa Kortman. Ke moithuti wa Masters sekolong sa booki Universiting ya Foreisitata. Ke etsa dipatlisiso ka ditlwaelo tsa bophelo tsa basadi ba bakhachane Botshabelo.

Kopo ya ho nka karolo:
Ke kopa ka boikokobetso o nke karolo dipatlisisong tsena. Ke kopa ho utlwa ditlwaelo tsa bo-setjhaba tsa hao bokhachaneng ba hao, e le ho netefatsa ditlamorao tse ntle tsa bokhachane.

Se amehang le patlisiso?
Re tla ba le puisano bonngweng ho netefatsa pato ya ditaba le botho ba hao. Re tla buisana bookelong kapa lapeng, ho ya ka moo o kgethang ka teng.

Melemo:
Diphetho tsa patlisiso ena di ka thusa ho fokotsa ditlamorao tse mpe tsa bokhachane. Di tshitshinyo ditla lebiswa ho lefapha la bophelo bo botle mabapi le diphetho.

Dikotsi: Ha hona dikotsi tse totobetseng tse lebelletsweng ho hlaha.

Ho se tsejwe: Lebitso la hao le ditaba di tla patwa ka hlompho le botho bo felletseng.

Ditjeo: Ho nka karolo ha hao ho mahala.

Diphetho: Diphetho tsa dipatlisiso di ka phatlalatswa dingolweng empa ho sa sebediswe mabitso a hao.

Nako: Puisano e ka nka metsotso e 45 ho isa horeng.

Karolo Patlisisong: Ho nka karolo ha hao ho tswa ho wena ka tokoloho. O na le tokelo ya ho hana kapa ho tswa mokgatheng ofe kapa ofe wa patlisiso.

Bakeng sa dintlha le ditlhakisetso, ke kopa o tshware moithuti kapa komiti ya tsa tokelo tsa botho ya lefatha la bophelo bo botle Universiting ya Foreisitata dinomorong tsena-

Moithuti: 081 009 1592

Health Science Resarch Ethics Committee: (051) 4017794/5

APPENDIX 5: CONSENT TO PARTICIPATE IN THIS STUDY

I, _____, confirm Ms P Kortman, Masters student in School of Nursing at the University of the Free State, asking my consent to take part in this research has told me about the nature, procedure, potential benefits and anticipated inconvenience of participation.

I have read, she explained and I understood the study as explained in the information sheet. I have had sufficient opportunity to ask questions and am prepared to participate in the study. I understand that my participation is voluntary and that I am free to withdraw at any time without penalty. I am aware that the findings of this study will be anonymously processed into a research report, journal publications or conference proceedings.
I have received a copy of the informed consent agreement.

I am also informed that for more information I may contact the researcher or ethics committee of the university on the numbers provided on the information leaflet.

Full Name of Participant:

_____

Signature of Participant: _____

Date: _____

Full Name(s) of Researcher:

_____

Signature of Researcher: _____

Date: _____

APPENDIX 5: TUMELLO YA HO NKA KAROLO PATLISISONG

Nna, _____, keya toboketsa hore Me P Kortman, moithuti wa Masters sekolong sa booki Universiting ya Foreisitata, ya kopang tumello ya ka ho nka karolo boithuting ba hae, o nhlaloseditse ka botlalo mokgwa, tsamaiso, melemo le ditshitiso tse ka qoswang ke karolo ya ka patlisisong ena.

Ke badile, a hlalosa mme ka utlwisisa patlisiso jwalo ka ha e hlalositswe pampiring ya dintlha. Ke bile le nako ho botsa dipotso, mme ke ikemiseditse ho nka karolo boithuting bona. Ke ya utlwisisa hore ho nka karolo ha ka ke qeto ya ka, mme ha hona kgatello ya letho, ebile nka tlohela ka nako efe kapa efe ha ke sa phutholoha, ntle le ditlamorao tsa letho. Ke ya utlwisisa hore di phumano tsa boithuti bona di ka sebediswa dingolweng le dibokeng ntle le ntsho ya mabitso.

Ke fumane pampiri ya tumello ya ka ya ho nka karolo.

Ke tsebisitswe hore bakeng sa dintlha tse ding, nka tshwara moithuti kapa komiti ya tokelo tsa botho universiting, dinomorong tseo ke di fumantshitsweng pampiring ya dintlha.

Mabitso ka botlalo a mme:

_____

Tekena: _____

Letsatsi: _____

Mabitso ka botlalo a moithuti

_____

Tekena: _____

Letsatsi: _____

APPENDIX 6: INTERVIEW SAMPLE

INTERVIEW 1

Researcher: Could you kindly tell me how your cultural practices ensure a positive pregnancy outcome?

Participant: Yes! If I miss my period for two months, when the third month also passes as well, I go to my traditional healer. I ask for a check-up to confirm if I am pregnant or not.

Researcher: mhmm…..

Participant: After confirmation and a checkup, the traditional healer will start making me "pitsa". Pitsa is a boiled ostrich egg shell mixed with LP Record. He gives me that in a 2L bottle. When the 2L finishes, I go back to him, then he gives me the powder and I eat it. At the end of the fifth month, the healer will make me another bottle of "pitsa". This bottle will now have boiled herbs, which I do not know what are they called, with the first one he explained that it is an ostrich egg shell and a LP Record, the one they used to play in the olden days, I don't know if you know it?.

Researcher: mhmm….

Participant: On the fifth month, it is then that he makes the herbs I do not know. I drink that bottle, he makes me a 5L one. I drink that 5L in the morning, during the day and at night. Sometimes I do not drink it like he said I should.

Researcher: mhmm…..

Participant: because I drink it once, sometimes two times a day, so it lasts me until 7 months. When I reach the 7th month, I no longer go to him, I go to church. When I arrive at church, the pastor starts praying for me Monday to Monday, trying to help me so that the witches will not tie my baby. We are bothered for our children.

Researcher: mhmm….

Participant: we are bothered! Sometimes you will find yourself going to the 10th month, sometimes the 11th month and even the 12th month. My next door neighbour even went to the 13th month of her pregnancy, and I don't want to see what she experienced happen to me. With my other two children that I gave birth to first, I have two children that I gave birth to first! I have always been using this man. He has been making these things for me, and I have never experienced problems giving birth. I give birth with ease.

Researcher: mhmm….

Participant: when my time to give birth arrives, I give birth immediately. With my other two children, when the time arrived, I gave birth immediately. So even with this one, I

have already started using my things. On the seventh month I go to the pastor, I am done with the healer.

Researcher: mhmm….

Participant: the pastor prays for me Monday to Monday, in other words I go to him every day, because the church is closer to home.

Researcher: mhmm….

Participant: I go to the pastor until nine months. On the 9th month, the is something that the pastor cooks for me.

Researcher: mhmm….

Participant: He says it is so that the child will not struggle being born, even the witches that are looking can see how far a person is.

Researcher: mhmm….

Participant: They can size our stomachs with their eyes, and tell how far along in the pregnancy are we. So he makes me that medicine on the 9th month, and then I rely on it until I have labour pains. When the pains start, he said I should not call the ambulance immediately when the pains start.

Researcher: mhmm….

Participant: Because when the pains are still weak, the witches will be watching when the ambulance stops at my house, then the will already start tying my baby, so that I should struggle giving birth. So I call the ambulance when the pains get stronger, when I arrive in the hospital, I am immediately going to give birth.

Researcher: mhmm….

Participant: Yes, that is my way of living.

Researcher: Can I please confirm if I heard correctly, that “pitsa” has stages? And do you know its importance according to their stages?

Participant: Yes, my traditional healer explained that on these three months!

Researcher: yes!

Participant: It just helps that my baby will be well formed. It forms the baby well in the three months.

Researcher: mhmm….

Participant: After these three months, he gives me the powder, that powder is the one that makes the baby grow. On the seventh month, I just drink it for protection against the witches.

Researcher: mhmm….

Participants: from the 7th month I am just protecting my baby against the witches.

Researcher: So they can't be used until 9 months? Why do they only end on the 7th month?

Participant: He said "dipitsa" that he has can be used for 7 months. His Job ends on the 7th month.

Researcher: mhmm…

Participant: He can't help a pregnant woman until the eighth and ninth month. He said when he has done seven months, he is finished with you. Everything is fine. So we are no longer trusting, that is why I decide to go to church.

Researcher: mhmm….

Participant: That is why I go to church because with him we stop the sessions after seven months.

Researcher: Okay.

Participant: Yes. He says his job ends there, so I don't trust! I don't trust! That's what I heard about my neighbour, so I go to church until my 9 months, and my baby is born.

Researcher: oh, between going to church and your cultural practices, when you do start going to the clinic?

Participant: You know I start the clinic on the 7th month, when the session with the traditional healer ends.

Researcher: mhmm….

Participant: I go to the clinic and the church. I start clinic on the 7th month because you will sit there the whole day at the clinic, so from the 3rd month that is not what I can do. I start on the 7th month, because you see on the 7th month?

Researcher: mhmm….

Participant: I start going to the clinic because I know I am only left with 2 months, then my baby is here.

Researcher: So who is teaching you the indigenous practices, and when?

Participant: I was taught this things by my mother. She used to tell us stories that while growing up, when she had us, how did she live.

Researcher: mhmm….

Participant: I was taught them by my mother. My mother says she struggled giving birth to me, she struggled until she was helped by some man who was a traditional healer. She was helped by him and she taught me that as soon as I am pregnant, I should go to the healer and look for help. So that I won't have the same problems she did.

Researcher: So according to you, what is your opinion of the concurrent use of your cultural practices and the clinical things?

Participant: Oh my cultural things?

Researcher: mhmm….

Participant: I would say they don't work together, that's why at the clinic they are always shouting at us.

Researcher: mhmm….

Participants: I hear that they don't go well together. That is why I end up not talking that I use my indigenous things, because they are things that help me. Even if they shout that we should not drink what and what, for me those things help me a lot, and I heard that they don't want them.

Researcher: So when you go to the clinic you don't tell that you use them?

Participant: Yes! Because they already shout when you tell them of "pitsa", so I don't tell them.

Researcher: mhmm…

Participant: I keep quiet, and not tell them. I only tell them that I don't drink anything, I just drink the pills that they are giving me at the clinic. I tell them I only use them, while on the side I have my things that I am drinking. I will never stop drinking them until I give birth.

Researcher: You use them both? The clinic ones and the cultural ones?

Participant: Yes! Even the ones from the clinic, I use them, but I don't like them at all. You see this ones I get from my healer, they help me a lot. The ones from the clinic I just use them because they tell us to attend the clinic, I just go so that they see that I am attending but I don't like them.

Researcher: You don't drink them accordingly?

Participant: I don't drink them accordingly, I use these ones a lot.

Researcher: So what are your views regarding your indigenous practices? Do you believe that they work or not?

Participant: They work a lot, that's why I say do you see this other two children of mine?

Researcher: mhmm….

Participant: I did not struggle compared to the stories of that lady who gave birth after thirteen months.

Researcher: Thank you so much for your time.

Participant: Thank you.