INDIGENOUS PRACTICES OF WOMEN DURING PREGNANCY, LABOUR, AND PUERPERIUM AMONGST CULTURAL GROUPINGS AT SELECTED HOSPITALS IN LIMPOPO PROVINCE, SOUTH AFRICA

By

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DISSERTATION

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DECLARATION

I declare that the dissertation hereby submitted to the University of Limpopo, for the degree of Master of Nursing (MNurs) has not previously been submitted by me for a degree at this or any other university; that it is my work in design and in execution, and that all material contained herein has been duly acknowledged.

Seopa A,M (Mrs)   19 April 2021

Surname ,Initials (title)   Date

DEDICATION

This dissertation is dedicated to my family for their support during this academic study. My husband, Mr. P.S Mabusela for his continuous support and assistance during the collection of data. My children, Thabo, Natasha, Boitumelo, and Tumisho for their understanding during study commitments.

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- The participants for their commitment and patience during interview sessions that I conducted and completing the questionnaires.

ABSTRACT

Indigenous practices are performances that occur naturally in a region or a growing living environment. Most women believe in indigenous practices because of their cultures and social structure. In South Africa regardless of the availability and accessibility of maternal and child health services, 50% of women were found that they still consult traditional birth attendants as their first choice during pregnancy, labour, delivery, and postnatal care. The purpose of the study was to determine the indigenous practices of women during pregnancy, labour and puerperium amongst cultural groupings at selected hospitals in Limpopo Province, South Africa.

A Convergent parallel mixed method design was used in the study to collect both qualitative and quantitative data at the same time. Non-probability purposive sampling was used to select 15 participants and Probability simple random sampling was used to select 125 women who were pregnant, in labour and puerperium using slovin's formula. Data were collected through a semi-structured interview with a guide for qualitative strand and a self-administered structured questionnaire for quantitative srtand. Data were analysed qualitatively using tech's open coding method and quantitatively using Statistical Package for the Social Sciences (SPSS) Version 25 with the assistance of the University of Limpopo's Bio-statistician.

The results of the study showed that most women use indigeneous practices for protection against witchcraft, fear of giving birth in caesarian section and many other reasons.THPs and church leaders are regarded as the most principled people in their community. Indigenous women are aware of the sign and symptoms during pregnancy, labour, and puerperium which may determine consultation to healthcare practitioners, but they choose THPs and church leaders. Most women still rely on their religious beliefs to assist during their labour. Pregnant women, those in labour and puerperium should be supported to practice their religious beliefs and practices. THPs and church leaders are obliged to teach their clients and ensure that they know the names and components of the traditional medicines and church rituals they use.The nursing education should include indigenous practices in the curriculum so, that healthcare practitioners know about the indigenous practices and can serve as assistance in the training and

development of health practitioners who continuously care for women during pregnancy, labour, and puerperium and as a result, may reduce maternal and child morbidity and mortality in Limpopo Province, South Africa.

DEFINITION OF CONCEPTS

i. Indigenous practice

Indigenous practices are performances that occur naturally in a region or a growing living environment (Harber, Katherine-Payton & Geoffrey, 2001). In this study, indigenous practices shall mean practices comprised by women during pregnancy, labour, and puerperium period among cultural groupings at selected hospitals in the Limpopo Province.

ii. Pregnancy

Pregnancy is defined as the process when the egg is fertilised by the sperm and then implanted in the lining of the uterus until it later develops into a foetus. The gestation period is divided into three trimesters first, second and third trimesters (Littleton & Engebretson, 2008). In this study, pregnancy is described as an embryo that is developing in the uterus of a woman, who engages in indigenous practices among cultural grouping at selected hospitals in the Limpopo Province.

iii. Pregnant woman

A pregnant woman is defined as a woman containing a developing embryo, foetus, or unborn offspring within the body (Medical Dictionary, 2012). In this study, a pregnant woman means, a pregnant female who engages in indigenous practices at selected hospitals in the Limpopo Province.

iv. Labour

Labour is defined as the physiologic process by which the foetus, placenta, and the membranes are expelled from the uterus (Littleton & Engebretson, 2008). In this study, labour refers to the process of delivering the baby and the placenta from the uterus to the vagina, to the outside world at selected hospitals in the Limpopo Province.

v. Puerperium

Puerperium is defined as the period lasting from delivery of the placenta to approximately six weeks after delivery, it is also known as the fourth trimester (Littleton & Engebretson,

2008). In this study, puerperium signifies the period that starts from the delivery of the baby to six weeks after the delivery.

vi. Healthcare Professionals

Healthcare professional is defined as an individuals who provide preventive, curative, promotional, or rehabilitative healthcare services in a systemic way to people, families, or communities (Medical Dictionary, 2012). In this study, healthcare professionals insinuate midwives that provide preventive, curative, promotional, or rehabilitative care to women during pregnancy, labour, and puerperium period.

vii. Cultural Groupings

Cultural groupings are defined as a group of people with shared norms, beliefs, attitudes, knowledge, practices, and behaviours (Medical Dictionary, 2012). In this study, cultural groupings imply to pregnant women who use indigenous practices.

viii. Traditional Health practitioner

Traditional healthcare practitioner is defined a person who is recognised by the community where he or she lives as someone competent to provide health care by using plant, animal, and mineral substances and other methods based on social, cultural, and religious practices (Medical Dictionary, 2012). In this study, traditional health practitioner applies to a qualified person who provides health care by using plant, animal, and mineral substances and other methods based on social and cultural practices.

LIST OF ABBREVIATIONS

ANC:	Antenatal Care
CLR:	Comprehensive Literature Review
DoH:	Department of Health
IP:	Indigenous Practices
MMR:	Mixed Methods Research
MODES:	Media, Observations, Documents, Experts and Secondary data
SA:	South Africa
TBAs:	Traditional Birth Attendants
THPs:	Traditional Health Practitioners
TREC:	Turfloop Research Ethics Committees
WHO:	World Health Organisation

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CHAPTER 1

OVERVIEW OF THE STUDY

1.1 INTRODUCTION AND BACKGROUND

Women in South Africa and across the world follow different traditional practices and beliefs in different rites, which depend on their culture and social structures (Okka, Durduran & Kodaz, 2016). Although some health systems currently provide expectant mothers with modern healthcare services before, during and after birth, traditional midwives (both internationally and domestically) are often involved both during and after birth due to habit or regional customs and various traditional practices to facilitate safer birth practices (Okka *et al*., 2016).

In India, practices relating to pregnancy, childbirth, and child development have been entrenched in cultural beliefs and traditions that are based on the knowledge contained in ancient Indian texts. In ancient Indian literature, Ayurvedic texts show evidence about rituals and behaviours aimed at promoting maternal health and ensuring healthy infant development. Many of these practices continue to be conserved and observed by Indians even those who are not staying in India (Cousik & Hickey, 2016).

In Southeast Asia, culture and traditions are observed during pregnancy and the postpartum period. The use of Medicinal plant is common among Southeast Asians such as Brou, Saek, and Kry to facilitate childbirth, mitigate postpartum hemorrhage, and use in infant care (De Boer & Lamxay, 2009).

Pregnancy is seen as a hot state in Southeast Asia, whereby it is understood that partition heat is lost and the woman comes into a state of excess cold, during the postpartum period. Therefore, care should be given to restore the mother to equilibrium. Quarantine as a treatment involves staying inside and near heat, washing only with hot water, drinking hot water and eating hot food, steam bath and mother roasting, dietary prescriptions, and consumption of medicinal plant decoctions. Mother roasting is believed to dry out and to stop the lochia, restore the uterus to pre-pregnancy condition and to ease postpartum abdominal pain (De Boer & Lamxay, 2009).

In Nigeria, nurses and midwives should be culturally competent to help the delivery of good quality in healthcare settings with various cultural health values and practices. These cultural differences also are thought to influence birth practices (Esienumoh, Akpabio & Etowa, 2016). It is important to understand traditional practices to prevent possible errors and to recover the level of modern health care. The most critical periods in the health of women are pregnancy, birth, and the postnatal period. These periods greatly mark the babies' health according to these cultural beliefs and customs (Okka *et al*., 2016).

In South Africa regardless of the availability and accessibility of maternal and child health services, 50% of women were found that they still consult traditional birth attendants as their first choice during pregnancy, labour, delivery, and postnatal care. Indigenous practices and beliefs influence and support the behaviour of women during pregnancy and childbirth. Religion also has an impact on childbirth, thus leading women to believe that they have to follow and practice their religious rituals to preserve their pregnant state and give birth to healthy infants (Ngomane & Mulaudzi, 2010).

In the Eastern Cape Province, South Africa, the majority of Xhosa speaking women follow indigenous health practices for both themselves and their babies because of the need to "strengthen" pregnancy against witchcraft and to prevent childhood illnesses. Herbs and Dutch remedies are common among Afrikaans speaking women and are used to treat indigenous illness. In pregnancy, herbs or minerals are often used as a tonic to clean the womb, to make the delivery process simple, to induce labour, and to protect the child from evil and have a healthy child (Peltzer, Phaswana-Mafuya & Treger, 2009).

The World Health Organisation (WHO, 2008) estimates that up to 80% of people in Africa make use of traditional medicine. This means that there are 80 times more traditional health practitioners than biomedical doctors. However, South Africa's Department of Health (DoH) estimates that there are 200 000 traditional healthcare practitioners in the country, which simply put, millions of people in South Africa and across the continent to make use of traditional forms of health care instead of biomedicine (Traditional Health Practitioners Act no 22, 2007). Therefore, there is a need for the health system to acquire more about the indigenous treatment modalities of indigenous communities, so that the system can create a stand for the integration

of services between Western and indigenous health interventions. It was indicated that such a move will facilitate collaboration between the health sector and traditional healers, particularly as traditional health practices have been legalised in South Africa.

In Limpopo Province, the findings of the study conducted by Mogawane, Mothiba, and Malema (2015) indicated that indigenous practices were looked upon as an honourable health intervention by Traditional Health Practitioners, families, and pregnant women. Most communities in Limpopo have trust in the indigenous practices therefore, there is a need for the healthcare professionals to accept these practices to advance improvement in the prevention of complications from pregnancy to puerperium (Mogawane, Mothiba & Malema, 2015).

It was against this background that the study aimed to determine the indigenous practices of women during pregnancy, labour, and puerperium amongst cultural groupings at selected hospitals in the Limpopo Province, South Africa.

1.2 PROBLEM STATEMENT

The healthcare professionals in Limpopo Province's health facilities seem to have lack of knowledge concerning cultural beliefs and practices which are used during pregnancy, labour and the postpartum period that is likely to influence the maternal mortality rate in South Africa. Ngunyulu, Mulaudzi, and Peu (2015) indicate that the necessity of training traditional birth attendants and traditional healers or assimilating them into the health system has been recommended in South Africa, but to date, no programmes have been put in place to integrate these two systems. The integration has on no account occurred and problems related to pregnancy, labour, delivery, and complications during the puerperium period still exist following indigenous practices.

The researcher has observed that most pregnant women who visited the Mankweng and Pietersburg Hospital to give birth were carrying Traditional medicines in bottles and some were having church tea and vaselline to apply on their body with the knowledge that they will induce and speed up labour, however there were complications that were observed during labour and this motivated the researcher to explore indigenous practices of women during pregnancy, labour and puerperium.

The study conducted by Maputle, Mothiba, and Maliwichi (2015) in the Capricorn District of Limpopo Province reported that pregnant women who used traditional

medicines experienced complications such as precipitated labour and fetal distress. Therefore, the research sought to establish the indigenous practices which are likely to be a threat to the health of women during pregnancy, labour, and puerperium amongst cultural groupings at selected hospitals in Limpopo Province, South Africa.

1.3 AIM OF THE STUDY

The aim of the study is:

- To determine the indigenous practices of women during pregnancy, labour and puerperium amongst cultural groupings at selected hospitals in Limpopo Province, South Africa.

1.4 RESEARCH QUESTIONS

The following research question served as a guide for the researcher when conducting the study:

- What are the indigenous practices of women during pregnancy, labour, and puerperium amongst cultural groupings at selected hospitals in Limpopo Province, South Africa?

1.5 OBJECTIVES OF THE STUDY

The objectives of the study are to:

- Explore the indigenous practices of women during pregnancy, labour, and puerperium amongst cultural groupings at selected hospitals in Limpopo Province, South Africa.
- Describe indigenous practices of women during pregnancy, labour and puerperium amongst cultural groupings at selected hospitals in Limpopo Province, South Africa.
- Identify indigenous practices of women during pregnancy, labour and puerperium amongst cultural groupings at selected hospitals in Limpopo Province, South Africa.

1.6 RESEARCH METHODS AND DESIGN

Mixed Methods Research (MMR) was used to gather more information and have a better understanding of indigenous practices of women during pregnancy, labour, and

puerperium amongst cultural groupings at selected hospitals in Limpopo Province, South Africa. A mixed methods research is defined as an approach to an inquiry which involve collecting both quantitative and qualitative data, mixing the two forms of data, and using distinct designs that involves philosophical assumptions and theoretical frameworks (Creswell & Clark, 2011). MMR was used by combining two sets of data which are qualitative and quantitative data simultaneously to yield strong results (Creswell & Clark, 2011). Convergent parallel mixed method design was used in the study to collect both qualitative and quantitative data at the same time.

1.7 QUALITATIVE STRAND

In the qualitative strand, the researcher sought to realize, from within, the individual reality of the study participants (Elmusharaf, 2012). Creswell (2013) defines qualitative research as an inductive method of exploring the experiences of human beings towards social phenomena to determine the core of such existences. The researcher in this strand collected subjective data through exploring the experiences of the participants of the study to understand the phenomenon under study.

1.7.1 Study Site

The study was conducted in government hospitals of the four districts of Limpopo Province namely Waterberg, Sekhukhune, Vhembe, and Mopani. The regional hospitals in these districts cater to patients referred from district hospitals. Most of the patients in regional hospitals are based in rural areas. The four regional hospitals are namely Mokopane, St Ritas, Tshilidzini, and Letaba.

1.7.2 Population

The population in this study comprised of all 187 women in pregnancy, labour, and puerperium period who were admitted at selected hospitals in the four districts of Limpopo Province, South Africa. Burns and Grove (2009) define the population as “the particular type of individual or element”. The target population was 50 participants in each regional hospital and continued until data saturation was reached when collecting qualitative data.

1.7.3 Sampling

Non-probability purposive sampling was used in the study to select participants who utilise indigenous practices during pregnancy, labour, and puerperium. The researcher selected participants that had the characteristics that fulfilled the inclusion criteria to

participate in the study. Non-probability purposive sampling is a sampling technique that is based on the judgement of the researcher regarding participants that are representative of the study phenomenon. The researcher selects the sample based on the knowledge of the phenomenon being studied (Brink, Christa Van Der Walt & Gisela Van Rensburg, 2017).

1.7.4 Data collection

The data were collected using a semi-structured interview with a guide. The researcher requested permission from the participants to collect data and provided them with a consent form to sign if they agree to be interviewed. All interview sessions that were conducted, were recorded using a voice record and field notes were also taken by the researcher during the interview for record-keeping. The session took approximately 20 minutes or less with each participant.The researcher then transcribed and analysed the recorded interviews.

1.7.5 Data analysis

Data were analysed using tech's open coding method whereby the researcher started by transcribing the collected data and in the final stage of analysis, themes, and sub-themes emerged.

1.8 QUANTITATIVE STRAND

Quantitative research is defined as a method of research that involves numbers and quantification in collecting and analysing data (Bryman,2012). The researcher selected participants to respond to a questionnaire under this strand and finally analysed the data used as statistics

1.8.1 Population

The population in this study comprised of all 187 women in pregnancy, labour, and puerperium period who were admitted at selected hospitals in the four districts of Limpopo Province, South Africa. Burns and Grove (2009) define the population as "the particular type of individual or element.The target population was the women who were admitted in the Maternity ward at the time of data collection who were either pregnant, in labour or pueroerium.

1.8.2 Sampling

The probability of simple random sampling was used in the study to select women who part take in the consumption of indigenous practices during pregnancy, labour, and puerperium. It involves the identification and selection of women during pregnancy and those in the puerperium period that utilise the indigenous practices. The researcher exercised Slovin's formula to calculate the sample size. It is computed as:

n = N / (1+Ne2), n =187/ (1+187x 0.05^2), n =188/ 1.5 = 125 samplings. n = no. of samples, N = total population and e = error margin / margin of error. The 187 is the number of populations for indigenous women. All pregnant women, those in labour and puerperium were listed in a master list and then selected randomly from this master list. Probability simple random sampling is a method of sampling where every member of the population has a known (non-zero) probability of being included in the sample (Alvi, 2016).

1.8.3 Data collection

The data collection is defined as the gathering of information to address a research problem (Polit & Beck, 2012). A self-administered structured questionnaire was used to collect data from pregnant women, those in labour and puerperium. The questionnaire comprised of four sections. Section A included Demographic Data. Section B was statements directed to women during pregnancy. Section C was statements directed to women during labour and Section D was statements directed to women during puerperium. All sections used a Likert-type scale to gather data. Questionnaires were written in English and translated to Sepedi, Tsonga and Venda languages. The researcher had a research assistant who was distributing the questionnaires and consent forms. among the respondents in the Martenity ward.The completion of questionnaire was 30 to 40 minutes per respondent.

1.8.4 Data analysis

Data analysis involved inferential statistics which allowed the researcher to conclude whether the relationship noted in a sample can occur in a larger population (Brink *et al.*, 2017). Data were analysed using Statistical Package for the Social Sciences (SPSS) Version 25 with the assistance of the University of Limpopo's Bio-statistician. The researcher used descriptive statistics,frequencies and percentages to assist in making sense of large volume of data.

1.8.5 Validity and Reliability

Polit and Beck (2012) define the validity of a questionnaire as the degree to which the instrument measures what it is intended to measure. Validity will be ensured by pre-testing the instrument to check if the questions asked are relevant to the study. Reliability relates to the consistency of a measure (Heale & Twycross, 2018). The stability of a questionnaire is the degree to which it produces similar results when administered twice. The researcher will use the test-retest method on a small population before the actual study (Polit & Beck, 2012).

1.9 SUMMARY OF CONVERGENCE OF THE RESULTS

The results of both qualitative and quantitative data collected revealed the following:

1.9.1 Diverging results on the utilisation of traditional medicines on an infant at puerperium period

The study revealed diverging results, the statement on whether the women have used traditional medicines on their child before in quantitative site, most of the participants are no longer using herbs on their children whereas in the qualitative site some participant reported that they will treat their baby for illness such as "Makgoma".

1.9.2 Converging results on food taken during pregnancy and puerperium period

Most of the indigenous women have restrictions on food. It was noted on both qualitative and quantitative results.

1.9.3 Diverging results in the use of indigenous practise to assist in labour

The results of the study indicate that most women in quantitative site did not use indigenous practises to assist in labour whereas in the qualitative site only one woman mentioned the use of traditional medicine to assist during labour.

1.9.4 Converging results on other traditional practices during pregnancy and puerperium period including care of the infant

It was observed that few participants have razor cut marks on their abdomen in quantitative results whereas participants in qualitative results reported that they will use razor cut marks on their neonate to treat some illness.

1.10 SIGNIFICANCE OF THE STUDY

The findings of this study are highly likely to be of beneficial to the following:

1.10.1 Nursing Care and Pregnant women

This study will assist pregnant women to be aware of the harmful indigenous practices that can affect their health and that of their child. It will also aid the nurses to be able to provide holistic nursing care, taking into consideration the cultures and believes of pregnant women.

1.10.2 Nursing Education

The results of the study are determined to add to the contribution of the nursing education to include indigenous practices in the curriculum so that healthcare practitioners know about the indigenous practices.

1.10.3 Nursing Administration

This study can serve as assistance in the training and development of health practitioners who continuously care for women during pregnancy, labour, and puerperium and as a result, to reduce maternal and child morbidity and mortality in Limpopo Province, South Africa.

1.11 BIAS

The researcher expended probability simple random sampling to ensure that participants have an equal chance of being included in the study during sampling under the quantitative strand (Polit & Hungler, 2013). Bias was avoided by bracketing out the researchers' ideas which can influence the study during interviews. This was achieved by respecting the dignity of the research participants, observing and following the fundamental principles of ethics. The researcher used non-probability purposive sampling to select participants under the qualitative strand and it reduced bias because the sample was constantly refined to meet the study aims. Bias is defined as any tendency which prevents unprejudiced consideration of a question (Pannucci & Wilkins, 2010).

1.12 CONCLUSION

In this chapter, the overview of the study was presented. The aim, objectives, and research questions, of the study, were outlined. The research methodology with the

research design, population, sampling, data collection, and analysis and convergence of the study results were described.

1.13 ARRANGEMENT OF CHAPTERS

Chapter 1: Overview of the study

Chapter one presents an overview of the study. The researcher introduced the study under the introduction and background.

Chapter 2: Literature review and theoretical framework

Chapter two presents literature review around the indigenous practices of women during pregnancy, labour and puerperium, and the theoretical framework on which the study is based. Several data sources were used to review literature related to the problem studied.

Chapter 3: Research methods and design

This chapter discusses the details of the methodology used in collecting data for the study. It also discusses research design, sampling, and data collection techniques and methods of analysing data used. This included both qualitative and quantitative strands.

Chapter 4: Presentation of research findings

Chapter four presents research findings and discussion of the findings and were supported by the literature and theoretical framework.

Chapter 5: Discussion of the research findings

Chapter five presents a summary of research findings followed by a discussion of the findings.

Chapter 6: Summary, limitations, recommendations, and conclusion

Chapter six covers the summary, limitations, recommendations, and conclusion of the study about indigenous practices of women during pregnancy, labour, and puerperium at selected hospitals in Limpopo Province, South Africa.

CHAPTER 2

LITERATURE REVIEW AND THEORETICAL FRAMEWORK

2.1 INTRODUCTION

The following data sources were used to review literature related to the problem studied that is: Google Scholar article, PubMed Central articles, Books, and Journals. Seven steps model for a Comprehensive Literature Review (CLR) as outlined by Onwuegbuzie and Frels (2016) which was used as a methodology for the literature review was followed in this study. The methodology for the literature review included the seven steps model for a Comprehensive Literature Review (CLR) as outlined by Onwuegbuzie and Frels (2016). They are as follows Step 1-Exploring Beliefs and Topics, Step 2- Initiating the Search, Step 3- Storing and Organising Information, Step 4- Selecting/Deselecting Information, Step 5- Expanding the Search (MODES), Step 6- Analysing/Synthesising Information and Step 7- Presenting the literature.

2.1.1 Indigenous practices of women worldwide

Many women in Konya, Turkey, and all around the world follow traditional practices and rituals during pregnancy, labour, and puerperium. Indigenous women believe in various traditional folk medicine practices that are still used in different regions of Turkey, which may have positive or harmful health effects, such as delayed diagnosis and treatment (Okka *et al*., 2016).

2.1.2 Indigenous practices of women in Canada

In Canada, indigenous women experience higher rates of hostile outcomes including stillbirth and perinatal death, and in some cases, low-birth-weight infants, prematurity, and infant death. Previous studies have identified factors that may potentially aggravate adverse maternal and infant health outcomes among Canadian indigenous populations. These factors comprise socio-cultural and socio-economic status, which may affect diet and lifestyle as well as the presence of hazardous environmental contaminants which all, directly and indirectly, impact the health and wellness of indigenous Canadian women (Kolahdooz, Launier, Nader, June, Baker & McHugh, 2016).

There is a lack of knowledge that precludes a comprehensive understanding of maternal health among indigenous women in Canada. However, prior to the development and implementation of health promotion policies and actions that address maternal health disparities, an in-depth understanding of the perspectives of Indigenous Canadian women regarding maternal health is essential (Kolahdooz *et al.*, 2016).

2.1.3 Indigenous practices of women in Asia

The greatest challenge for Western healthcare professionals is that once they have grasped the basics of different cultural remedies and treatments, they need to understand the beliefs and attitudes about the sickness that drives these ancient practices. Health beliefs can have a profound impact on the clinical care of Asian patients in the United States, affecting the accuracy of health histories and compliance with treatment recommendations from Western providers (Carteret, 2011). Thus, cross-cultural mindset requires understanding one's own health beliefs and behaviours first and then applying that baseline of understanding as a means of making effective comparisons across cultures. Clinicians should keep in mind that individuals subscribe to group norms to varying degrees (Carteret, 2011).

2.1.4 Indigenous practices of women in Thailand

Traditional Thai medicine is based on the mixed indigenous traditions of Indian, Chinese, and Khmer influences. Historically, Jivaka Kumar Bhaccha is considered the "Father Doctor" of Thai medicine. Thai traditional medicine has three branches that correspond to the three essences: Thai massage, herbalism (including dietary regimen), and spiritual or religious healing. The three branches are used to balance each of the essences. For example, there are ten tastes of foods and herbs that are recognised by Thai medicine and tastes opposite of the disease process would be used to treat it (Angloinfo, 2016).

In Thailand, once a woman finds out she is pregnant, she tells her partner first, followed by her mother and her mother-in-law. Pregnancy is considered to be a "hot" condition in Thai medicine and there are foods to maintain warmth which are preferred, such as ginger tea, coconut milk, young coconut meat, salty foods, tamarind, fish, garlic, onion, and warm liquids. Those who consume pak plang, a slippery vine-like green vegetable, will have an easy birth since it will make the baby's body slippery.

Ya- tom herbal medicine could be prepared as a tea and would make the baby strong and easy to deliver if the pregnant woman drinks the tea three times a day for three consecutive days (Angloinfo, 2016).

2.1.5 Indigenous practices of women in African perspectives

Munyaradzi, Marvellous, Stanzia, and Memory (2016) indicate that some traditional practices are associated with maternal risk. Both religion and culture affect the utilisation of maternal and new-born health services from a motivational and supply perspective. In Zimbabwe, health, disease, and sickness all have spiritual foundations. The Apostolic church members display maternal practices that are significantly different from most other religious groupings. For example, their pregnant women display a higher propensity to deliver outside the formal health system, without skilled attendance. This increases the risk of maternal and neonatal mortality.

2.1.6 Indigenous practices of women in South African perspectives

According to a study conducted by Ngomane and Mulaudzi (2010), in ancient times, indigenous practices constituted the major source of survival in Africa, America, Asia, and Australia. Together with many other traditional health practices, the care of pregnant women formed part of the center of these practices. This, however, was affected by exploration and the invasion of traditional practices by modern civilisation. The impact of this colonisation was major and resulted in indigenous communities feeling condemned if they continued with their indigenous practices in public because they were regarded as sinning.

Ngomane and Mulaudzi (2010) indicate that indigenous women found in Limpopo, Bohlabelo use herbs to preserve and protect the infant from harm. The unborn infants are protected by restricting the mother's intake of other foods. For example, pregnant women are not allowed to eat eggs, to prevent complications during pregnancy (Ngomane & Mulaudzi, 2010).

Postpartum practices which include placental rituals and other birth-by rituals are common in various societies. These rituals often include culturally determined behavioural sequences that operate as anxiety-releasing mechanisms and they serve to offer a spiritual means of 'control' over the future health and welfare of the mother, child, and even the community (Hussain, Ahmed & Bano, 2015).

The Department of Health (2008) states that traditional health practitioners are providing health care services in South Africa but their competencies are not recognised. Therefore, there is a need for the health care system to learn more about Indigenous Practices to create a platform for the integration of services between Western medicine and Indigenous Practices. In South Africa, the Traditional Health Practices and indigenous birth attendance have been legalised under the Traditional Health Practitioners Act, Act 22 of 2007. It is, therefore, authoritative for midwives to understand the Indigenous Practices of pregnant women (Mogawane, Mothiba & Malema, 2015).

The study conducted by Peltzer, Phaswana-Mafuya, and Treger (2009) indicate that Traditional Birth Attendants cannot be expected to carry out HIV/AIDS prevention and treatment activities such as administering HIV tests or delivering antiretroviral drugs to women giving birth at home because of their lack of resources and skills. Traditional Birth Attendants have the potential for improving maternal and newborn health at the community level but generally, they are not trained to deal with complications.

2.2 THEORETICAL FRAMEWORK

Absolon's Indigenous wholistic theory was used in this study as a conceptual framework because it focuses on indigenous practices of women during pregnancy, labour, and puerperium. The indigenous wholistic theory is wholistic and multi-layereded, which encompasses the emotional, mental, and physical elements of being (Absolon, 2010). In the study, the theory assisted the participants to relearn, pick up, and own the teachings and practices that originated from wholistic theory to have a good life and healthy pregnancies. If indigenous worldviews, traditions, values, and beliefs are foundational to living a good life, then the absence or attack of indigenous worldviews, traditions, and identity may create imbalance and disease.

The below diagram is a specific representation illustrating theoretical underpinnings using the four directions as spiritual, emotional, mental, and physical elements. Within each element are some specific theoretical factors that warrant consideration in indigenous based practice. The arrows in the diagram illustrate the interrelationships and interdependence between all the components (Absolon, 2010).

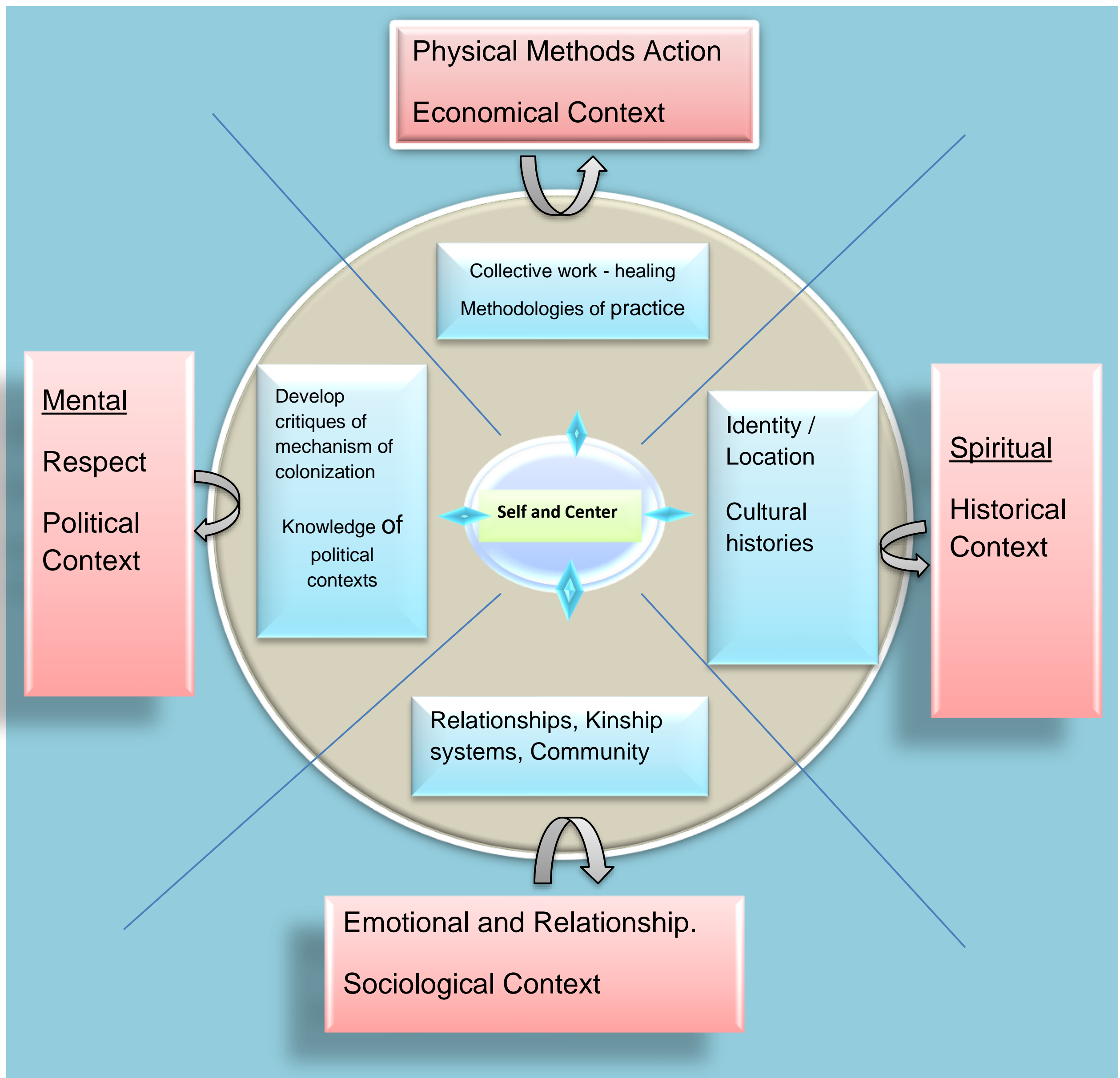

Figure 1.1. Absolon's indigenous wholistic theory

2.2.1 Spiritual Context

Absolon (2010) states that every being is a spirit being and acknowledging one's spirit begins with acknowledging oneself. Spiritual knowledge entails awareness, understanding, and a respectful consciousness of the sacred world to indigenous people which interconnect within the historical context. In this study, the findings of the research indicated that most participants follow and adhere to spiritual beliefs to protect their pregnancy. Indigenous wholism suggests a balance within all aspects and elements of the whole, which is achieved through interconnections, interdependence, and interrelationships. It is ought to be noted that most participants in this study refer

to spirituality and spiritual healing as distinguished from religion and religious healing, for example, some participants were following instructions from ZCC, Apostolic, and St Angenas.

Birch, Ruttan, Muth, and Baydala (2009) outline seven dimensions that are beneficial in the development of nursing practices with Aboriginal people including spirituality, respect, trust, caring, traditions, connection, and holism. Spirituality, in the Aboriginal context, is the most important of the dimensions discussed, and yet is probably the least understood by health care providers. During interviews, some participants reported that healthcare practitioners do not have knowledge on indigenous practices and that they observed it when they look surprised to see them wearing the string around their waist.

Traditionally, the relationship with the child is understood to begin before birth. Preparations for good birth and a healthy baby include avoiding stress, listening to teachings of older women, remaining physically active, connecting with the child, and caring for oneself in a spiritually healthy way.

In this study, the spiritual context seeks to maintain the balance and a sense of peace and assist the participants to be able to identify themselves. The healthcare providers need to understand and acknowledge the culture and spirit of the indigenous women during pregnancy, labour, and puerperium to maintain a good relationship.

2.2.2 Sociological Context

Kinship systems and their relationship connections are recognised in the sociological context. Kinship systems serve to connect threads between individuals; families; communities and extend beyond biology. For example, kinship systems can be based on the clan system where relationships and roles are determined by clan identity and function. The theory ensures that participants build and nurture quality relations to live in a good way.

According to Absolon's theory, it is important to identify community strengths in all areas of prevention, intervention, rehabilitation, support, and postvention approaches. Thus, to contribute to the development of grassroots, community strengths approach. Principles of partnership and empowerment should guide relationships with

community members such as engaging with local community members in the planning and delivery of service.

Indigenous communities have immense strength and resources from which kinship ties, healing, recovery, wellness, survival, and collectively exist. From an indigenous perspective, the culture of a community is where the heartbeat of that nation resides (Absolon, 2010).

Community interests ought to be considered essential elements of practice and community involvement fostered at all levels of service delivery, such as planning, visioning, brainstorming, designing, creating, evaluating, assessing, intervening, and treating.

Absolon (2019) describes the elders as another cornerstone of indigenous knowledge, culture, and heritage. Oral traditions, languages, and historical accounts would be lost without the wisdom, knowledge, and experience of the elders. The elder's protocols vary depending on the nation, territory. Thus, identifying reliable elders will occur in consultation and communication with community resource people.

Nevertheless, indigenous women consult with the elders to get advice on how to protect their pregnancy and get instructions from them. However, the elders are essential to learning and teaching through mechanisms such as storytelling, ceremony, songs, dances, and passing on teachings. In this study, one of the participants reported that her mother instructed her to use indigenous practices to protect her pregnancy. Healing and wellness programmes often employ elders to work with children, youth, and families. In Anishinaabe Health in Toronto, the elders work with children, youth, and families in the delivery of healing and wellness programmes and services (Solomon & Wane, 2005). The researcher has noted that most of the participants visited the Traditional Health Practitioners because the elders in their family advised them to do so. Existing African knowledge of family members towards practices of THPs and church leaders are imposed on women during pregnancy, labour, and the puerperium.

Birch *et al.*, (2009) recommend the importance of partnering with Aboriginal physicians, nurses, midwives, and their representative organisations; conducting community-based research to determine labour and delivery needs; identifying,

describing Aboriginal values, and beliefs related to childbirth, its place in the family and community. Following Aboriginal women's birth experiences in hospital settings with the overarching goal of informing institutional practices. These models have in common a focus on healthcare delivery in which the provision of care shows awareness of both the client's cultural background, one's own personal and professional culture

2.2.3 Mental Context

The political context acknowledges the mental aspects and power of knowledge. Respect is a core principle from which indigenous methodologies ought to emerge and it calls upon us to look again, speculate, consider and operationalise indigenous knowledge as a source of healing and recovery (Absolon, 2010). Honesty is an important indigenous ethic and when endorsed brings strength to sharing ideas, experiences, and knowledge. During interviews, most of the participants were honest about using the indigenous practices.

Truth and honesty need humbleness, love, and all these values will teach the indigenous women how to be real in healing also restoring wounded relationships within self and others (Absolon, 2016). During the study, some pregnant women as well as those in puerperium reported how honest they are with their indigenous practices and also how accountable they are to follow their principles and values set for them.

When considering the mental or knowledge portal of a holistic and ethical action toward social inclusion and indigenous people, as it is stated earlier, the importance of understanding who Indigenous peoples are in terms of our cultural histories, territories, languages, and our colonial histories cannot be emphasised enough. For example, when considering indigenous peoples' cultural histories and locations, Canada is a composite of diverse and vast Indigenous territories comprised of over six hundred First Nation communities on reserve; urban indigenous communities and rural Indigenous communities (Dickason & Newbigging, 2015).

Hill, (2014) postulates that the emotional aspect of healing the self is particularly important in modern society. As it is the aspect of the self that is neglected, (personally) and avoided (professionally), most practitioners utilise Euro-western psychotherapy. The emotional aspect of the self is the feeling or affective aspect of the self that allows

indigenous people to relate to other parts of Creation. Indigenous women in this study reported that health care practitioners do not understand the use of indigenous practices such as having the string around your waist to prevent miscarriage.

Most importantly, indigenous people believe that their emotions make them human. The capacity for emotional relating is common across other parts of creation as well. Individuals need to continuously challenge what they know, learn new things, change thought patterns, and positively stimulate the mental part of the self.

Despite everything, indigenous peoples know they belong and they know through their creation stories that they have a purpose in creation. Presence and places are important considerations. Indigenous peoples want to see other indigenous peoples' presence in places that are welcoming, warm, and respectful (Absolon, 2016).

2.2.4 Economical Context

Absolon (2010) indicates that the economical context acknowledges the physical aspects of the whole where methods of practice and action are considered. Healing is a restoration of balance using tools such as the Medicine Wheel and it encourages a socio-economic analysis to contemporary conditions. In this study, the researcher has observed that some pregnant women were not getting a proper diet due to the belief of not being allowed to eat a certain food during pregnancy.

Economic conditions among Indigenous people are varied, though there is a prevalence of poverty and low socioeconomic status. The high incidences of unemployment and poor housing conditions continue. Most of the participants in this study are unemployed which may also contribute to their diet during pregnancy and in the puerperium. Many indigenous women are based in the rural communities of South Africa.

2.2.5 Self and Center

The center represents the fire of life where all directions meet and locate the teachings of integration, balance, interconnections, and holism. The center also represents the Self - the core of the cumulative aspects of self: the spirit, heart, mind, and body (Absolon, 2010). In the study, the "self" represents the participants involved in the research study.

The wholistic analysis enables the researcher to get a better understanding indigenous people in their whole context, as the Centre represents the cumulative aspects of all four doorways. In this study, the researcher noted that the participants identify themselves according to their belief patterns. For example, some participants follow their traditional beliefs, and some followed church beliefs. Indigenous worldview affects how people see themselves in their community. Recognising cultural knowledge implies that the existence of methods of healing and practice that have been exercised and applied in Indigenous contexts (Absolon, 2016). The participants in the study indicated a strong sense of ownership to the indigenous practices and they can recognise each other by their practices.

2.3 CONCLUSION

This chapter discussed the Absolon's indigenous holistic theory and the elements used to guide the pregnant women, those in labour, and puerperium so that they live a healthy life. The theory describes the five elements which are interrelated and interdependent to each other to provide harmony and a sense of peace. This chapter outlines the reviewed literature about indigenous practices of women during pregnancy, labour and puerperium amongst cultural groupings, and the theoretical framework in supporting them.

CHAPTER 3

RESEARCH METHOD AND DESIGN

3.1 INTRODUCTION

This chapter outlines the Mixed Method Research (MMR) which was applied in this study, to investigate the indigenous practices of women during pregnancy, labour, and puerperium period amongst different cultural groupings. It also outlines the way the participants were drawn from the entire population as well as the limitations of the study. Interviews were conducted in four district hospitals of Limpopo Province in South Africa. In summary, this chapter explains the procedures that were followed to execute this study.

3.2 RESEARCH METHOD

Mixed methods research was utilised to gather information and have a better understanding of indigenous practices of women during pregnancy, labour, and puerperium amongst cultural groupings. The mixed methods research is defined as a method, which concentrate on collecting, analysing, and mixing both quantitative and qualitative data in a study or series of studies. Its central principle is that the use of quantitative and qualitative approaches, in combination, provides a better understanding of research problems than either approach alone (Creswell & Clark, 2011). In this study, the researcher conducted a one-on-one interview with the participants and used the research assistant to collect data through administered questionnaires on the same day.

3.3 RESEARCH DESIGN

The convergent parallel design of mixed-method research was used in the study to collect both qualitative and quantitative data at the same time. In this study, qualitative and quantitative data were collected and analysed separately at the same time on women who use indigenous practices during pregnancy, labour, and puerperium period. The results of qualitative and quantitative strands were compared for either differences or similarities and then interpreted (Creswell, 2014). This design aided the researcher to have a detailed understanding of indigenous practices of women during pregnancy, labour, and puerperium period (Brink et al., 2017).

3.4 STUDY SITE

The study was conducted in the government regional hospitals, four districts in the Limpopo Province. The regional hospitals cater to patients referred from district hospitals. Most of the patients in regional hospitals are based in rural areas. The four regional hospitals and their districts are as follows:

3.4.1 Waterberg District - Mokopane hospital

Mokopane hospital is situated in Mahwelereng township in the Waterberg district of the Limpopo Province, South Africa. It is a regional hospital and has three sections of maternity ward which are postnatal = 30 beds, labour = 10 beds, and antenatal = 20 beds.

3.4.2 Sekhukhune District – St Ritas Hospital

St Ritas Hospital is a regional hospital that caters to Matlala and Jane-Furse Hospitals. The maternity unit comprises eight beds in the labour ward, 12 beds in antenatal ward, and postnatal ward with 24 beds.

3.4.3 Vhembe District – Tshilidzini Hospital

Tshilidzini Hospital is situated in Phundamaria Main Road, Shayandima in Limpopo Province. Shayandima is located 11.2km South-West of Thohoyandou and 63.8km East of Louis Trichardt in the Limpopo Province. The maternity unit comprises 13 beds in the labour ward, 32 beds in antenatal ward, and postnatal ward with 14 beds.

3.4.4 Mopani District – Letaba hospital

Letaba Hospital is a regional hospital situated next to Minute Maid Farm, Lynberg Road. The total number of beds is 400. The maternity unit comprises of 11 beds in the labour ward, 22 beds in antenatal ward and postnatal ward with 16 beds.

Limpopo Province has the following districts. The selected hospitals have been mentioned against each district on the map Figure 1.

Figure 1: The Limpopo Province map showing the five districts of Limpopo Province and selected hospitals for the study.

3.5 QUALITATIVE STRAND

3.5.1 Population

Population refers to a particular type of individual or element that the researcher is interest in (Burns and Grove,2009). The target population in this study comprised of all 187 women in pregnancy, labour, and puerperium who were admitted at selected hospitals in four districts of Limpopo Province, South Africa during the study period. The target was 50 participants until data saturation was reached during qualitative data collection.

3.5.2 Inclusion criteria

The inclusion criteria included all pregnant women and those in labour and puerperium period who use indigenous practices because they have knowledge regarding indigenous practices and have the following characteristics:

- Traditional herbs brought to pregnant women during admission for maintenance of general wellbeing during pregnancy.
- Ropes that are tied in knots around the waist for protection against miscarriage.
- Razor cut marks are observed on the abdomen for protection against witchcraft.
- Follow religious practices and instructions during pregnancy, labour, and puerperium for treating pregnancy-related symptoms, inducing, or assisting labour.

3.5.3 Exclusion criteria

The exclusion criteria were pregnant women and those in labour and puerperium period who were not using indigenous practices because they lacked knowledge about indigenous practices during interviews.

3.5.4 Sampling

Purposive non-probability sampling was used in the study to select participants and involved the identification and selection of pregnant women, and women in the puerperium period who use indigenous practices. The researcher conducted 15 interviews from each district hospital until data saturation was reached and no evidence of new information emerges which guided the end of the interview sessions.

The selection of participants was done at the regional hospitals with only pregnant women and those in labour and puerperium who use indigenous practices because they had more knowledge about the phenomenon studied (Burns & Groove, 2009).

Non-probability purposive sampling was utilised when the entire population cannot be used, non-randomly selected, and for understanding opinions of subsets of the population. The researcher selected participants based on who she thinks would be representative of the population (Polit & Beck, 2012). Purposive sampling allowed the researcher to decide what needs to be known and sets out to find people who can and

are willing to provide the information by knowledge or experience they have (Ilker, Sulaiman & Rukayya, 2016).

3.5.5 Data collection

Semi-structured interviews with a guide was used to collect data.The researcher obtained permission from the participant by signing a consent form before collecting data. Interviews were conducted to determine the indigenous practices of women during pregnancy, labour, delivery, and puerperium period. Data collection refers to the process whereby the most appropriate method is used to systematically collect information, to a specific standard, with integrity, and the purpose is to address the research problem (Polit & Beck, 2012).

The interviewer asked one central question to women "What are the indigenous practices that you use during pregnancy, labour, and puerperium period?". The interviewer used probes to allow the respondents to elaborate on the topic and clarify areas that were not clear to the researcher.

The interview was conducted in a comfortable private room and the session took approximately 20 minutes or less with each participant. A voice recorder was used to record all interview sessions that were conducted, and field notes were taken by the researcher during the interview for record-keeping and to capture non-verbal cues (Brink *et al*., 2012). The interviews were also conducted with the presence of the interpreter when the researcher does not understand the language of the participants. The interview sessions which needed the interpreter were provided for the participants at Letaba Hospital who speak Xitsonga and those at Tshilidzini Hospital who speak Tshivenda.

3.5.5.1 Preparation of the research field

The researcher followed the preparatory phase of data collection as outlined by Hennink, Hutter, and Bailey (2011). The researcher contacted the office of the CEO of the Department of Health in Limpopo to request consent to conduct the study at the four selected district hospitals in Limpopo Province. The researcher was asked to submit the research proposal and the ethical clearance certificate (TREC No: TREC/236/2018: PG) electronically so that it could be approved and permission letter

to conduct research in the health facilities be issued. The CEO issued the letter of permission to conduct the study on the 7th February 2019.

The researcher took the letter of permission and the research proposal and submitted it to the four district health offices in Limpopo namely Waterberg, Vhembe, Sekhukhune, and Mopani. Permission was therefore granted, and the letter was then submitted to the following hospitals i.e. Mokopane, St Ritas, Letaba, and Tshilidzini.

The office of the CEO in the hospitals referred the researcher to the Nursing Manager because the research involved the patients in the nursing care units. The researcher contacted the Operational Manager to arrange for the visits and time for data collection.

3.5.5.2 Interview

The researcher shared the study with the participants especially the purpose, objectives, ethical standards, and requested to further speak with each one of them in a separate room. This was done to check if they meet the inclusion criteria. It was noted that it was difficult for the participant to agree that they use indigenous practices in an open area then when requested to go to an isolated room they agreed. The researcher explained the aim and objectives of the study to the participant, confidentiality, and anonymity aspects were also outlined.

The interview sessions took place in a separate private room which is comfortable for the participants. The researcher greeted the participant and explain the aim and objectives of the study. The interview began after consent was obtained. A semi-structured interview was conducted. The researcher explained the use of voice recorder and field notes for record-keeping (Brink *et al*., 2017). In other hospitals where the researcher does not understand the languages namely, Tshivenda and Xitsonga respectively, the interpreter was arranged to assist with the interpretation throughout the interview session.

All participants were asked identical questions, “What are the indigenous practices that you use during pregnancy, labour and puerperium period?”. The researcher also used probes to allow the participants to elaborate on the topic especially with the

aspects that needed more clarity. The interview session took approximately 20 minutes and less with each participant.

3.5.5.3 Communication strategies used

Most crucially, effective communication requires an understanding of the participant and the experiences they express. It requires skills and simultaneously the sincere intention of the researcher to understand what concerns the participants and the phenomenon studied. To understand the participants only is not sufficient but the researcher should also convey the message that he/she is understandable and acceptable. It reflects the knowledge of the participants, the way they think and feel, and their capabilities (Lambrini & Ioanna, 2014).

The researcher communicated with the participant politely and allayed their anxiety by greeting each one of them during the interview. Participants could speak in their mother language so that they freely express their feelings. Listening skill was the main important strategy as it assisted the researcher to gather more information from participants. Body language, gestures, facial expressions, and even posture were taken into consideration.

3.5.6 Data analysis

Data analysis is defined as the organisation and interpretation of narrative data to determine important underlying themes, categories, and patterns of their relationships (Polit & Beck, 2010). Tape recordings of the interview sessions conducted were transcribed verbatim. The transcribed interviews and the field notes collected were then analysed. The literature was used to support the findings. The researcher used eight Steps of Tesch's inductive, descriptive open coding data analysis technique Creswell (2014) by following these steps:

3.5.6.a Step 1 – Reading through the data

The researcher had a sense of the whole data by reading all verbatim transcripts carefully. This gave ideas about the data segments and how they look like. The meaning arised during reading were written down and all ideas as they come to mind. The researcher carefully and repeatedly read the transcripts of all participants and understood them.

An uninterrupted period to digest the thought about the data was created. The researcher engaged in data analysis and wrote notes and impressions of the data.

3.5.6.b Step 2 – Reduction of the collected data

The researcher scaled-down the data collected to codes based on the existence or frequency of concepts used in the verbatim transcriptions. The researcher then listed all topics that emerged during the scaling down. The researcher grouped similar topics together, and those that did not have association were gathered separately. Notes were written on margins and the researcher started recording thoughts about the data on the margins of the paper were the verbatim transcripts appear.

3.5.6.c Step 3 – Asking questions about the meaning of the collected data

The researcher read through the transcriptions again and analysed them. This time the researcher asked herself questions about the transcriptions of the interview, based on the codes (mental picture codes when reading through) which existed from the frequency of the concepts. The questions were “Which words describe it?” “What is this about?” and “What is the underlying meaning?”

3.5.6.d Step 4 – Abbreviation of topics to codes

The researcher started to abbreviate the topics that have emerged as codes. These codes need to be written next to the appropriate segments of the transcription. Differentiation of the codes by including all meaningful instances of a specific code’s data were done. All these codes were written on the margins of the paper against the data they represent with a different pen colour as to the one in Step three.

3.5.6.e Step 5 – Development of themes and sub-themes

The researcher developed themes and sub-themes from coded data and the associated texts and reduced the total list by grouping topics that relate to one another to create meaning of the themes and sub-themes.

3.5.6.f Step 6 – Compare the codes, topics, and themes for duplication

The researcher in this step reworks from the beginning to check the work for duplication and to refined codes, topics, and themes where necessary. Using the list of all codes she checked for duplication.

3.5.6.g Step 7 – Initial grouping of all themes and sub-themes

The data belonging to each theme were accumulated in one column and preliminary analysis was performed, which was followed by the meeting between the researcher and co-coder to reach consensus on themes and sub-themes that each one has come up with independently.

3.6 MEASURES TO ENSURE TRUSTWORTHINESS

Trustworthiness or rigor of a study refers to the degree of confidence in data, interpretation, and methods used to ensure the quality of a study (Polit & Beck, 2014). The following criteria to ensure the trustworthiness of the study were ensured:

3.6.1 Credibility

Credibility refers to confidence in the truth of the data and interpretations of them (Polit & Beck, 2010). Thus, credibility was ensured by visiting the participant before the date of the actual study to build relationships, however some participants were seen on the actual date of the interview because of their short stay after delivery of the baby. A voice recorder was used when collecting data to ensure that information is not missed. The researcher allowed the participants to clarify the information that was provided and to confirm the truth of the data collected and analysed. An independent coder was requested to analyse the data independently and after a consensus meeting was held with the researcher to agree on the themes and subthemes reached independently (Polit & Beck, 2008). The researcher was able to conduct a follow-up interviews with the participants who stayed for longer in the hospital.

3.6.2 Transferability

The transferability refers to the extent to which qualitative results can be transferred to other settings or groups (Polit & Beck, 2010). Transferability was ensured through a thick description of the research method used and the non-probability purposive sampling chosen to include participants in the study during qualitative data collection.

3.6.3 Dependability

Therefore, dependability refers to the stability or reliability of data over time and conditions (Polit & Beck, 2010). Dependability was ensured by compiling the raw data which were collected, transcribed verbatim. The researcher used non-probability purposive sampling and a semi-structured interview with a guide when collecting the data. The recorded semi-structured interviews and field notes were examined by the supervisor to confirm if it is correct and was sent to the independent coder for analysis.

3.6.4 Confirmability

The confirmability is defined as the objectivity that is the congruence between two or more independent people about the data's accuracy, relevance, or meaning (Polit & Beck, 2010). Confirmability was ensured by rechecking the information provided by the participants and having a follow-up meeting with them so that they confirm the information provided. The researcher prepared one question which was asked to all the participant the same way to avoid being bias. The voice recorder is available as evidence to confirm that the data collected was not manipulated or biased. The independent coder which is an expert in qualitative research was involved to strengthen the data analysis of the collected data.

3.7 QUANTITATIVE STRAND

The quantitative strand included the method of selecting participants, data collection, data analysis, ethical consideration, and conclusion.

3.7.1 Sampling

Probability simple random sampling was used in the study to select women who use indigenous practices during pregnancy, labour, and puerperium. In this study, the researcher used Slovin's formula to calculate the sample size. It is a random sampling technique formula to estimate the sampling size. It is computed as:

n = N / (1+Ne2), n =187/ (1+187x 0.05^2), n =188/ 1.5 = 125 samplings. n = no. of samples, N = total population and e = error margin / margin of error. The 187 is the number of populations for indigenous women. The 125 is the sample size.

All pregnant women, those in labour and puerperium were listed in a master list and then selected randomly from this master list. The total number of populations was then calculated using Slovin's formula. Probability simple random sampling refers to a

sampling method where each member of the population is equally likely to be chosen as part of the sample. It has been detailed that "the logic behind simple random sampling is that it removes bias from the selection procedure and should result in representative samples" (Saunders, Lewis & Thornhill, 2012).

3.7.2 Data collection

The researcher used a structured administered questionnaire to collect data from pregnant women, those in labour and puerperium. A questionnaire is a data collection instrument that consists of a series of questions and other prompts to gather information from respondents (Karim, 2013). The questionnaire comprised of four sections. Section A included Demographic Data. Section B was statements directed to indigenous women during pregnancy. Section C was statements directed to indigenous women during labour and Section D was statements directed to indigenous women during puerperium. All sections used a Likert-type scale to gather data (See Appendix 8).

The questionnaire consisted of positively and negatively worded statements with five different response options ranging from strongly agree to strongly disagree (Parahoo, 2014). The researcher distributed the questionnaire herself and was available for the respondents to clarify any issues of concern during data collection. The researcher greeted the participant and explain the aim and objectives of the study. The researcher gave the participant questionnaires which were written in their home language to have a better understanding of the questions (See Appendices 9, 10 & 11).

3.7.3 Data analysis

The data analysis involved inferential statistics which permitted the researcher to conclude whether the relationship noted in samples can occur in a larger population (Brink *et al.*, 2012). Data were analysed using Statistical Package for the Social Sciences (SPSS) Version 25 with the assistance of the university statistician. According to Brink *et al.* (2012), the researcher is ought to examine the accuracy, completeness of the data collected . Therefore, incomplete, and inaccurately completed questionnaires can be discarded. In this study, there were no incomplete questionnaires. The data are presented in percentages and tables in this study.

3.7.4 Validity and Reliability

Polit and Beck (2010) define the validity of a questionnaire as the degree to which the instrument measures what it is intended to measure. Validity will be ensured by pre-testing the instrument to check if the questions asked are relevant to the study:

- Content validity

Content validity refers to the degree to which an instrument has an appropriate sample of items for the construct being measured and adequately covers the construct domain. Content validity will be achieved by requesting the supervisors involved in the research study to give their opinion on whether the questions asked adequately covers the content of the study (Polit & Beck, 2010).

- Face Validity

Face Validity will be ensured by spending much time in the field for an in-depth understanding of the phenomena under study. The researcher will ask friends to test-run the instrument to see if the questions appear to be relevant, clear and unambiguous (Polit & Beck, 2010).

- Criterion validity

Criterion validity refers to the extent to which a research instrument is related to other instruments that measure the same variables. Criterion validity will be ensured by adhering to the inclusion criteria (Heale & Twycross, 2018).

3.8 ETHICAL CLEARANCE

The ethical standards adhered to throughout the study supported the researcher to protect the participants of the study. The standards adhered to included obtaining permission for the study, Informed consent, confidentiality, privacy, anonymity, avoiding risk, and checking what are the benefits of this study to the people involved.

3.8.1 Permission

The researcher found the ethical clearance from the University of Limpopo, Turfloop Research Ethics Committees (TREC No: TREC/236/2018: PG) School of Health Care Sciences Senior Degrees Committee. Permission was granted by the Limpopo Department of Health to access the hospitals, the letter from the Department of Health was submitted to the four district Health Offices of Limpopo Province. An approved

letter from the District Health office was sent to the relevant district hospitals. Chief Executive Officer of the selected hospitals and the Nursing Manager granted permission to conduct the study in their hospitals.

3.8.2 Informed Consent

The researcher explained to the participants the nature of the research to be conducted and their role and contribution to the research. The purpose and objectives of the study were outlined to the participants. The participants were also informed that their involvement in the study was voluntary and that they can withdraw from the study at any time they wish to, but the information that they would have provided by the time of termination will be used for the study. The participants were requested to sign an informed Consent (See Appendix 4) form after explanations by the researcher and before the commencement of the interview and filling of the questionnaire (See Appendix 8) (Brink, 2012).

The consent form was signed after the participant agreed. The researcher explained to participants that they can withdraw from the study at any time they wish to do so without being victimised, but the data they would have given at the time of withdrawal will be used for the study purposes.

3.8.3 Confidentiality and privacy

The researcher maintained confidentiality by not disclosing the information collected from participants, but the information was shared amongst those who were involved. Which are the researcher and research supervisors. A private room was used for interviews to ensure privacy and no disturbance. The researcher made every effort to prevent anyone outside of the project from connecting participants with their responses (Babbie, 2013).

3.8.4 Anonymity

The information of the participants such as names and addresses were omitted to maintain anonymity. The questionnaires given to respondents were not having names to respect confidentiality. The researcher used numbers to link the participants to their responses so that no one could be able to identify them (Babbie, 2013).

3.8.5 Benefits and Risks

The researcher described the benefits of the study which was to reduce maternal mortality rate. The researcher ensured that participants are not harmed for participating in the study and that they can withdraw at any time without punishment.

3.9 CONCLUSION

Convergent parallel mixed method design was used in this study. Non-probability purposive sampling was used to identify the relevant participants for the study under the qualitative strand. In the quantitative strand the researcher used probability simple random sampling to select women who utilise indigenous practices during pregnancy, labour, and puerperium. The researcher used semi-structured interviews, with a guide, to collect data. In quantitative strand data were collected using questionnaires. Methods of collecting and analysing data were discussed. Chapter four will discuss the study findings.

CHAPTER 4

PRESENTATION AND CONVERGENT OF RESULTS

4.1 PRESENTATION OF QUALITATIVE RESULTS

This chapter presents the discussion of the findings from the semi-structured interviews. The findings are presented in themes and sub-themes.

4.1.1 Introduction

The previous chapter presented the methodology and research design which guided the study which covered an explanation of the study site, population and sampling, research method and design, data collection method used, and data analysis. This chapter presents and discusses the research findings from the individual semi-structured in-depth interviews conducted with indigenous practices of women during pregnancy, labour, and puerperium amongst cultural groupings at selected hospitals in Limpopo Province, South Africa.

Four themes and their sub-themes emerged. Each theme and sub-theme are discussed and supported by direct quotes from the transcripts. The quotes from the participants are indicated in italics in the discussion of themes and sub-themes. The participants were all black from rural areas. Literature is presented to support the findings.

Table 1: Themes and sub-themes reflecting the indigenous practices of women during pregnancy, labour, and puerperium amongst cultural groupings at selected hospitals of Limpopo Province

Main themes	Sub-themes
1. Description of several indigenous practices by women during pregnancy, labour, and the puerperium	1.1 Women's confirmation of using traditional medicines and adherence to THPs and church leaders' instructions during pregnancy, labour, and the puerperium 1.2 Reasons for using traditional medicines and adherence to THPs and church leaders' instructions outlined 1.3 An outline of activities that occurs during consultations with THPs and church leaders during pregnancy, labour, and the puerperium

	1.4 The description that responsibility to prepare traditional medicines prior consumption is left for women themselves 1.5 The description that church rituals are viewed as important during pregnancy, labour and puerperium was emphasised 1.6 Traditional and church rituals related to the protection of pregnancy up to puerperium outlined 1.7 Initial and subsequent consultation times to use church rituals and traditional medicines outlined 1.8 An outline of paradoxical (different) activities that are performed differ from one person to the other 1.9 An outline of restrictions and what is allowed by THPs and church leaders and reasons thereof during pregnancy, labour, and the puerperium
2. Description of existing knowledge related to specific care provided by THPs and church leaders	2.1 Lack versus the existence of knowledge related to names of traditional medicines provided by THPs and church leaders 2.2 An outline that believes are core towards accepting specific care provided by THPs and church leaders 2.3 Existence versus lack of knowledge related to reasons of doing as instructed by THPs and church leaders 2.4 Existing knowledge of family members towards practices of THPs and church leaders are imposed on women during pregnancy, labour, and the puerperium 2.5 Existing knowledge related to the treatment of various complications outlined
3. Description of the consequences of following or not following THPs and	3.1 Inherent believes determine outcomes of using traditional medicines and its good or bad results 3.2 An outline of several consequences of not following either THPs or church leaders' instructions

church leaders' instructions	3.3 A description that THPs and church leaders outline to women that consequences of not following their instructions 3.4 A description of existing myths and how they could affect women during pregnancy, labour and puerperium
4. Description of factors that determine consultations to THPs and church leaders	4.1 Description of various conditions which lead women to consult THPs and church leaders 4.2 Description of signs and symptoms during pregnancy, labour, and puerperium which determine consultations to THPs and church leaders 4.3 Pressure and instructions from family members mentioned as one factor that determine consultations to THPs and church leaders 4.4 Pressure and instructions from THPs and church leaders themselves mentioned as one factor

4.1.2 Theme 1: Description of several indigenous practices by women during pregnancy, labour, and the puerperium

This theme is divided into nine sub-themes which describes the practices used at THP and at church to protect women during their pregnancy, labour, and puerperium.

The nine sub-themes are as follows:

- Women's confirmation of using traditional medicines and adherence to THPs and church leaders' instructions
- Reasons for using traditional medicines and adherence to THPs and church leaders' instructions outlined
- An outline of activities that occur during consultations with THPs and church leaders
- The responsibility to prepare traditional medicines prior to consumption is left for women themselves
- The church rituals are viewed as important

- Traditional and church rituals related to the protection of pregnancy up to puerperium outlined
- Initial and subsequent consultation times to use church rituals and traditional medicines outlined
- An outline of paradoxical (different) activities that are performed differ from one person to the other
- An outline of restrictions and what is allowed by THPs and church leaders and reasons thereof

Sub-theme 1.1: Women's confirmation of using traditional medicines and adherence to THPs and church leaders' instructions

The indigenous woman described the importance of using traditional medicine and strictly following church instructions given by their pastors. In the study, this is supported by one of the participants who said: "*I use church rituals whereby the prophet gave me instruction to drink solemn water (Mohamolo) until I give birth*". According to Aziato, Odai, and Omenyo (2016), women use religious artifacts such as blessed water and oil during prayers. The blessed water and anointing/ blessed olive oils are ordinary water and olive oil that the religious leader prays over. These artifacts may be used once-off or continuously for the duration of pregnancy.

Some of the participants confirmed the importance of adherence to traditional medicine. It was supported by a woman who said: "*In my previous pregnancy I didn't adhere to traditional medicines and I had a miscarriage, but now that I used traditional medicines my baby survived*". Malan and Neuba (2011) explain that there are traditional herbal remedies used and given to pregnant women. Treatment in the early stages of pregnancy is believed to prevent miscarriage and to ensure proper growth of the foetus and stability of the woman's health.

Another participant reported the importance of following church instructions. She said: *"I was given a string to tie around my abdomen and to cut it off on my ninth month of pregnancy".* A growing phenomenon in Ghana is religious Pentecostal/Charismatic leaders praying for pregnant women and some giving the women religious artefacts such as anointing oil for their use. Some of these leaders also directly anoint the

women and give them other spiritual directions concerning the use of artefacts or the performance of other specific activities aimed at safe delivery (Ahmadi, 2013).

Sub-theme 1.2: Reasons for using traditional medicines and adherence to THPs and church leaders' instructions outlined

Participants indicated that they use traditional medicines and church rituals for protection to their pregnancy, labour, and puerperium. Most of them reported that their main reason is to protect against witchcraft. The following quote support this statement: "*I used herbal medicine and church rituals to protect my pregnancy against enemies*". Aziato *et al*. (2016) Indicate that most women in previous studies received prayer support from their pastors to protect them from miscarriages during pregnancy. The pastors gave some revelations that concerned around witchcraft and the condition of the baby and they prayed against any negative effect on the outcome of the pregnancy.

One participant mentioned that she was using traditional medicine as instructed by her elders. This was confirmed by the following statement: "*In my culture when I'm pregnant my grandmother will advise me to visit the Traditional Healer to check the state of my pregnancy, He will ask me questions and prescribe herbal medicine if I have a problem*". The above statement is supported by Abdullahi (2011) who reported that common sources of information on traditional medicines were from the recommendation of family, friends, and traditional birth attendants. African traditional medicine is also fixed within cultures, and the information is handed down between close family members.

During the interview, one of the participants said: *"I used traditional medicine to protect my pregnancy against miscarriage".* This is supported by Nyeko, Nazarius, and Abdullah (2016) who mentioned some of the reasons for traditional medicines usage which included general wellbeing during pregnancy, promotion of fetal growth, spiritual cleansing, to protect the pregnancy against evil impact, to have a male baby, for induction of labour, assisting childbirth, and as dietary supplements.

Sub-theme 1.3: An outline of activities that occurs during consultations with THPs and church leaders

The indigenous woman described different activities that took place during a consultation with THPs and church leaders. Traditional health practitioners have other activities that take place during the consultation such as tie the string around the women's abdomen to protect against miscarriage. One of the women said: "*The THP tied a red string around my waist so that I don't have a miscarriage*". This is supported by Cheboi, Kimeu, and Rucha (2019) who reported that a pregnant woman wears a special necklace, laced with charms for protection. It is suspected that pregnancy complications are contagiously compounded by the "evil eyes". The scholars allude that the necklace is removed to allow the woman to give birth when she begin to have labour pains.

At church, the pastor may prepare the special tea for the client especially on the first visit. One of the participants mentioned that: "*During my pregnancy, I consulted the pastor of Apostolic church and he prepared a special tea for me to drink during my pregnancy*". This is supported by Kutsira (2013) study who indicated that in all Independent African Churches' water is an crucial sacrament in the Church of the Lord. It is used in ritual services, both within and outside the church. As a new Moses, the minister or prophet blesses and scatters holy water on the new people of God during services as a visible sign of sanctification. But its healing power is undeniable.

Thus, some of the THPs were teaching their clients how to cook traditional medicines. This is supported by a woman who said: *"I visited the THP during pregnancy and he cooked the medicine to show me how it is done".* A study conducted by Ngubane (2014) reported how THPs prepare traditional medicines and indicate that one plant preparation was reported to be taken topically by rubbing it on the pregnant woman's belly using a cloth. Most of the reported plant preparations were taken after it was cooled and strained.

Sub-theme 1.4: The responsibility to prepare traditional medicines prior to consumption is left for women themselves

There were different activities that indigenous women carried out for the preparation of traditional medicines and church rituals as instructed by their THPs and church leaders. One of the participants said: "*I cook the root of a tree with water that makes*

2 litres then drink it when it's cold, you stop drinking it when its colour disappears'. This statement indicates that it is the responsibility of the woman to carry out the instructions provided to them during consultations to prepare their herbal medicine.

The findings of the study indicated that other participants carried activities from churches that relate to indigenous practices. The following quote supports the statement: "*After three months of pregnancy, I went to church and they told me to go fetch water from the river and light three candles inside the room so that I don't have a miscarriage*". Cheboi, Kimeu, and Rucha (2019) argue that the pregnant woman should be limited from heavy duties such as digging, fencing, grinding, fetching water, and splitting firewood allegedly to avoid miscarriage, bleeding, and preterm delivery and back pain.

One of the women mentioned that: *"I was instructed to take the white part of the egg and mix it with water to drink when my time for delivery comes so that I will deliver easily".* This is supported by Laelago, Yohannes, and Lemango (2016) who mentioned that herbal medicines used by pregnant women were self-prepared mostly by mixing different parts of plants, while some took prepared and pre-packaged herbal medicinal products.

Sub-theme 1.5: The fact that church rituals are viewed as important was emphasised

It was found that some of the indigenous women interviewed believe in church rituals only. This is supported by a participant who said: "*I use church rituals from ZCC only, the pastor gave me a string to tie my abdomen and to remove it when I'm nine months pregnant so that I can give birth*". This is supported by Rhys (2014), who mentioned that spirituality relies on faith rather than scientific rigour and that science offers patients 'a 25% chance of recovery', whereas spirituality provides hope, support and comfort.

The researcher noted that there were also participants who used THPs and church rituals from other churches as well for example Apostolic and Zion Christian Churches. This is supported by a participant who said: "*I consulted the Apostolic church and the pastor gave me a red and green string to tie around my waist during pregnancy and to remove it on the last month of my pregnancy*". Religion and spirituality are two

prominent cultural elements that give meaning to human conduct, values, and experiences (Ramezani, Fazlollah, & Mohammadi, 2016).

Therefore, some of the participants mentioned the importance of church rituals. This is supported by the participant who said: *"I was not feeling well when I visited the church but after using church rituals, I felt fine"* Ohaja, Murphy-Lawless and, Dunlea (2019) study indicates that pregnant women are liable to spiritual attacks which may negatively distress the pregnancy and can be prevented by offering spiritual care.

Sub-theme 1.6: Traditional and church rituals related to the protection of pregnancy up to puerperium outlined

The responses from the study participants indicate that the use of traditional and church rituals continues until puerperium. This is supported by the participant who said: "*If my baby suffers from "Thema" [when the baby cry often and bend the head backward to rub it against the back of the neck] and "Hlogwana [when the baby is passing greenish watery stools and has sunken, not pulsating fontanel] then the Traditional Healer will give me the medicine to heal it*". Sivadasan, Anand, and Girishkumar (2014) mentioned a few of the practices carried out during puerperium such as massaging the mother and baby will be done with an oil formulation namely, 'mukkoottu' made up of coconut oil, gingelly oil and turmeric with modifications. This oil massage is believed to be capable of sharpening the body of new borne and to reinstate the relaxation of the abdominal muscle of the mother. Medicated water called 'vevuvellam', which is believed to have wound healing, anti-inflammatory, and analgesic properties is used for bathing.

One of the participants was asked if she is still going to use traditional medicines at home and she replied by saying: *"I'm still going to visit the Traditional Healer because he told me that there is witchcraft coming to my house so he must come and clean my yard to protect my baby".* According to the participant, traditional rituals continues even after birth. Karahan, Aydın, Güven, Benli, and Kalkan (2017) study discussed different measures to protect new mothers and the baby during puerperium such as putting a copy of the Koran near the bed, placing a knife under the baby's bed, pinning a safety pin to the baby's clothes, wrapping a red and black string around the bed, and not leaving the baby's clothes outside at night.

Sub-theme 1.7: Initial and subsequent consultation times to use church rituals and traditional medicines outlined

The use of indigenous herbal medicines for managing pregnancy and childbirth is more common and more defined than attending the Antenatal Care (ANC). Some of the indigenous women consulted the traditional health practitioners more than once during their pregnancies.

During the interview, one participant said: "*I consulted the THP at the beginning of my pregnancy, and sometimes during pregnancy, I consult just to check if everything is ok*". This statement indicates that indigenous women consult more at the THPs than at the ANC clinic. In the study conducted by Mothupi (2014), it is indicated that many pregnant women believe that traditional medicines were more effective than western medicine, as well as better accessibile and at lower costs.

Traditional medicines and church rituals are prescribed throughout the pregnancy up to childbirth. This is done to strengthen the pregnancy and to protect the child from evil spirits. This is supported by a woman who said: "*The THP gave me "Motetema [a small root that is cooked with water to drink]" to prepare and drink but when it's finished, I fetch another one that is different from the previous one, it differs according to your stage of pregnancy*". The use of different types of TM and other substances by pregnant women was reported. These included holy water, soil from a burrowing mole, pouzolzia mixta, elephant dung, manual exercises, cocktails of unknown herbs, Cannabis stivum, castor oil, rooibos tea, and hot water/steam baths (Mureyi, Monera & Maponga, 2012).

Another participant mentioned that: *"My prophet prescribed Vicks to rub on my abdomen and also tea which is called Bophelo [A special holy tea made by pastors in church] to drink every day until birth*". An indigenous woman values the opinions of their THPs and church leaders more than that of health practitioners. One participant said: "I *consulted THP when I realised that I'm pregnant, in the middle of my pregnancy and also on my nineth month of pregnancy*". Most African people still rely heavily on traditional medicine; traditional healers are often the first and last line of defence against most diseases such as headaches, coughs, diarrhea, wound healing, and skin diseases. One advantage in preferring traditional medicine is that traditional healers are found within a short distance, are familiar with the patient's culture and the

environment and the costs associated with treatments are negligible (Cheikhyoussef, Shapi, Matengu & Ashekele, 2011).

Sub-theme 1.8: An outline of paradoxical (different) activities that are performed differ from one person to the other

The results of the present study show that indigenous practices differ from one person to another. This is supported by a woman who said: "*I use the water from church for bathing from pregnancy until I give birth and the tea I drink once a day for three days only*". In other countries different activities were also reported, the study conducted by Archibong, Enang, and Bassey (2017) indicated that several procedures can be arranged in the following sequential order: confession, atonement, sacrifice, absolution, purification rites, and counselling. In faith – healing practices, it is believed that the positive way to be delivered from the power and effects of malaise especially those caused by demons is through constant religious devotion or prayer.

On the other hand, some of the participants were using church rituals continuously until they give birth. This was confirmed by a participant who said: "*I also use church rituals whereby the prophet gave me instruction to drink warm water called "Mohamolo" [solemn water] until I give birth"*. Some religious beliefs hold that members should not pursue or receive medical care for any condition including pregnancy. These beliefs can result in increased prenatal and maternal mortality. The art and science of reestablishing and preserving health have been closely associated with religion since ancient time (Archibong, Enang & Bassey, 2017).

One of the participants said: *"I consulted the Traditional Healer who gave me herbal medicines to drink"*. On the other hand, another participant reported: *"The traditional Healer gave me "Lehloni" or "Sebabo [traditional medicine to treat sores in the stomach]" medicine because I have sores in my stomach"*. This is supported by Cheboi, Kimeu, and Rucha (2019) who indicated that a belt (leketio), a traditional strap made of animal skin and cowrie shells is an important indigenous Marakwet repertoire which is used for the woman to strap up after delivery to protect and involute the uterus.

Sub-theme 1.9: An outline of restrictions and what is allowed by THPs and church leaders and reasons thereof

Indigenous women are expected to follow certain behavioural traits and precautions. The restrictions offer a complex understanding of phenomena within particular communities and they are regarded as manifestations of the sacred. They are planned to safeguard communities from threats to the cosmic order and to correct any disturbances of its order (Van Bogaert & Ogunbanjo, 2008).

One of the participants mentioned that: *"When I'm pregnant I'm not allowed to attend the funerals because they are regarded as a "hot" place"*. Heidari, Ziaei, Ahmadi, Mohammadi, and Hall (2015) reported several traditional beliefs and practices associated with pregnancy, labour, and the postpartum period. Some of them include food and water restrictions, avoiding specific places such as the graveyard, not going out at specific times in the day, not associating with some people deemed to be evil, and drinking special herbal preparations. Some women are limited from work during pregnancy while others are not.

Another participant said: "*I was told that I should not urinate anywhere in the yard to prevent giving birth in operation*". Few women from previous studies reported traditional beliefs and practices such as not eating or not drinking outside the home and suggest that such practices may contribute to negative penalties for the woman and the unborn child. It suggests that although ancestral protection is desired, the health and well-being of women should be taken into consideration during such rituals (Oni & Tukur, 2012).

Furthermore, another participant mentioned: "*I was restricted from eating cold food because I will shiver during labour*". Celik, Capik, and Engin (2012) indicated that some of the foods traditionally considered harmful during pregnancy, such as eggs, liver, fish, strawberries, and peaches, are highly nutritious; therefore, it is important that pregnant women receive nutritional education from health professionals.

Theme 2: Description of existing knowledge related to specific care provided by THPs and church leaders

This theme has five sub-themes that emerged during data analysis describing the practices used by THP and at church to protect their pregnancy and take care of the women during labour and puerperium period.

The five sub-themes are as follows:

- Lack versus the existence of knowledge related to names of traditional medicines provided by THPs and church leaders
- An outline that believes are core towards accepting specific care provided by THPs and church leaders
- Existence versus lack of knowledge related to reasons of doing as instructed by THPs and church leaders
- Existing knowledge of family members towards practices of THPs and church leaders are imposed on women during pregnancy, labour, and the puerperium
- Existing knowledge related to the treatment of various complications outlined

Sub-theme 2.1: Lack of knowledge versus the existence of knowledge related to names of traditional medicines provided by THPs and church leaders

During the interview the researcher noted that some of the participants do not know the names of the traditional medicines they use from their THPs and church leaders. This is supported by a woman who said: "*I consulted the Traditional Healer who gave me herbal medicines to drink but I do not know the name of the medicine*". Hlatshwayo (2017) corroborates that in rare cases, traditional medicines are subcontracted from local specialists and in such situations it becomes impossible for the pregnant women to take note of the composition of the herbal concoctions administered to her since herbalists do not reveal the type and names of herbs they administer. This is a strategy utilised to retain their expertise and to ensure they are always called upon during times of pregnancy and other related diseases.

The findings also reflected that indigenous women who used church rituals did not know the names of those rituals prepared for them. One of the participants said: *"I use church tea from Zion Christian Church but I forgot the name of the tea*". According to Okutu (2011), socio-cultural belief systems, religion, values, and practices also shape an individual's knowledge and perception of health and disease, and healthcare-seeking practices and behaviours. These values and belief systems are shaped by the dominant organisational philosophy.

The study revealed that some participants identify the herbal medicines according to the colour. This is supported by a participant who said: "*I was given a traditional medicine to drink but I don't know the name, the colour is brown like tea*". Malan and Neuba (2011) indicate that there is a lack of association between age, number of children, and the knowledge of obstetric plants. This situation could be mainly explained by the fact that pregnant women seek the help of an advisor (mother or close relative) or a specialist, a kind of a traditional birth attendant, who is knowledgeable about herbs and their uses. Furthermore, another participant said: "*I was given herbal medicine but I forgot the name, it is a powder and black in colour*". This is supported by Frazao-Moreira (2016) who stated that even though healers and patients alike share a common worldview, the exact and thorough features of said processes, or in other words, the specific actions performed by healers to donate the plants with symbolical efficacy, are in most cases not known to the patients.

Sub-theme 2.2: An outline that believes are core towards accepting specific care provided by THPs and church leaders

THPs and church leaders are seen as principled people in indigenous cultures. Hlatshwayo (2017) summarises rituals as central to the indigenous African ways of life. Through rituals, ancestors are appealed to render protection and guidance. They regulate the rhythm of African ways of life for most indigenous communities. It, therefore, becomes the responsibility of societies to hold rituals that are life-giving and to disregard those that are cruel.

Sub-theme 2.3: Existence versus lack of knowledge related to reasons for doing as instructed by THPs and church leaders

It was found that indigenous women had a lack of knowledge related to the reasons for using indigenous practices. One of the participants indicated that: "*I consulted the pastor at church because at home we are Christians and we follow church principles and if I am instructed to do so I then go to them and obey their instructions*". The study conducted by Agus, Horiuchi, and Porter (2012) indicated that belief in God and acceptance of all of God's decision was absolute in Indonesian women, religion also had an influence on women's insight of how to maintain and preserve their pregnancy.

Furthermore, a participant in support said: "*In my culture when I'm pregnant I visit the Traditional Healer to check the state of my pregnancy, he will ask me questions and*

tell me if I have a problem or not, if I am okay he doesn't give me any traditional medicine". Shewamene, Dune, and Smith (2017) reported that frequent traditional medicine users in most of the studies were women with no formal education and low income. This may be related to the fact that many women living in rural villages in Africa have fewer opportunities for education and employment. This may in turn limit women's knowledge about available healthcare options outside of traditional and cultural health practices.

On the other hand, some of the participants understand the reason for using indigenous practices. This is supported by a participant who said: '*When I had swollen legs my THP gave me the medicine called "Motsa [medicine to treat a pregnant woman who has swollen legs]". It is prepared by burning it on fire and inhaling its smoke*". It is important to understand women's unique health needs and experiences. The differences are on how they view and take care of their health, their cultural, religious beliefs, practices related to health, and decisions-making. For example, the findings revealed that participants are more likely to self-treat or use alternatives (e.g., traditional medicines), depending on the perceived cause and severity of conditions (Thummapol, Barton & Park, 2018).

Sub-theme 2.5: Existing knowledge related to the treatment of various complications outlined

Indigenous women were taught by their THPs and church leaders to bring their children for treatment during complications. This is supported by a woman who said: "*There is a medicine that the Traditional Healer will give me to apply on my child's forehead and he also used a razor cut but that depends on the condition of the baby*". One of the authors namely Frazão-Moreira (2016) indicated in his study that when the baby is born, it is bathed with traditional medicine and also begins to drink it when the breastfeeding period ends. The mother takes the child to the house of the healer, who will proceed with a symbolic ceremony.

One of the participants stated that THPs knows of different treatments for various complications. This statement was confirmed by a participant who said: "*If my baby suffers from "Thema" and "Hlogwana" then the Traditional Healer will give me the medicine to heal it*". Truter (2007) in support indicated that traditional health

practitioners dealt with ailments that were treated culturally and that did not respond to Western medication and ought to be treated by traditional healers.

Another participant said: *"When I realised that I'm pregnant I visited the church and the pastor gave me Vicks to apply on my abdomen until I give birth, it was only applied once a day and it was to protect against miscarriage".* Williams (2018) reported that prayer sessions were used against unfavourable pregnancy outcomes such as miscarriage, stillbirth, and caesarian section which for them, was a most dreaded and abnormal outcome.

Theme 3: description of the consequences of following or not following THPs and church leaders' instructions

This theme is divided into four sub-themes which describes the practices used at THP and at church to protect their pregnancy and during labour and puerperium.

The four sub-themes are as follows:

- Inherent believes determine outcomes of using traditional medicines and church rituals which will either lead to good or bad results
- An outline of several consequences of not following either THPs or church leaders' instructions
- A description that THPs and church leaders outline to women that consequences of not following their instructions
- A description of existing myths and how they could affect women

Sub-theme 3.1: Inherent believes determine outcomes of using traditional medicines and church rituals which will either lead to good or bad results

Most of the participants believe in church rituals without taking into consideration their good or bad results. This is supported by a woman who said: "*After three months of pregnancy, I went to church and they told me to go fetch water from the river and light three candles inside the room so that I don't have a miscarriage and I did that believing that this will assist me*". Aziato *et al*. (2016) suggest that pregnant women deal with a lot of voices such as those of their pastors, mothers, husbands, and health professionals. The fear of a negative consequence of the pregnancy and caesarian section compound the problem. Therefore, women then engage in religious practices

to guarantee extra protection during pregnancy. In this regard, midwives and gynecologists should understand that spirituality is an important component of the care of pregnant women.

The indigenous women go through different rituals that ensure the safety of both the mother and child. One participant mentioned that: *"I went to consult the Traditional Healer; he said the baby is not in the right position and then he gave me medicines for bathing and to rub on my stomach".* A wide variety of traditional practices have been identified by Morris, Short, Robson, and Andriatsihosena (2014) within the pregnancy, delivery, and postpartum period which may harm women and/or their unborn or newborn's health. Other practices that may potentially be harmful include turning the baby in-utero, herb ingestion during pregnancy, delivery, and postpartum, also squatting over hot coals post-delivery.

One of the participants was asked if she will continue using indigenous practices after pregnancy and she responded by saying that: *"There is a medicine that the Traditional Healer will give me to apply on my child's forehead. He will also use razor cut but that depends on the condition of the baby".* This is supported by Yalçın (2012) who mentioned other traditional practices applied by Turkish women such as bathing the baby with salted water.

Sub-theme 3.2: An outline of several consequences of not following both THPs and church leaders' instructions

The findings indicate several consequences that may occur if the woman does not follow THPs and church leaders' instructions. One of the participants said: "*I didn't use THP's instructions before and I had a miscarriage, but now that I have used them my baby survived*". Another participant said: *"I was told not to eat cold food because I will shiver extremely during labour and because I did not follow those instructions it happened to me"*. Cheboi, Kimeu, and Rucha (2019) reported that communities' restrict food such as eggs as they make the baby big; causes high blood pressure and colic pain in the baby, therefore, it is prohibited in some areas of Kenya.

The researcher has noted that most of the participants reported miscarriage, caesarian sections, and death as the consequences that may occur for not following both THPs and church leaders. One participant said: *"The Pastor told me that during labour I must remove my string that is tied around my waist so that I don't give birth by operation".*

This is supported by Angarita Navarro and Bejarano Beltran (2019) who indicate that midwives from the Pacific region of Colombia, as well as midwives from the Wayuu community, prepares infusions for the pregnant; similarly, they prepare drinks to "ease labour" and beverages with yerba of the virgin and basil to increase uterine contractions.

Sub-theme 3.3: A description that THPs and church leaders outline to women consequences of not following their instructions

THPs and church leaders explained the consequences that may occur to women for not following their instruction so that they understand and comply with the rituals provided to them. This statement is supported by a participant who said: "*I was told by the Pastor that I may lose my pregnancy if I don't follow the instructions from the church*". Agus, Horiuchi, and Porter (2012) a study discovered that women believed that following the traditional rituals, praying to God would make them healthier and they felt uncomfortable if they disobeyed these rituals.

Furthermore, another participant said: "*My THP told me that I might deliver in a caesarian section if I don't comply to the traditional medicines*". During pregnancy, women strengthen their prayers to God for protection, safe delivery, and blessings. Some women panic when a caesarean section is mentioned for fear of death during surgery and others who undergo a caesarean section is stigmatised. This stigma exceeds its generations. Therefore, pregnant women would discover all spiritual and traditional options to ensure that they deliver naturally (Jesse, Schoneboom & Blanchard, 2007).

Sub-theme 3.4: A description of existing myths and how they could affect women

The study findings reveal that most participants believe that existing myths can affect their pregnancy, labour, and puerperium period. This is indicated by a woman who said: "*My THP said I should not kill or slaughter chicken as it can result in giving birth by operation*". There are some cultural beliefs in the indigenous Wayuu community, possibly based on myths, such as not eating catfish to prevent complications when giving birth, it can be considered a belief predisposed by the fishermen of the region. Wayuu women narrate it to a complication at birth, believing that the fetus does not

come down when they eat catfish since this fish gives birth from their mouth (Angarita Navarro & Bejarano Beltran, 2019).

Another participant also indicated that: "*During birth, because there is a lack of ambulance and public transport, I took the stone and carried it on my back to prevent giving birth on my way to the hospital. When I arrived, I took it off my back*". It was found that 1.6% of the participants believed that if a pregnant woman sits on a mattress with scissors below she will have a girl, but if a knife is hidden under the mattress, then she will give birth to a boy (Karahan *et al.*, 2017).

Theme 4: Description of factors that determine consultations to thps and church leaders

This theme is divided into four sub-themes which describes the practices used at THP and at church to protect their pregnancy and during labour and puerperium.

The four sub-themes are as follows:

- Description of various conditions which lead women to consult THPs and church leaders
- Description of signs and symptoms during pregnancy, labour, and puerperium which determine consultations to THPs and church leaders
- Pressure and instructions from family members mentioned as one factor that determine consultations to THPs and church leaders
- Pressure and instructions from THPs and church leaders themselves mentioned as one factor

Sub-theme 4.1: Description of various conditions which lead women to consult THPs and church leaders

Most of the participants reported that they visit the THPs and church leaders due to various conditions. One of the participants said: "*I went to visit the Traditional Healer because I was not feeling well, I was having stomach pains*". Various Signs for using herbal medicine during pregnancy were stated as nausea, vomiting, abdominal pain, cold, and others (Laelago, Yohannes, & Lemango, 2016).

Indigenous women adhere to their culture and use the THPs and church leaders for protection against witchcraft. This is supported by a woman who said: "*I use herbal medicine to protect against witchcraft and enemies*". Witchcraft was referred to as someone wanting to harm the woman or her pregnancy because of jealousy or hatred towards her or her family. These insights also contributed to delayed care-seeking, either because women did not want to divulge their pregnancy before it was visible, or because biomedical care was not considered valid (Påfs, Musafili, Binder-Finnema, Klingberg-Allvin, Rulissa & Essen, 2016).

Other participants indicated that: *"I used church rituals because at home they are Christians"*. This is supported by the study conducted by Archibong, Enang, and Bassey (2017) who mentioned that religious beliefs are common and have a great impression on health-related decisions and behaviours. The American Academy of Paediatrics, (AAP) (2010) also recognises that religion plays a major role in the lives of many children and adults in the United State and is aware that some in the United States believe prayer and other spiritual practices can substitute medical treatment of the ill.

Sub-theme 4.2: Description of signs and symptoms during pregnancy, labour, and puerperium which determine consultations to THPs and church leaders

The researcher noted that indigenous women are aware of the signs and symptoms during pregnancy, labour and puerperium period which may determine consultation to the healthcare practitioner, but they choose to consult the THPs and church leaders. One participant indicated that: "*When my baby was not kicking, the THP gave me a herb called "Matsa (a leaf that is boiled with water and its steam is inhaled)". I used it for steam and thereafter the baby was kicking as normal*". This is supported by Lawan, Takai, Abdullahi, Kamal and Umar (2017) who indicated that pregnant women patronise herbal mixtures for the treatment of nausea and vomiting, low back pain, to support or terminate the pregnancy, for anesthesia and also to prepare for labour or other unrelated health issues such as colds and respiratory illnesses, skin problems or to achieve good psychological health.

Another sign and symptoms quoted were the relief of breast pain and the participant said: "*I was also having breast pain and the THP advised me to take a piece of an aloe tree and cut it into four-piece and place it on fire then rub it on the breast to relieve the*

pain". This is supported by Wulandari and Whelan (2011) who indicated that most women in Indonesia and Bali who needed something for other symptoms including headaches, believed going to the traditional practitioner and receiving a medicine would make them feel better. Moreover, the practice for taking traditional herbal remedies during pregnancy had been passed down for many generations and there were no related side effects.

Furthermore, indigenous women mentioned two major illnesses which may occur during puerperium which is *"Thema"* and *"Hlogwana".* One woman described them, and she said: "*Thema is recognised when the baby cries often and bends the head backward to rub it against the back of the neck. Hlogwana is recognised when the baby passes yellowish stools like fried eggs*". Traditional healers can provide physical, psychological and spiritual care and are said to either be located in the villages within which they serve or to move around from village to village providing care as they go, by using remedies including plants and trees, piercing and cuts and prayer (Farley, Bala, Lenglet, Mehta, Abubakar, Samuel, de Jong, Bil, Oluyide, Fotso, Stringer, Cuesta & Venables, 2020).

Sub-theme 4.3: Pressure and instructions from family members mentioned as one factor that determine consultations to THPs and church leaders

Most of the participants verbalised that they are pressured by the parent to follow indigenous practices. This is supported by a participant who said: "*I was very sick during my pregnancy and my parents said I must start at the Traditional Healer first*". Family members influence some women to go for prayers and use religious artefacts during pregnancy and some used the artefacts secretly (Aziato *et al*., 2016).

Another participant said: "*My parents told me I'm not supposed to attend any funeral because it is considered a "hot" place*". Hlatshwayo (2017) confirms that when a woman is pregnant, she is advised to stop from being spiteful and to limit her number of visits especially when her pregnancy begins to show. She is advised to avoid departing paths as this is believed to lead to a breach delivery.

Another woman confirmed this claim by saying: "*In my nineth month, my mother went around the yard where water normally flows and collected the wet soil called "Letaga" and gave me to curse the people I think might be jealous of me and my pregnancy. After the curse, you keep the water inside your mouth and face the northern side and*

spit it out". Mothupi (2014) highlighted that family and friends are the ones that influence the pregnant woman to either seek western or traditional medicines during pregnancy. They represent the social and cultural environment in which the pregnant woman lives.

It was revealed that indigenous women followed the practices as instructed by the elders at home. This was supported by the participant who said: "*The elders at home told me that I should not eat eggs as they cause delay during birth"*. The elders are regarded as the most qualified, and full of wisdom. They are considered to be holders of the vital information as relates to ways of life and they are knowledgeable about the way of the ancestors and this facts is communicated to the family and the community at large. They are familiar with the exclusions, violations, rites, and rituals that ought to be obeyed (Hlatshwayo, 2017).

Family members especially the elders may impose the woman towards using indigenous practices. This is indicated by a woman who said: "*In my nineth month, my mother went around the yard where water normally flows and collected the wet soil called "Letaga " [wet soil mixed with traditional herbs] and gave me to curse the people I think might be jealous of me and my pregnancy. After the curse, you keep the water inside your mouth and face the northern side and spit it out*". This is supported by Cheboi, Kimeu, and Rucha (2019) who mentioned that adverse pregnancy and its outcomes are thought to be caused by supernatural causes such as spirits and ancestors. In the spirits and ancestor's aetiology, bad omens are punishments for couples or extended family wayward behaviour. Therefore, the cleansing ceremony is done to lessen family and communal social misfortunes such as inter and intra fights.

4.2 PRESENTATION OF QUANTITATIVE RESULTS

This section presents the findings from questionnaires completed by women during pregnancy, labour, and puerperium who met the inclusion criteria of the study. The data were collected using questionnaires and analysed using the SPSS Statistic 25 Microsoft Excel with the assistance of the statistician at the University of Limpopo. The questionnaire comprised four sections. Section A included demographic data. Section B was statements directed to indigenous women during pregnancy. Section C was statements directed to indigenous women during labour and Section D was statements

directed to indigenous women during puerperium. Data were analysed according to the sections of the questionnaire and presented in terms of tables.

4.2.1 Section A: Demographic data

Table 4.1: Age

AGE			
Age	Frequency	Percent	Valid Percent
12-20	25	21.7	21.7
21-30	49	42.6	42.6
>30	41	35.7	35.7
Total	115	100.0	100.0

Table 4.1 indicates the variable age of a woman during pregnancy, labour and puerperium. The study results revealed that most respondents who participated were between the ages of 21- 30 years at 42.6% and those least participating were between 12- 20 years at 21.7%. This could be of the fact that the age of 21 -30 is regarded as the childbearing age as compared to the age of 12-20.

Table 4.2: Ethnic Group

ETHNIC GROUP				
		Frequency	Percentage	Valid Percentage
	African	115	100.0	100.0

This table indicates ethnic group of the respondents, they were asked about their ethnic group which includes African, White, Coloured, and Indian. The result indicated that 100% of the respondents were Africans. This could be because the study was conducted in the hospitals situated in rural areas.

Table 4.3: Occupation

OCCUPATION			
	Frequency	Percentage	Valid Percentage
Employed	35	30.4	30.4
Unemployed	80	69.6	69.6
Total	115	100.0	100.0

The respondents were asked about their employment status and the findings presented in table 4.3 indicates that 69.6% of women who participated were unemployed whereas 30.4% were employed. Most women who are pregnant are required by their husbands or elderly people at home to either stop working or work less and take care of the pregnancy.

Table 4.4: Settlement

SETTLEMENT			
	Frequency	Percentage	Valid Percentage
Urban	8	7.0	7.0
Rural	107	93.0	93.0
Total	115	100.0	100.0

The respondents were requested to tick the type of settlement they reside in. Different types of settlements were mentioned such as urban and rural. The findings presented in table 4.4 shows that the majority (93%) of women who responded were from rural areas whereas 7.0% were from urban areas. The study was conducted at the hospitals that are situated in rural areas and cater for the majority of women from rural areas.

Table 4.5: Marital status

MARITAL STATUS			
	Frequency	Percent	Valid Percent
Single	41	35.7	35.7
Married	74	64.3	64.3
Total	115	100.0	100.0

The findings presented in table 4.5 indicates the variable of marital status from the women during pregnancy, labour, and puerperium. The respondents were asked about their marital status and had to choose between being married or single. The study revealed that 35.7% of women who responded were single whereas 64.3% were married. The researcher has noted that most women in the study are married which in most cultures women should be married first and conceive afterwards.

4.2.2 Section B: Statements directed to women during pregnancy

This section presents the findings which were directed to women during pregnancy. It included statements about the use of indigenous practices during pregnancy.

Table 4.6: Indicates the result of the statement about engagement in indigenous practices during pregnancy

I have engaged in indigenous practices during pregnancy			
	Frequency	Percent	Valid Percent
Agree	55	47.8	47.8
Disagree	60	52.2	52.2
Total	115	100.0	100.0

Table 4.6 presents the statement that needed the respondents to either agree or disagree that they have engaged in indigenous practices during pregnancy. The study

revealed that 52.2% disagreed, whereas 47.8% agreed to have engaged in indigenous practices. Most of the respondents do not feel free to acknowledge that they use indigenous practices during pregnancy which might have resulted in a larger percentage disagreeing to have engaged in them.

Table 4.7: Indicates the result of the statement on the beliefs in indigenous practices

I believe in indigenous practices			
	Frequency	Percentage	Valid Percentage
Agree	69	60.0	60.0
Disagree	46	40.0	40.0
Total	115	100.0	100.0

Table 4.7 presents the results of the statement on whether the respondents believe in indigenous practices or not. The study results revealed that 60% of women believe in indigenous practices whereas 40% of women do not believe in indigenous practices. Most of the respondents believe in indigenous practices as they use them to protect their pregnancy and childbirth.

Table 4.8: Indicates the result of the statement on whether indigenous practices are good for women during pregnancy

Indigenous practices are good for women during pregnancy			
	Frequency	Percentage	Valid Percentage
Agree	60	52.2	52.2
Disagree	55	47.8	47.8
Total	115	100.0	100.0

A total of 52% of respondents agreed that indigenous practices are good during pregnancy whereas 47.8% disagreed. Indigenous practices were used in the society

to guide people's behaviour, and against taboos also that is why many women agree that they are good for their pregnancy.

Table 4.9: Presents the results of the statement on whether THPs are better than Healthcare professionals

THPs are better than healthcare professionals			
	Frequency	Percentage	Valid Percentage
Agree	43	37.4	37.4
Disagree	72	62.6	62.6
Total	115	100.0	100.0

The respondents were requested to either agree or disagree on a statement that said THPs are better than Healthcare professionals. The results revealed that 62.6% of women disagree that THPs are better than Healthcare professionals whereas 37.4% agree. Most of the respondents are aware that the THPs are not better than the Healthcare professionals but they continue to use their services more than that of the healthcare professionals.

Table 4.10: Presents the results of the statement on whether indigenous practices affect quality care provided by healthcare professionals

Indigenous practices affect quality care provided by healthcare professionals			
	Frequency	Percentage	Valid Percentage
Agree	41	35.7	35.7
Disagree	74	64.3	64.3
Total	115	100.0	100.0

The respondents were requested to either agree or disagree on whether indigenous practices affect quality care provided by health professionals. Most women who account for 64.3% disagree that indigenous practices affect quality care whereas 35.5% agree. The results suggest that most women know that indigenous practices

do not affect the quality care provided by healthcare professionals but according to the researcher some of the indigenous practices e.g. herbal medicines may affect the quality of the care provided by healthcare professionals.

Table 4.11: Indicates results of the statement on whether Healthcare professionals know of indigenous practices

Healthcare professionals have knowledge			
	Frequency	Percentage	Valid Percentage
Agree	56	48.7	48.7
Disagree	59	51.3	51.3
Total	115	100.0	100.0

Table 4.11 presents the results of the respondents who were asked to either agree or disagree on the statement on whether healthcare professionals know of indigenous practices. The study indicates that 51.3% of women disagree that healthcare professionals know of indigenous practices whereas 48.7% agree. Therefore, most women indicated that healthcare professional do not know of indigenous practices and the rationale behind this can be due to the negative attitude, cultural and language differences that most pregnant women complained about.

Table 4.12: Indicates the results of the statement on whether women have used a rope around their waist during pregnancy

I have used a rope around my waist during pregnancy			
	Frequency	Percentage	Valid Percentage
Agree	61	53.0	53.0
Disagree	54	47.0	47.0
Total	115	100.0	100.0

The respondents were asked if they used the rope around their waist during pregnancy and the result shows that 53.0% of women agreed that they used a rope around their

waist during pregnancy while 47.0% disagreed. The use of a rope is still used by most pregnant women either as an instruction from church or THP. The rationale behind this can be to protect their pregnancy against all forms of evil .

Table 4.13: Indicates results of the statement on whether the women received religious instructions from the church during pregnancy

I received religious instructions from the church during pregnancy			
	Frequency	Percentage	Valid Percentage
Agree	64	55.7	55.7
Disagree	51	44.3	44.3
Total	115	100.0	100.0

The study revealed that 55.7% of women agreed that they received religious instructions from their church during pregnancy whereas 44.3% of women disagreed. Most women believe in religious practices and church leaders are regarded as the most principled people in the society, as such they have great influence towards the society.

Table 4.14: Indicates the results of the statement on whether the women have razor cut marks on their abdomen to protect pregnancy

I have razor cut marks on my abdomen to protect my pregnancy			
	Frequency	Percentage	Valid Percentage
Agree	22	19.1	19.1
Disagree	93	80.9	80.9
Total	115	100.0	100.0

The respondents were requested to either agree or disagree on whether the women have razor cut marks on their abdomen to protect pregnancy. The study revealed that

80.9% of women disagree that they have razor cut marks on their abdomen to protect their pregnancy whereas 19.1% agreed. The researcher has noted that most women no longer have razor cut marks on their abdomen and this means that they have realised its negative impact on their pregnancy and childbirth.

Table 4.15: Indicates the results of the statement of restrictions on other food during pregnancy

I have restrictions on other food during pregnancy			
	Frequency	Percentage	Valid Percentage
Agree	65	56.5	56.5
Disagree	50	43.5	43.5
Total	115	100.0	100.0

The respondents were asked if they were restricted on other food during pregnancy, and the results revealed that 56.5% of women agreed that they have been restricted on other food during pregnancy whereas 43.5% of women disagreed. The researcher has noted that most women were restricted from other food during pregnancy which may cause a lack of balanced food with other vitamins that are necessary to maintain the pregnancy.

Table 4.16: Indicates the results of the statement on whether indigenous practices need to be integrated into the healthcare system

Indigenous practices need to be integrated into the healthcare system			
	Frequency	Percentage	Valid Percentage
Agree	70	60.9	60.9
Disagree	45	39.1	39.1
Total	115	100.0	100.0

Table 4.16 presents the result of the respondents who were asked if they agree or disagree that indigenous practices need to be integrated into the healthcare system. The results revealed that 60.9% agreed that indigenous practices need to be integrated into the healthcare system whereas 39.1% disagreed. According to the researcher, it is important to have the integration of indigenous practices into the healthcare system because many people in rural areas follow their cultural belief and adhere to their norms and values.

4.2.3 Section C: Statements directed to women during labour

Table 4.17: Indicates the results of the statement on whether the women have used traditional medicine to assist during their labour

I used traditional medicine to assist during labour			
	Frequency	Percentage	Valid Percentage
Agree	49	42.6	42.6
Disagree	66	57.4	57.4
Total	115	100.0	100.0

Table 4.17 presents the results of women who were requested to either agree or disagree on whether they have used traditional medicine to assist during their labour. The results revealed that 57.4% of women disagreed that they used traditional medicine to assist during their labour, whereas 42.6% agreed. The result suggests that most pregnant women no longer use traditional medicines to assist in labour, because they give birth in hospitals than at home.

Table 4.18: Indicates the results of the statement on whether the women have relied on their religious beliefs to assist during their labour

I relied on my religious belief to assist during labour			
	Frequency	Percent	Valid Percent
Agree	81	70.4	70.4
Disagree	34	29.6	29.6
Total	115	100.0	100.0

Table 4.18 presents the results of respondents who were asked to either agree or disagree that they relied on their religious beliefs to assist during their labour. The results revealed that 70.4% of women agreed that they relied on their religious beliefs to assist during their labour whereas 29.6% disagreed. The rationale behind these results is that most pregnant women believe in religious practices and have trust in their church leaders.

Table 4. 19: Indicates the statement on whether traditional medicines should be used during labour

Traditional medicines should be used during labour			
	Frequency	Percentage	Valid Percentage
Agree	59	51.3	51.3
Disagree	56	48.7	48.7
Total	115	100.0	100.0

The respondents were requested to either agree or disagree on whether traditional medicines should be used during labour. The results revealed that 51.3% agreed that traditional medicines should be used during labour whereas 48.7% disagreed. The researcher has noted that most women agreed to the use of traditional medicine during labour and this indicates that they value and adhere to the instructions of THP.

4.2.4 Section D: Statements directed to women during puerperium period

Table 4.20: Indicate the results of the statement on whether women have used traditional medicines on their neonates

I used traditional medicine on my neonate			
	Frequency	Percentage	Valid Percentage
Agree	48	41.7	41.7
Disagree	67	58.3	58.3
Total	115	100.0	100.0

Table 4.20 presents the results of women who were asked if they have used traditional medicines on their neonates. The results revealed that 58.3% disagreed that they used traditional medicines on their neonate whereas 41.7% agreed. The results suggest that most women do not use traditional medicine on their neonate, and it can be because they are scared of the risks that the child can be exposed to.

Table 4.21: Indicates the results of the statement on whether church rituals are good for neonates

Church rituals are good for neonates			
	Frequency	Percent	Valid Percent
Agree	63	54.8	54.8
Disagree	52	45.2	45.2
Total	115	100.0	100.0

The respondents were requested to either agree or disagree on whether church rituals are good for neonates. The results revealed that 54.8% agreed that church rituals are good for neonate whereas 45.2% of women disagreed. Most women are Christian and believe in church rituals than in THPs.

Table 4.22: Indicates the results of the statement on whether the women have used traditional medicines on their child before

I have used traditional medicine on my child before			
	Frequency	Percent	Valid Percent
Agree	52	45.2	45.2
Disagree	63	54.8	54.8
Total	115	100.0	100.0

Table 4.22 presents the results of the women who were asked whether they have used traditional medicines on their children before. The study revealed that 54.8% of women disagreed that they have used traditional medicine on their child before whereas 45.2% agreed. The result suggests that most women have not used traditional medicine in their children before and it can be because some respondents were pregnant for the first time.

4.3 CONVERGENT OF THE RESULTS

The results of the study were divided into three sections i.e. Pregnancy, Labour, and Puerperium. The results were summarised in table form and discussed in detail below the table.

Quantitative results	**Qualitative results**
Results on Pregnancy	**Results on Pregnancy**
Consultation of THPs and church throughout pregnancy	THPs are not better than healthcare professionals.
THPs are not better than Healthcare professionals.	Several consultations of THPs and church throughout pregnancy.
Most women agreed to the combination of indigenous practices into the healthcare system.	Most women indicated that they visited the church to protect their neonates.
Participants show lack of understanding on traditional medicines.	Most women used a rope around their waist either from THPs or church.
Most women rely on church rituals to protect their neonates.	Only one woman out of 24 interviewed mentioned the use of both ANC and THPs.
Most women agreed that indigenous practices are good for pregnancy.	Lack of knowledge on names of traditional medicines and church rituals.
Most women believe in indigenous practices	The responsibility of using indigenous practices is left on pregnant women only.

4.3.1 Converging results on the utilisation of traditional medicines and church rituals throughout pregnancy

The study revealed results that are converging, the statement on the consultation of THPs and church throughout pregnancy was confirmed by both participants in the quantitative and qualitative sites.

4.3.2 Converging results on whether THPs are better than Healthcare professionals

The researcher identified other results that indicate convergence. Both participants in quantitative and qualitative sites mentioned that THPs are not better than healthcare professionals.

4.3.3 Diverging results on the integration of indigenous practices into the Healthcare system

Most women agreed to the integration of indigenous practices into the healthcare system in a quantitative site but in a qualitative site, only one woman out of 24 interviewed mentioned the use of both ANC and THPs.

4.3.4 Converging results on the use of a rope around the waist to protect the pregnancy

The study indicates results that are converging. Most women used a rope around their waist to protect pregnancy either from THPs or church in both quantitative and qualitative sites.

4.3.5 Converging results on the use of church rituals in protecting the neonates

It was observed in both quantitative and qualitative site that most women rely on church rituals to protect their neonates.

4.3.6 Diverging results on whether indigenous practices are good or bad for pregnancy

Participants in the quantitative reported that indigenous practices are good for pregnancy, but the researcher noted that during interviews some participants mentioned that the responsibility of preparing traditional medicines and church rituals were left on them alone.

4.3.7 Converging results on whether participants believe in indigenous practices

The study results indicate that participants in both quantitative and qualitative sites believe in indigenous practices.

4.3.8 Converging results on whether participants know the names of traditional medicines

The study exposed that most participants have no idea about the names of traditional medicines and church rituals they used.

CHAPTER 5

DISCUSSION OF RESEARCH FINDINGS

5.1 INTRODUCTION

The previous chapter outlined the presentation of results. This chapter discusses the findings of the study. The study aimed to determine indigenous practices of women during pregnancy, labour and puerperium amongst cultural groupings at selected hospitals in Limpopo Province, South Africa. It include the results of both quantitative and qualitative strands.

It is divided into four sections. Section A is Biographic data. Section B is a Statement directed to a woman during pregnancy. Section C is a Statement directed to the women during labour, and Section D is a Statement directed to women during puerperium.

5.2 SECTION A: BIOGRAPHIC DATA

The researcher has identified that most women who participated in the study were between the ages of 21- 30 years and the least participating were between the ages of 12- 20 years. The result of the study indicates that all participants were Africans Belisle, Hennink, Ordóñez, John, Ngubane-Joye, Hampton, Sunpath, Preston-Whyte and Marconi (2015) indicated that up to 80% of the South African population use traditional medicine as a fundamental element of the quality of the health care they offer. The reason behind this could be the fact that most black people stay in rural communities where the study was conducted. Most women who participated in the study were unemployed and few of them were employed. The majority of participants were from rural areas and few were from urban areas. The study conducted by Masango and Nyasse (2015) indicated that traditional medicines are available to almost 80 % of the South African population, predominantly in the rural areas and are sometimes, the only form of treatment that is available. The results of the study designate that most participants in the study were married. The institution of marriage is a rite of passage that marks the development into adulthood and of forming a family. It is also a rite of passage that officially separates individuals from the parental unit to being parents in their own right (Ikamari, 2005). According to Hlatshwayo (2017), every married woman is introduced to the beliefs and practices on pregnancy and

childbirth during the traditional marriage initiation period, one's age represents the quality and quantity of experience and wisdom one holds concerning producing, managing, preserving indigenous knowledge on pregnancy and childbirth.

5.3 SECTION B: FINDINGS ON WOMEN DURING PREGNANCY

The researcher noted that 60% of women in the study believe in indigenous practices and have consulted during their pregnancy. During the interviews, some participants mentioned that sometimes during pregnancy they consult to check the state of their pregnancy. This may indicate that the participants prefer traditional care as compared to western care of attending ANC. The study conducted by Ngomane and Mulaudzi (2010) signposted that indigenous women have beliefs of witchcraft which are a contributing factor to the delay in first attendance of an antenatal clinic. They also mentioned previous studies that confirm that women are expected to attend an antenatal clinic in their eighth week of pregnancy, but they only start visiting a clinic at 26–27 weeks of gestation. Traditional healers are regarded as socially acceptable to communities, as they are of the same culture as the community members and they are usually the first health care providers to be consulted in the case of illness as well as culture-based health problems (Mathibela, Egan, Du Plessis & Potgieter, 2015). It was found that the value given to traditional practices is quite high in Turkey and the reason that the women attach various levels of importance to the traditional practices can be that these practices mentally relieve them (Altuntuğ, Anık & Ege, 2018).

The study revealed results that indicate that 56.5% of participants were restricted from certain food and certain behaviours. For instance, one participant was not allowed to eat eggs and cold food, and another was not allowed to attend funerals as they were considered "hot" place. The study conducted in Kenya also supports this finding as it is indicated that pregnant women are forbidden from attending funerals while the spouse is prohibited from digging the grave. It is believed that some behaviours are infectious and transferable. Therefore, this custom protect the couple and new-born from unworthy ways of the function or that of the deceased (Cheboi, Kimeu & Rucha, 2019). The study conducted in Nigeria by Williams (2019) indicated that contact with the dead or things associated with death could cause spiritual destruction and fetal death. Pregnant women were in a potentially vulnerable state, not just to the spirit but to infectious diseases. Taboo foods were generally avoided for health reasons. Pregnant women avoid some foods because they believe if that food is eaten, it would

cause problems for the mother and the babies during pregnancy or labour. Meanwhile, taboo foods that were avoided for sociocultural reasons are mainly based on the nature of the food (Dianaa, Rachmayanti, Anwar, Khomsan, Christianti, & Kusuma, 2018).

The use of herb ingestion during pregnancy is common in this study, but the participants do not know about the pharmacologically active properties inside it. The study conducted by Mawoza, Nhachi, and Magwali (2019) indicated that various authors have shown that some of the plants used are toxic if used in large doses. The pharmacological effects of some of the agents used, however, have not yet been scientifically evaluated and caution should, therefore, be practiced when some of these plants are being used. In traditional African societies, herbs are used in their raw or cooked forms without subjecting them to laboratory investigations for safety and efficacy. Thus they can cause side effects and interactions (Lawan *et al.*, 2017. Nyeko *et al.* (2016) argue that relying on herbal medicines during pregnancy, instead of scientifically proven treatment can have serious consequences, suggested to include fetal distress and premature deliveries, intrauterine growth restriction and decreased fetal survival, and congenital malformations, among others.

The results of the study indicate that most women believe that indigenous practices are good for their pregnancy, however, they were given the responsibility to prepare the traditional medicines and church rituals alone at home without the supervision of either the THP or church leader. This can pose a risk to pregnant women. Nordeng, Al-Zayadi, Diallo, Ngolo and Paulsen (2013) argues that it is important for THPs to recognised that some plants could have harmful effects for pregnant women, that the effect would vary according to which part of the plant was used, how they were prepared and their administration route, and adapt their recommendations to whether the woman was pregnant or not. Pregnant women in Wayuu indicated that they do not lift heavy stuff, because there is a higher incidence of premature births caused by lifting heavy objects. Although a weight limit for pregnant women does not exist, it is recommended that they do not lift heavy objects (Angarita & Bejarano, 2019). There has been reporting rates to inadequate regulatory supervision, and the widely held belief that herbal medicinal products are natural and hence safe, the prevalence of adverse events and herb-drug interactions associated with herbal medicinal product use is unclear (Muñoz, Stewart, Shetty, Catherine, James, & McLay, 2019).

The study revealed that sometimes pressure and instructions from family members are some of the factors which determine consultations to THPs and church leaders. Different reasons were mentioned for using traditional medicines such as to protect against witchcraft and as an instruction from family or parents. Morris *et al.*, (2014) suggest that educational interventions about pregnancy care should also include female elders, mothers, aunts, and sisters who are traditionally more involved in pregnancy, delivery, and postpartum care. Mawoza, Nhachi, and Magwali (2019) suggest that the use of traditional medicine has been passed down from generation to generation and are perceived to be safer and more efficacious than conventional medicines in pregnancy. Furthermore, the results suggest that family members and friends play a huge role in influencing the use of traditional medicine during pregnancy. This has mainly been attributed to cultural practices that have been passed down from one generation to the next.

The participants indicated that on their initial visits, the THPs and church leaders are the ones preparing the medicines and church rituals first and give them to use. This is supported by Nordeng *et al.* (2013) who indicated that THPs in Mali show pregnant women how to prepare the herbal medicine in a "milder" way or to only administer the herbal medicine dermally or as fumigation instead of oral ingestion. For example, Sarcocephalus latifolius (syn. Nauclea latifolia) was recommended by several THPs against fever, but then as a "milder" water extract of leaves instead of trunk bark. Some participants in the study also emphasized the use of oil for healing. Some received healing and assistance when they were pregnant by being given oil by the prophets for the protection of both the baby and mother. The church can also use objects to administer healing. Women recalled having prayer objects during pregnancy (Kutsira, 2013).

The study results indicate that majority of 51.3% of women disagree that healthcare professionals are knowledgeable about indigenous practices. Ohaja, Murphy-Lawless, and Dunlea (2019) study suggests that there is a need for birth practitioners to be conscious of the religious and spiritual needs of women during pregnancy and birth. Morris *et al.*, (2014) also indicated that negative experiences and lack of trust in facilities are barriers to accessing biomedical care in many countries, so improving the quality of public health care services and rebuilding trust in them is paramount. Indigenous knowledge is an essential part of life in rural communities. This knowledge

has a great impact on how communities understand health, illness, causes of disease, and consequently their care-seeking behaviours. These traditional healthcare practices could be useful or detrimental. Rather than ignoring and condemning it, this knowledge should be explored, strengthened through research and scientific evidence, documented and dispersed, especially to healthcare providers, so that they can be informed about the actual practices in which women engage during pregnancy and childbirth (Montesanti, 2011).

Most of the participants follow instructions from THPs and church leaders without considering the consequences and risks. This usually happens because the pregnant women fear the negative outcome of pregnancy e.g. giving birth through caesarian section. Agus, Horiuchi, and Porter (2012) indicated that women followed traditions even though they did not understand why, and they believed that if they defied the ritual it would harm them. Almost all traditional beliefs and practices identified by women were directed toward the consequences of not adhering to the practices. Kutsira (2013) identified the most important form of healing for the church members of Johanne Marange Church (JMC) which is protection from evil spirits and evil attacks. This is also common in the framework of maternal health. JMC women are protected by the healing practice of the church from evil during pregnancy.

The researcher noted that 55.7% of participants have received religious instruction from the church but do not have a reason for using church rituals. It was mentioned by one of the participants that she used church rituals because at home they are Christians. Healthcare providers should be respectful of a patient’s religious and spiritual needs. Many patient’s anxieties are reduced when they turn to their faith during healthcare challenges. Because many patients turn to their beliefs when difficult healthcare decisions are made, healthcare professionals need to recognise and accommodate patients religious and spiritual needs (Swihart, 2020). Archibong, Enang and Bassey (2017) observed that religious service, fasting, and prayers during clinic days have powerful effects on women psychological outcomes and make their choice of health-seeking for birth yield positive results. The individual feels valued and unique, therefore, decreases the chances of attending or seeking further medicament through modern health care facilities via a government approved clinics and hospitals and Primary Health Centre (PHC) respectively.

The results of the study revealed that 51.3% of women disagree that THPs are better than healthcare professionals, but the researcher noted during the interviews, that some participants visited THPs more frequently than healthcare centres. According to most of the participants, indigenous practices do not affect the quality care provided by healthcare professionals. According to 60.9% of women in the study, indigenous practices need to be integrated into the healthcare system. Religion and spirituality should be merged into the healthcare practitioner's armamentarium of knowledge in communicating with patients. Listening to a patient's beliefs along with how those beliefs are secured to the patient's health can help build and positive relationship between the health practitioner and the patient (Swihart, 2020). Some studies performed in China have confirmed that women feel safer and more at comfort when they can access both traditional and modern medical assistance. Knowledge of traditional beliefs and widely executed social customs will enable the correction of those that can be harmful and will increase the quality of care by recognising harmless rituals with respect and understanding of the patient's beliefs (Işık, Akçınar & Kadıoğlu, 2010). Active communication is essential to culturally competent care. For Aboriginal people to be fully involved in their care, services must be available in Aboriginal languages. The cultural and language differences can lead to miscommunication, misdiagnoses, and unsuitable treatments. It is important to understand non-verbal communication such as tone of voice, nodding of the head, and avoiding eye contact (Birch *et al.*, 2009).

Indigenous women believe in myths and how they affect their pregnancy. According to the results of the study conducted by Angarita and Bejarano (2019), on the Mexican p'urhépecha community, the interviewed indigenous affirmed that during pregnancy they should not carry water, because the child might be born with bruises, which is normally associated with Mongolian spots babies are born with. Pregnant Kalenjin women of Kenya are restricted from killing any animal. The commonly reported animals that should not be killed because of supernatural reasons include dogs, cats, snakes, chicken, and insects. If a snake or these animals go to people's houses especially at night or to the pregnant woman's bed or house, they may not be killed, as it is believed that they personify the spirit of a deceased ancestor or relative, and that have been sent to indicate to the woman that her next child will be born safely (Riang' a, Nangulu & Broerse, 2018).

Indigenous women are aware of the sign and symptoms during pregnancy, labour, and puerperium which may determine consultation to healthcare practitioners, but they choose THPs and church leaders. Various conditions were outlined by participants which lead to them consulting either THPs or church leaders e.g. one participant reported that she consulted for stomach pains. The study conducted by Zamawe, King, Jennings, and Fottrell (2018) postulates that the frequently reported clinical indications for herbal medicine use are nausea and vomiting, labour pain, induction of labour, swollen feet and back pain. On the other hand, the non-clinical motives include poor access to health facilities, cultural beliefs, and practices associated with pregnancy, dissatisfaction with biomedical health systems, and the belief that herbal remedies are relatively safe and effective. Traditional Birth Attendants, mothers-in-law, and older female relatives are important community resource persons whom pregnant women routinely consult throughout pregnancy and childbirth, especially in rural areas. The situation is made particularly challenging by the fact that most informal maternal care providers, especially in the rural areas, have no formal training in maternal care and child delivery, instead, they rely on their traditional knowledge, which is not well known in the literature (Riang' a *et al.*,2018).

Furthermore, other participants confirmed the importance of adherence to traditional medicines so that they do not have a miscarriage. Each activity that participants carry out as instructed by either THPs or church leaders has a consequence outlined so that the participants know what is likely to occur should they not comply. The indigenous woman described the importance of using traditional medicine and strictly following church instructions given by their church leaders. The study conducted by Atekyereza and Mubiru (2014) elaborates that expectant women have to observe certain taboos during the pregnancy period, in the process of preparing for birth, during child delivery, and after birth. It is believed that once these taboos are observed, the health of the mother and child will be assured. Cultural barriers force women to obey traditional practices of childbirth. They, for example, deceive women that pregnancy is a test of endurance and subsequently strength of motherhood. This cultural view also hampers the chances of women seeking professional maternal care. The socio-cultural beliefs that women hold in pregnancy are culturally constructed, reconstructed, and further rooted in taboos, rituals, also practices of their communities.

Consequently, the participants do not know about traditional medicines or church rituals they are using e.g. it was found that participants could not mention or remember the names of the traditional medicines and church rituals given to them. Frazao-Moreira (2016) supports this statement by indicating that the elder members can identify the ailments that the plants can cure, and only healers know which parts of the plants should be used, as well as the specific combinations, preparation, and dosing that apply in each particular circumstance. Some studies have shown that in the United Kingdom, approximately 40% of pregnant women use herbal medicinal products to treat pregnancy-related problems or as nutritional supplements to better pregnancy outcomes (Muñoz et al., 2019).

The practice of a rope around the waist from both THPs and church leaders were reported. Over eighty percent (80.9%) of participants revealed that they have not used razor cut on their abdomen to protect pregnancy however in the qualitative strand the woman indicated that she will use razor cut on her neonate to treat some of the illness that may occur. Karahan *et al.*, (2017) postulate that women attempt to protect themselves from "evil deeds " with several sayings, wearing a talisman, blackening the face, wearing amulets with prayers inside, and carrying various minerals, glass, stones, or seeds and grains, such as black sesame seeds.

5.4 SECTION C: FINDINGS ON WOMEN DURING LABOUR

Only a few participants in the study approved that they used traditional medicines to assist during labour, however, 70.4% of women indicated that they relied on their religious believes to assist in labour. Onuzulike (2008) explains that religion includes the beliefs and practices of the Africans, also how they relate to the natural or supernatural ways that give meaning to life. It informs the way of life of the Africans; it is considered the strongest element in traditional African culture and exerts great influence upon the conduct of the Africans. Nyeko *et al.*, (2016) suggest that the inconsistency in the timing of use of the herbal medicines could be explained by the differences in the perceived desired effects, and the reasons for use at a particular time; socio-cultural variability, belief, as well as differences in the types of herbs used by the different population groups.

The study results revealed that about 51.3% of women agree that traditional medicines should be used during labour. It was also noted that pregnant women in

other countries use traditional medicines to assist in labour. In a study in Zambia, the use of medicinal herbs was believed to accelerate the delivery process, to assist in difficult deliveries, and for body cleansing following a miscarriage (M'soka, Mabuza & Pretorius, 2015). Various herbal remedies are used during the prenatal period to prepare the uterus, cervix for childbirth, relieve the pain during labour, and improve endurance during delivery. The use of herbs during labour is likely to have negative effects on the new-borns and the mothers. This is because several traditional herbs are poisonous and therefore pose danger to the mothers and new-borns (Dika, Dismas & Rumanyika, 2017). The study conducted By Mawoza, Nhachi and Magwali (2019) observed high prevalence of Traditional medicines use in pregnancy and during labour in both studies at Zimbabwe, the reason behind was that Zimbabwean culture and traditions encourage pregnant women to use traditional medicines to either treat pregnancy-related illnesses or to facilitate labour as they are believed to be safe.

5.5 SECTION D: FINDINGS ON WOMEN DURING PUERPERIUM PERIOD

This study elaborates that participants were using traditional medicines during puerperium period, for example, some pregnant woman mentioned that she will continue to use traditional medicines to heal her child on an illness such as *Hlogwana* (when the baby is passing greenish watery stools and has sunken, not pulsating fontanel) if it occurs. It is important to inform pregnant women and their families about the potentially harmful effects of such customs. The use of herbal medicinal products appears to extend into the postnatal period with 31% of breastfeeding women reporting the use of complementary and alternative medicines, including herbal medicinal products, to treat a variety of ailments or to improve milk flow (Muñoz *et al.*, 2019). The study conducted by Bassoumah and Adam (2018) reported the observed practice of applying herbal concoctions to newly born babies, immediately after birth, could be dangerous to the baby's health. Other researchers corroborate that these concoctions may contain harmful substances or contaminants that can cause ill-health to the baby.

Most women who participated in the study still followed some traditional practices and church rituals during pregnancy, and the postpartum period. The researcher has identified that most women have used traditional medicine on their neonate and 54.8% agree that church rituals are good for their neonates. Indigenous women can identify complications, as they were imparted by their THPs to bring their children should they

experience complications. Atekyereza *et al.*, (2014) advocate that since social definitions of pregnancy held by women influence their antenatal care-seeking behaviour. It is important to sensitise women and those who attend to them to understand these social constructs. Since their discernments have an influence on pregnant women, or mothers who seek antenatal care, and postnatal care for better maternal or child health. The health care delivery system needs to critically and strategically determine how the custodians of traditional cultural values which are related to conception and child delivery are integrated to tap into their supplementary role while at the same time containing negative influences from such cultural values. The study conducted by Abdurrahman (2015), indicated that childbirth is highly expected by the community of Kampung Naga, so, the process is received with delightfullness. Welcoming the birth of a baby is conducted through Selamatan (prayer ritual/social unity through a communal feast) as a form of thanksgiving, to Allah who has bestowed a child to a family. When the Selamatan takes place, the neighbours are invited to pray for the new-born baby, giving a name to the baby, and eating meals together. Currently, in Kampung Naga, the birth process is performed by midwives assisted by village traditional midwives (paraji).

CHAPTER 6

SUMMARY, LIMITATIONS, CONCLUSIONS, AND RECOMMENDATIONS

6.1 INTRODUCTION

The previous chapter has discussed the findings of the study. This chapter presents a summary, limitations, conclusions, and recommendations of the study which focused on indigenous practices of women during pregnancy, labour and puerperium amongst cultural groupings at selected hospitals in Limpopo Province, South Africa.

6.2 SUMMARY

6.2.1 The aim of the study

The aim of the study was:

- To determine the indigenous practices of women during pregnancy, labour, and puerperium amongst cultural groupings at the selected hospital in Limpopo Province, South Africa.

6.2.2 Objectives of the Study

The objectives of the study were:

- To explore the indigenous practices of women during pregnancy, labour, and puerperium amongst cultural groupings at selected hospitals in Limpopo Province, South Africa.
- To describe the indigenous practices of women during pregnancy, labour, and puerperium amongst cultural groupings at selected hospitals in Limpopo Province, South Africa.
- To identify the indigenous practices of women during pregnancy, labour, and puerperium amongst cultural groupings at selected hospitals in Limpopo Province, South Africa.

6.2.3 Research question

The research question was: What are the indigenous practices of women during pregnancy, labour, and puerperium amongst cultural groupings at selected hospitals in Limpopo Province, South Africa?

6.2.4 Research Methods and Design

Convergent Parallel Design of Mixed Method Research was used in the study to collect both qualitative and quantitative data at the same time. In this study, the researcher collected and analysed qualitative and quantitative data separately at the same time on women who use the indigenous practices during pregnancy, labour, and puerperium period. The results of qualitative and quantitative strands were compared for either differences or similarities and then interpreted (Creswell, 2014).

In quantitative strand, a self-administered structured questionnaire was used to collect data from pregnant women, those in labour and puerperium. Data were analysed using Statistical Package for the Social Sciences (SPSS) Version 25 with the assistance of the university statistician. In the qualitative strand, data were collected using a semi-structured interview with a guide and analysed using eight Steps of Tesch's inductive, descriptive open coding technique (Creswell, 2014).

6.3 RESEARCH FINDINGS

6.3.1 Qualitative findings

The study found that women use traditional medicines and church rituals during pregnancy, labour, and the puerperium period for many reasons. Themes and sub-themes were developed with the use of independent coders to analyse the data.

6.3.1.1 Theme 1

It is comprised of nine sub-themes where women described different indigenous practices they used during pregnancy, labour, and puerperium. Most women described different reasons for using THPs and church rituals such as for protection against witchcraft, fear of giving birth in caesarian section, etc. Therefore, some women mentioned the importance of adherence and of following a restricted diet. Different activities took place at the THPs and the church, but the responsibility was left with the women-only to carry out the instructions given. The researcher noted that some of the women-only relied on church rituals as they are viewed as important.

Most women mentioned traditional and church rituals that are related to the protection of pregnancy up to puerperium.

6.3.1.2 Theme 2

It has five sub-themes that describe the existing knowledge of women related to a specific care provided by THPs and church leaders. There were lack of knowledge related to the names of the traditional medicines or church rituals used. Thus, some of the women reported that they do not have a specific reason for using indigenous practices and that they were instructed by the elders in their family to use traditional medicines and church rituals. The women confirmed THPs have knowledge related to the treatment of various complications. Indigenous women were taught by their THPs and church leaders to bring their children for the treatment of complications.

6.3.1.3 Theme 3

It has four sub-themes that describe the consequences of not following either the THPs or the church's instructions. Women were aware of the consequences that are likely to happen if they do not follow instructions from THPs or the church. The researcher observed that some of the women use and believe in myths. The researcher observed that most women believe in church rituals without taking into consideration if it yields good or bad results. The THPs and church leaders also described the consequences of not following instructions to encourage compliance.

6.3.1.4 Theme 4

It comprises three sub-themes which describe the factors that determine consultations to THPs and church leaders. Most women mentioned various conditions that lead them to consult at the THPs and the church. Pressure from family was mentioned as one of the factors that determine consultation. Most women are aware of the signs and symptoms during pregnancy, labour, and puerperium which are ought to

determine consultation to the healthcare practitioner, but they choose to consult the THPs and church leaders.

6.3.2 Quantitative findings

It is divided into four sections. Section A is Biographic data. Section B is a statement directed to women during pregnancy. Section C is the statement directed to women during labour and Section D is the statement directed to women during puerperium. The results were obtained from a questionnaire that was completed by 115 respondents during their pregnancy, labour, and puerperium.

6.3.2.1 Section A: Biographic data

The following variables (Age, Ethnic group, Occupation, Settlement, and Marriage) were requested from the participants. The study results revealed that most women who participated were between the ages of 21- 30 years which can be regarded as the childbearing age. The study was conducted in the district hospitals which are situated in the rural areas, where many black people reside. Most pregnant women who reside in rural areas are requested by their husbands or elders in the family to either stop working or work less to avoid complications of pregnancy. Most participants were married, which signpost that one of the norms and values that are set out in the society, and the period where women are imparted about indigenous knowledge.

6.3.2.2 Section B: Findings on women during pregnancy

The study results revealed that 60% of women believe in indigenous practices but only 47.8% agreed to have engaged in them during pregnancy. This demonstrates the adherence to the norms and values of their communities. The respondents were requested to either agree or disagree with the statement that said THPs are better than healthcare professionals and the results revealed that 62.6% of women disagree that THPs are better than healthcare professionals whereas 37.4% agree.

This study has discovered that 52% of the respondents agreed that indigenous practices are good during pregnancy. The respondents were asked if they used a rope around their waist during pregnancy. The result showed that 53.0% of women agreed, to have used a rope around their waist during pregnancy while 47.0% disagreed. The study indicates that 51.3% of women disagree that healthcare professional have knowledge on indigenous practices whereas 48.7% agree.

The study revealed that 55.7% of women agreed that they received religious instructions from the church during pregnancy, whereas 44.3% of women disagreed. Thus about 60.9% of women agreed that indigenous practices need to be integrated into the healthcare system whereas 39.1% disagreed. It was found that 56.5% of women agreed that they have been restricted on other food during pregnancy. The respondents were requested to either agree or disagree on whether the women have razor cut marks on their abdomen to protect their pregnancy. The study revealed that 80.9% of women disagree that they have razor cut marks on their abdomen to protect their pregnancy whereas 19.1% agreed.

6.3.2.3 Section C: Findings on women during labour

The women were requested to either agree or disagree on whether they have used traditional medicine to assist during their labour and the results revealed that 57.4% of women disagreed that they used traditional medicine to assist during their labour whereas 42.6% agreed. The respondents were asked to either agree or disagree that they relied on their religious beliefs to assist during their labour and the results revealed that 70.4% of the women agreed that they relied on their religious beliefs to assist during their labour whereas 29.6% disagreed. It was point out that 51.3% of women agreed that traditional medicines should be used during labour whereas 48.7% disagreed.

6.3.2.4 Section D: Findings on women during puerperium period

The respondents were asked if they have used traditional medicines on their neonate and the results revealed that 58.3% disagreed that they used traditional medicines on their neonate whereas 41.7% agreed. It was ascertained that 54.8% of the respondents agreed that church rituals are good for neonate whereas 45.2% of the women disagreed. The study revealed that 54.8% of the women disagreed that they have used traditional medicine on their child before whereas 45.2% agreed.

6.4 RECOMMENDATIONS

6.4.1 Theme 1

The healthcare professionals should understand the religious needs of pregnant women, those in labour and puerperium so that they can provide holistic care. Nutritious diet should be promoted, and dieticians are ought to be involved during pregnancy, labour, and puerperium period.

6.4.2 Theme 2

THPs and church leaders are obliged to teach their clients and ensure that they know the names and components of the traditional medicines and church rituals they use. Pregnant women should be educated about the effects of herbal medications and the importance of taking guidance from their healthcare providers.

6.4.3 Theme 3

THPs and church leaders should encourage pregnant women to attend ANC and to comply with the treatment prescribed by healthcare professionals. THPs and church leaders should ensure that their rituals do not lead to complications during pregnancy and labour.

6.4.4 Theme 4

The harmful practices such as the use of razor cut on the women's abdomen, and the child's head should be avoided. Educational sessions should be provided during ANC and post-natal checkups. THPs, as well as church leaders from Christianity, are ought to be actively involved in maternal healthcare programmes.

6.5 LIMITATION OF THE STUDY

The study was conducted in four districts of the Limpopo Province, and may not serve as a representative of the entire country. The use of the translator during interviews

may have not being able to describe the idea of the participant as compared to the direct description from the participant herself.

6.6 CONCLUSION

The pregnant women in Limpopo Province, South Africa still use and believe in indigenous practices to protect their pregnancy, labour, and puerperium. The use of razor cut marks on their abdomen seems to be fading away, however, it still used during puerperium on the children. THPs and church leaders are regarded as the most principled people in their community. Pregnant women, those in labour and puerperium should be supported to practice their religious beliefs and practices. This study will assist pregnant women to be aware of the harmful indigenous practices that can affect their health and that of their child. It will also aid the nurses to be able to provide holistic nursing care, taking into consideration the cultures and believes of pregnant women.The researcher recommend that the nursing education should include indigenous practices in the curriculum so, that healthcare practitioners know about the indigenous practices and can serve as assistance in the training and development of health practitioners who continuously care for women during pregnancy, labour, and puerperium and as a result, may reduce maternal and child morbidity and mortality in Limpopo Province, South Africa. The integration of both the THPs and church leaders into the healthcare systems can assist the healthcare professionals in rendering culturally holistic care.

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APPENDIX 1: ETHICS CERTIFICATE TREC (Turfloop Research and Ethics Committee)

University of Limpopo
Department of Research Administration and Development
Private Bag X1106, Sovenga, 0727, South Africa
Tel: (015) 268 3935, Fax: (015) 268 2306, Email: anastasia.ngobe@ul.ac.za

TURFLOOP RESEARCH ETHICS COMMITTEE CLEARANCE CERTIFICATE

MEETING: **27 November 2018**

PROJECT NUMBER: **TREC/236/2018: PG**

PROJECT:

Title: Indigenous Practices of Women During Pregnancy, Labour and Puerperium Amongst Cultural Groupings at Selected Hospitals in Limpopo Province South Africa.
Researcher: AM Seopa
Supervisor: Prof TM Mothiba
Co-Supervisor/s: Mrs MA Bopape
School: Health care sciences
Degree: Master of Nursing

PROF TAB MASHEGO

CHAIRPERSON: TURFLOOP RESEARCH ETHICS COMMITTEE

The Turfloop Research Ethics Committee (TREC) is registered with the National Health Research Ethics Council, Registration Number: **REC-0310111-031**

Note:
i) **Should any departure be contemplated from the research procedure as approved, the researcher(s) must re-submit the protocol to the committee.**
ii) **The budget for the research will be considered separately from the protocol.**
PLEASE QUOTE THE PROTOCOL NUMBER IN ALL ENQUIRIES.

Finding solutions for Africa

APPENDIX 2: LETTERS REQUESTING PERMISSION TO CONDUCT RESEARCH

University of Limpopo (School of Health Care sciences)

Department of Nursing

Private Bag X1106

Sovenga

0727

……………………… 2019

Department of Health

Research and Ethics Committee

Private Bag X908

POLOKWANE

0700

REQUEST FOR PERMISSION TO CONDUCT RESEARCH AT PIETERSBURG, MOKOPANE, LETABA, TSHILIDZINI AND ST RITAS HOSPITAL.

Dear sir/Madam

I (UL student) hereby request to be granted a permission to collect research information on the following topic: Indigenous practices of women during pregnancy, Labour and Puerperium amongst cultural groupings at selected Hospitals in the Limpopo Province South Africa. Information will be collected from all pregnant women and those in labour and puerperium period that uses indigenous practices because they anticipate knowledge on indigenous practices. The indigenous women will be determined by the following characteristics:

- Razor blade cut marks that are observed on the abdomen.
- Traditional herbs brought to pregnant women during admission.

- Ropes that are tied in knots around the waist.
- Yellow egg yolk smeared on the whole abdomen.

The study has been approved by the University of Limpopo. The study will guide the researcher to develop a guideline that integrates indigenous practices into the health system and as a result reduce morbidity and mortality in Limpopo Province South Africa.

Researcher's Signature……………. Date:………..….2019

Cell number…………….

APPENDIX 3: APPROVAL LETTER FROM LIMPOPO DEPARTMENT OF HEALTH

LIMPOPO
PROVINCIAL GOVERNMENT
REPUBLIC OF SOUTH AFRICA

DEPARTMENT OF HEALTH

Ref: LP-201901_003
Enquiries: Stander SS
Tel: 015 293 6650
E-mail : research.limpopo@gmail.com

Seopa AM
University of Limpopo
Private Bag X1106
Sovenga
0727

Greetings,

RE: Indigenous practices of woman during pregnancy, labour and puerperium amongst cultural grouping at selected hospital in Limpopo Province South Africa

1. Permission to conduct the above mentioned study is hereby granted.
2. Kindly be informed that:-
   - Research must be loaded on the NHRD site (http://nhrd.hst.org.za) by the researcher.
   - Further arrangement should be made with the targeted institutions, after consultation with the District Executive Manager.
   - In the course of your study there should be no action that disrupts the services, or incur any cost on the Department.
   - After completion of the study, it is mandatory that the findings should be submitted to the Department to serve as a resource.
   - The researcher should be prepared to assist in the interpretation and implementation of the study recommendation where possible.
   - The above approval is valid for a 1 year period.
   - If the proposal has been amended, a new approval should be sought from the Department of Health.
   - Kindly note, that the Department can withdraw the approval at any time.

Your cooperation will be highly appreciated.

Head of Department

07. 02. 2019
Date

Private Bag X9302 Polokwane
Fidel Castro Ruz House, 18 College Street. Polokwane 0700. Tel: 015 293 6000/12. Fax: 015 293 6211.
Website: http/www.limpopo.gov.za

The heartland of Southern Africa – Development is about people!

APPENDIX 4: CONSENT FORM

University of Limpopo (Turfloop Campus) Consent Form

Statement concerning participation in a research project.

Name of project/study

Indigenous practices of women during Pregnancy, Labour and Puerperium amongst cultural groupings at selected Hospitals in Limpopo Province South Africa.

I have read the information and heard the aims and the objectives of the proposed study and was provided the opportunity to ask questions and given adequate time to rethink the issue. The aim and the objectives of the study are clear to me. I have not been pressurized to participate in any way.

I understand that participation in this clinical trial/study/project is completely voluntary and that I may withdraw from it at any time and without supplying reasons. I know that this study/project has been approved by the Research and Ethics Committee, University of Limpopo and the Limpopo Department of Health. I am fully aware that the results of this study/project will be used for scientific purposes and may be published. I agree to this, provided my privacy is guaranteed.

I hereby give consent to participate in this study/project.

………………………………………………… ……………………………

Name of participant signature

…………………………… ……………………… ……………………………

Place Date Witness

……………………………………………………………………………………………………

Statement by the researcher

I provided verbal and/or written information regarding this study/project. I agree to answer any future questions regarding the study/project to the best of my ability.

I will adhere to the approved protocol.

……………………………… ………………………… …………………..

Name of researcher Signature Date

APPENDIX 5: CERTIFICATE FROM INDEPENDENT CODER

Qualitative data analysis

Master of Nursing

Ms A SEOPA

THIS IS TO CERTIFY THAT:

Professor MS Maputle has co-coded the following qualitative data:

Unstructured one-to-one interviews with pregnant, labour and puerperium women

For the study:

THE INDIGENOUS PRACTICES OF WOMEN DURING PREGNANCY, LABOUR AND PUEPERIUM AMONGST CULTURAL GROUPINGS AT SELECTED HOSPITALS IN LIMPOPO PROVINCE, SOUTH AFRICA

I declare that the candidate and I have reached consensus on the major themes reflected by the data. I further declare that adequate data saturation was achieved as evidenced by repeating themes.

Prof MS Maputle

September 2019

MS Maputle (PhD)

APPENDIX 6: TRANSCRIPT

DATA ANALYSIS

Researcher: Seopa A M

Date: 16 May 2019

Duration: 13 min: 59 sec

Researcher: "Good day mommy, how are you"?

Participant I: "I'm fine and how are you".

Researcher: "I'm fine. My name is Seopa Anikie; I am a Masters student at University of Limpopo, I am also a Professional Nurse. I am doing research on indigenous practises of woman during pregnancy, labour and puerperium amongst cultural groupings at selected hospital in Limpopo Province. I would like for you to describe the indigenous practises that you use as explained. I want to establish the indigenous practices that are a threat to health of women during pregnancy, Labour and puerperium so that we can improve the quality of Maternal and neonatal care.

Participation in this study is voluntary and if you agree to take part you are going to have to sign for me a consent form. Should you wish to withdraw during the interview, you are free to do so but the information you would have provided will be used for the interest of the study. I also have a voice recorder to record our conversation since I cannot write down everything that we will be saying and also to serve as evidence that this information is from participants. This information is confidential, and you will remain anonymous in this interview. I am going to call you participant I. Do you agree to continue with the interview"?

Participant I: "Yes".

Researcher: "What are the indigenous practices that you use during pregnancy, labour and puerperium"?

Participant I: I use the Traditional Healer. When I'm pregnant my mother tells me what not to do.

Researcher: What did she say/

Participant I: She said I should not urinate anywhere in the yard.

Researcher: Did she tell you the reason?

Participant I: She said in order to prevent giving birth by operation. She said I should not kill or slaughter chicken as it can make give birth by operation.

Researcher: You mentioned that you used the Traditional Healer, what did he give you?

Participant I: When my baby was not kicking he gave me an herb called "Matsa". I used it for steam and there after the baby was kicking as normal.

Researcher: How often do you steam?

Participant I: Only when the baby is not kicking. I was also having breast pain and he advised me to take a piece of an aloe tree and cut it into four piece and place it on fire then rub it on the breast to relieve pain.

Researcher: How often do you visit the traditional healer?

Participant I: Sometimes during pregnancy I consult just to check if everything is ok.

Researcher: What other practices does the Traditional Healer do when you are pregnant until you give birth?

Participant I: When I had swollen legs he gave me the medicine called "Motsa". It is prepared by burning it on fire and inhaling its smoke.

Researcher: Kindly explain the practices that you use during labour?

Participant I: At my 9th month, my mother went around the yard where water normally flows and collected the wet soil called "Letaga" and gave me to curse the people I think might be jealous of me and my pregnancy. After the curse you keep the water inside your mouth and face the northern site and spit it out.

During birth because there is lack of ambulance and public transport, I took the stone and carried it on my back to prevent giving birth on my way to the hospital. When I arrived I took it off my back.

Researcher: Are you going to use the Traditional practices on your baby as well?

Participant I: It depends on the illness. If my baby suffers from “Thema” and “Hlogwana” then the Traditional Healer will give me the medicine to heal it.

Researcher: Please explain how will you diagnose the two-illness mentioned earlier?

Participant I: Thema is recognised when the baby cry often and bend the head backward to rub it against the back of the neck. Hlogwana is recognised when the baby passes yellowish stools like fried eggs.

Researcher: Is there medicine that you take during labour?

Participant I: No

Researcher: Are there food that you are not allowed to eat during pregnancy, labour and puerperium?

Participant I: No, I eat foods that are comfortable to my stomach.

Researcher: Thank you for your time.

APPENDIX 7: INTERVIEW GUIDE
SEMI-STRUCTURED INTERVIEW
Introduction

The following steps will be followed during the interview:

The researcher will greet the participant and introduces herself.

Explain the purpose of the study, ethical considerations and the significance of the study to the participant.

Explain the use of voice recorder and what is expected of the participant during the interview.

The participant will sign consent form if s/he agree to participate in the study.

The interview questions

- **Central Question for the indigenous women**

"What are the indigenous practices that you use from pregnancy to puerperium?"

Sepedi: "Ke setjo sefeng seo o se somisago go thoma ole moimana go fihlela o belega"?

Venda: "Nde tshitho tshifhio tshe vha tshisomisa u vha u moimana o swika u tshe beba"?

Tsonga: "E xinto xihi le xi unga xi tirisa o sokela loko o tikele o fikela o beleka"?

Probing questions for the indigenous woman

- Would you please elaborate further on the indigenous practices used from pregnancy to puerperium?

Sepedi: O ka hlalosa go ya pele ka setjo se ose somisago go thoma ole moimana go fihlela o belega?

Venda: Vha nga talotshedza hoya panda naa?

Tsonga: Unga hlamosela kuya emahlweni?

- Can you say a little more about indigenous practices used during pregnancy?

Sepedi: O ka tlaleletsa seo o fetsago go se bolela mabapi le tshomiso ya setjo go thoma ole moimana go fihlela o belega?

Venda: Vhanga tadzisela kha zwine vha kho ubva u fedza u amba zwino?

Tsonga: Unga engetela eka leswi hu hetaka ku swi hlamosela?

- What effects does not using indigenous practice from pregnancy to puerperium have on you?

Sepedi: Ke ditlamorago dife tse di ka hlolago ke gose shomishe setjo go thoma ole moimana go fihlela o belega?

Venda: Ndimaseando itwa afhio ane arali vha saxomisi tshirema moswi vha moimana u swika vha tshibeba?

Tsonga: Kungavhahini swita ndaku loko anga tirisi xi Tsonga loko ari moimana ufika mi vheleka?

- Is it compulsory to use indigenous practices form pregnancy to puerperium?

Sepedi: E kaba ke kgapeletso go somisa setjo go thoma ole moimana go fihlela o belega?

Venda: U ngavha u kombetshedzwa u xomisa tshirema moswi vha moimana u swika vha tshibeba?

Tsonga: Ku ngavha ku fosteriwa ku tirisa Xitsonga loko moimana u fika mi vheleka?

- Kindly describe the indigenous practices that you use from pregnancy to puerperium?

Sepedi: Ka kgopelo hlalosa setjo se o somisago go thoma ole moimana go fihlela o belega?

Venda: Nga khumbelo u nga kona u talutshedza uri vha tshomisa tshirema tshifhiwo moswi vha moimana u swika vha tshibeba?

Tsonga: Hiku kombela uri mitirisa tshitsonga xa njani loko moimana u fika mi vheleka?

- What effects does using indigenous practices form pregnancy to puerperium have on you?

Sepedi: Ke ditlamorago dife tse di ka hlolago ke go somisa setjo go thoma ole moimana go fihlela o belega?

Venda: Ndimaseando itwa afhio ane arali vha xomisa tshirema moswi vha moimana o swika vha tshibeba?

Tsonga: Kungavhahini swita ndaku loko u tirisa Xitsonga loko ari moimana ufika mi vheleka?

- Would you recommend the use of indigenous practises in your future pregnancies?

Sepedi: O ka kgetha go somisa setjo le ka maumo ao a katlago ka moso?

Venda: Vha nga khetha u xomisa tshirema mosi vha tshi dovha moimana ahabe tshi fhinga tshidaho?

Tsonga: Minga swikota uku Langa ku tirisa tshi Tsonga loko naba moimana nkare utako?

APPENDIX 8: STRUCTURED QUESTIONNAIRE

Name of Hospital:

Participant no:

Date:

Section A: Demographic Data

Please answer each question by ticking the appropriate box.

1. Age

12-20	1	21-30	2	>30	3

2. Ethnic Group

African	1	White	2	Coloured	3	Indian	4

3. Occupation

Employed	1	Unemployed	2

4. Settlement

Urban	1	Rural	2

5. Marital Status

Married	1	Single	2

Section B. Statements directed to women during pregnancy.

1. I have engaged in indigenous practices during pregnancy.

Agree	1	Disagree	2

2. I have consulted the Traditional Practitioner throughout my pregnancy.

Agree	1	Disagree	2

3. I believe in indigenous practices.

Agree	1	Disagree	2

4. Indigenous practices are good for women during pregnancy.

Agree	1	Disagree	2

5. Traditional birth attendants are better than Healthcare professionals.

Agree	1	Disagree	2

6. Indigenous practices affect quality of care provided by Healthcare professionals.

Agree	1	Disagree	2

7. Healthcare professionals have knowledge on indigenous practices.

Agree	1	Disagree	2

8. I have used a rope around my waist during pregnancy.

Agree	1	Disagree	2

9. I received religious instructions from the church during pregnancy.

Agree	1	Disagree	2

10. I have razor cut marks on my abdomen to protect my pregnancy.

Agree	1	Disagree	2

11. I have restrictions on other food during pregnancy.

Agree	1	Disagree	2

12. Indigenous practices needs to be integrated into healthcare systems.

Agree	1	Disagree	2

Section C. Statements directed to women during labour.

1. I have used traditional medicine to assist during my previous labour.

Agree	1	Disagree	2

2. I relied on my religious belief to assist during my previous labour.

Agree	1	Disagree	2

3. Traditional medicines should be used during labour.

Agree	1	Disagree	2

Section D. Statements directed to women during puerperium period.

1. I use traditional medicines on my neonate.

Agree	1	Disagree	2

2. Religious medicines are good for neonate.

Agree	1	Disagree	2

3. I have used traditional medicine on my children before.

Agree	1	Disagree	2

APPENDIX 9: Lephephe la dipotsiso tsa sepedi.

Leina la Sepetlele:

Moarabi:

Date:

Ka kgopelo araba potsiso engwe le engwe ka go swaya mo le pokising la maleba.

Karolo A: Seemo sa bodulo

1. Mengwaga

12-20	1	21-30	2	>30	3

2. Mohlobo

Mothomoso	1	Mothomosweu	2	Mocoloured	3	MoIndia	4

3. Moshomo

Kea shoma	1	Gake shome	2

4. Bodulo

Motsesetoropo	1	Motseselegae	2

5. Nyalo

Ke nyetswe	1	A ka nyalwa	2

Karolo B: Mantsu a a lebaneng basadi ba baimana.

1. Ke shomishitse setjo ge kele moimana.

Ke dumela	1	Kea gana	2

2. Ke bone ngaka ya setjo ge kele moimana.

Ke dumela	1	Kea gana	2

3. Ke dumela go setjo.

Ke dumela	1	Kea gana	2

4. Setjo se loketse basadi ba baimana.

Ke dumela	1	Kea gana	2

5. Dingaka tsa setjo di phala tsa maphelo.

Ke dumela	1	Kea gana	2

6. Setjo se paledisa thuso ya bokgwari gotwa go ba tsa maphelo.

Ke dumela	1	Kea gana	2

7. Batho ba tsa maphelo bana le tsebo ya setjo.

Ke dumela	1	Kea gana	2

8. Ke bofile mpa yaka ka thapo(Motlamo) ge kele moimana.

Ke dumela	1	Kea gana	2

9. Ke filwe ditaelo tsa kereke ge kele moimana.

Ke dumela	1	Kea gana	2

10. Ke gailwe ka legare geke le moimana go tshireletsa mpa yaka.

Ke dumela	1	Kea gana	2

11. Kena le dijo tse kese ke dumelelwego go dija geke le moimana.

Ke dumela	1	Kea gana	2

12. Setjo se swanetse go tsenelelana le tsa maphelo.

Ke dumela	1	Kea gana	2

Karolo C: Mantsu a a lebaneng basadi ge ba belega.

1. Ke somisitse dihlare tsa setjo go nthusa go belega.

Ke dumela	1	Kea gana	2

2. Ke holofetse go bodumedi go nthusa go belega.

Ke dumela	1	Kea gana	2

3. Dihlare tsa setjo di swanetse go somisiwa pele ga pelego.

Ke dumela	1	Kea gana	2

Karolo D: Mantsu a a lebaneng basadi ka morago ga pelego.

1. Ke somisa dihlare tsa setjo mo leseyeng laka.

Ke dumela	1	Kea gana	2

2. Dihlare tsa bodumedi di loketse leseya.

Ke dumela	1	Kea gana	2

3. Ke somisitse dihlare tsa setjo mo baneng baka ba pele.

Ke dumela	1	Kea gana	2

APPENDIX 10: Papila ra Swivhutiso yexi Tsonga.

Vito la Xibedlele:

Siku:

Xhienge A: Vuxokoxoko bya vutshamo.

Hlamula xivhutiso xingwane na xingwane hiku marka /u dwajula andeni ka xebokixana

1. Malembe

12-20	1	21-30	2	>30	3

2. Mhlobo

Munhuwantima	1	Mlungu	2	Mocoloured	3	Moindia	4

3. Ntiro

Natira	1	Anitiri	2

4. Tshama

Eshilungwini	1	Matikwashikaya	2

5. Xiyimo xa vukati

Ntekilwe	1	Anitekewana	2

Xhienge B: Marito lama nga langotama na ba basati baba imana.

1. Ne tirisisle ndaboko loko nere moyimane.

Nepfumela	1	Anipfumele	2

2. Ndzibone n'anga ya xinto loko ne tekele

Nepfumela	1	Anipfumele	2

3. Nepfumela e ka xinto.

Nepfumela	1	Anipfumele	2

4. Xinto swe lolamile ka basati ba ko tika.

Nepfumela	1	Anipfumele	2

5. N'anga a xinto e hundza batiri ba rehanyu.

Nepfumela	1	Anipfumele	2

6. Xinto xe tsandekisa pfuneko wankoka wa botomi ho suka ka barehanyu.

Nepfumela	1	Anipfumele	2

7. Vhanu vha swa rihanyu vhana vutivi bya xinto.

Nepfumela	1	Anipfumele	2

8. Nibohile ntambo a nongeni loko nirhi muyimane.

Nepfumela	1	Anipfumele	2

9. Nikume titayilo akerekeni niyari muyimani.

Nepfumela	1	Anipfumele	2

10. Nina mavali a khwirini yashintu kusirelela loko nirhi muyimane.

Nepfumela	1	Anipfumele	2

11. Kuna swakudya swine anifanelangi kuswidya loko nirhi muyimane.

Nepfumela	1	Anipfumele	2

12. Xinto xe fanele o ngenelela e ka swa rihanyu.

Nepfumela	1	Anipfumele	2

Xhienge C: Marito lama nga langotama na ba basati ba ko beleka.

1. Nitirisile murhi wa ndaboko ko nepfuna ko beleka.

Nepfumela	1	Anipfumele	2

2. Ne tshembele repfumelo ko nepfuna ko beleka.

Nepfumela	1	Anipfumele	2

3. Murhi ya xinto e fanele o tira ndzinga se beleka.

Nepfumela	1	Anipfumele	2

Xhienge D: Marito lama nga langotama na ba basati endzako ka ko beleka.

1. Ndzi tirisa murhi wax into e ka n'wana wa mena.

Nepfumela	1	Anipfumele	2

2. Murhi wa re pfumelo o lolamirile e ka n'wana.

Nepfumela	1	Anipfumele	2

3. Ndzi tirisile murhi wa xinto e ka vhana vha mina vho sungula.

Nepfumela	1	Anipfumele	2

APPENDIX 11: Bambiri la Mbudziso dza tshi venda.

Dzina la Sibadela:

Duvha:

Tshipinda tsha A

Ndihombela ore vha fhendule mbodziso egwe na egwe nga u crossa tshe bokising.

1. Mengwaha

12-20	1	21-30	2	>30	3

2. Lushaka

Muthumutsho	1	Muthumotshina	2	Mocoloured	3	Moindia	4

3. Mushumo

Vhaashuma	1	Avhashumi	2

4. Madzulo

Doroboni	1	Mahayani	2

5. Marital status

Milovoriwini		Amilovoriwangi	

Tshipinda tsha B: Maipfy o lebanaho na ba fumakadzi vha vhaimana.

1. Ndo shumisa tshi venda nde moimana.

U tenda	1	U hanedza	2

2. Ndo bona n'anga ya tshi venda nde moimana.

U tenda	1	U hanedza	2

3. Ndo fulufela tshi venda.

U tenda	1	U hanedza	2

4. Tshi venda tsho lugela vha fumakadzi vha vhaimana.

U tenda	1	U hanedza	2

5. N'anga ya tshi venda e phira vha vhu tshilo.

U tenda	1	U hanedza	2

6. Tshi venda tshi kondisa thuso tsha vhude kha zwa vhutshilo.

U tenda	1	U hanedza	2

7. Vha vhutshilo vhane dibo kha zwa tshivenda.

U tenda	1	U hanedza	2

8. Ndo shumisa thambo khunduni dza nga ndi muimana.

U tenda	1	U hanedza	2

9. Ndo wana ndaela kerekeni ndi muimana. Venda.

U tenda	1	U hanedza	2

10. Ndina dzinola kha thumbu u tshireledza thumbu yanga.

U tenda	1	U hanedza	2

11. Ndi na zwiliwa zwine ndisi fanele uzwil,a ndi moimana.

U tenda	1	U hanedza	2

12. Tshi venda tshi fanela u dzhanelela kha zwa vhutsilo.

U tenda	1	U hanedza	2

Tshipinda tsha C: Maipfy o lebanaho na ba fumakadzi vhane vha khouya u beba.

1. Ndo shumisa mishonga ya tshi venda u thusa u beba.

U tenda	1	U hanedza	2

2. Ndo fulufela lutendo ho thusa u beba.

U tenda	1	U hanedza	2

3. Mishonga ya tshi venda e tea o shumiswa satho beba.

U tenda	1	U hanedza	2

Tshipinda tsha D: Maipfy o lebanaho na ba fumakadzi ngamurahu ha u beba.

1. Nde shumisa mishong ya tshi venda kha n'wananga.

U tenda	1	U hanedza	2

2. Mishonga ya tshi venda yo lugela n'wana.

U tenda	1	U hanedza	2

3. Ndo shumisa mishonga ya tshi venda kha vhana bang abo hu thoma.

U tenda	1	U hanedza	2

APPENDIX 12: CERTIFICATE FROM EDITOR

RIGHTMOVE MULTIMEDIA

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28 April 2020

Ms. A.M Seopa
University of Limpopo
0727

To whom it may concern,

This document certifies that the dissertation was professionally edited for Ms. A.M Seopa

This editing certificate is meant to acknowledge that I, Mrs. K.L Malatji, a professional Editor under a registered company RightMove Multimedia, have meticulously edited the Dissertation of Ms. Seopa (200519539) Master in Nursing Science at the University of Limpopo. Entitled: "INDIGENOUS PRACTICES OF WOMEN DURING PREGNANCY, LABOUR AND PUERPERIUM AMONGST CULTURAL GROUPINGS AT SELECTED HOSPITALS IN LIMPOPO PROVINCE SOUTH AFRICA" Thus, I confirm that the readability of this work in question is of a high standard.

Sincerely,
Mrs. K. L Malatji